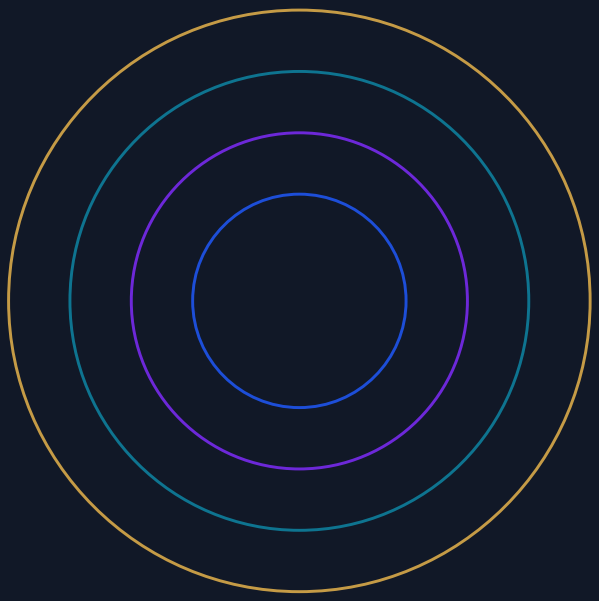
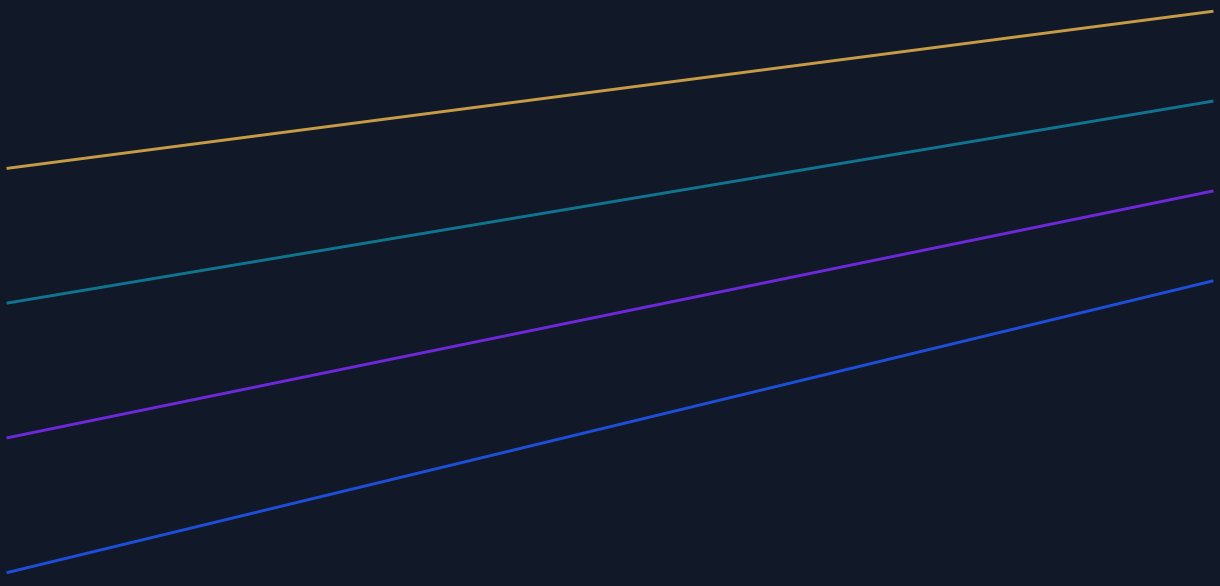
CUMULATIVE CONSCIOUSNESS THERAPY



10-Part / 70-Page-per-Spectrum Application Atlas

A 707-page knowledge-base atlas applying the theory of layered consciousness, neural-physical breadth, negative focus, governance and Meta-Complexity Differentiation to ten highly researched disorder spectra.



Zouhair Moussaif - Cumulative Consciousness and Neuro-Composite Therapy Project

Version 1.0 - Research architecture, clinical hypotheses, KB schema and intervention logic

Clinical Safety Covenant

Status of this document

This atlas is a research and theory-building document. It is not a diagnostic manual, treatment prescription, emergency guide, medication plan, supplement protocol or substitute for licensed clinical care.

How to use it

Use each page as a knowledge-base object: a way to formulate questions, generate hypotheses, design research variables and structure clinical thinking. The established evidence base remains the first safety layer.

Red lines

Acute suicidality, psychosis with danger, mania, severe withdrawal, eating-disorder medical instability, violence, delirium, intoxication, abuse and severe self-neglect require appropriate professional or emergency pathways before theoretical interpretation.

Epistemic humility

The theory can propose mechanisms, but it must earn credibility through prediction, measurement, peer critique, and comparison with simpler explanations. The book repeatedly marks theory claims as experimental.

Master Theory: From Consciousness Layers to Clinic

Container
A container is a temporary organization of perception, body state, emotion, memory, belief, social expectation and action option. A symptom becomes powerful when one container gains too much governance over the whole field.

Cumulative overlay
Consciousness rarely contains one layer only. Fear, desire, shame, bodily signal, memory and intention can coexist. Disorder often appears when coexistence collapses into domination by one narrow layer.

Governance and will
Governance is the ability to rank layers, delay action, tolerate ambiguity, protect long-term values and choose the next act without denying bodily reality. Will is not moral force alone; it is organized degrees of freedom.

Negative focus
Negative focus is the active capacity to avoid falling into a single cognitive attractor. It is not suppression. It is the skill of holding a thought as one possible event without letting it become sovereign.

Neural-physical breadth
Neural-physical breadth is the body-brain capacity to distribute activation across posture, breath, movement, sleep, sensory environment, relational safety and cognition. When breadth narrows, symptoms become sticky.

Operational Lexicon and MCD Metric

MCD-D: Difference-resolution
How precisely the person can distinguish signals: thought versus fact, past versus present, body alarm versus danger, need versus impulse, shame versus responsibility.

MCD-T: Internal time-binding
How well the system binds experience across time: this happened before, this is happening now, this could happen later, and this is not happening yet.

MCD-A: Alternative generation
How many viable possibilities the person can generate under stress. Too few produces rigidity; too many without ranking produces overwhelm, impulsivity or compulsive analysis.

MCD-E: Effective enactment
How well chosen possibilities become action. A person may understand everything and still have low enactment because energy, fear, context or body state blocks movement.

Clinical equation
Distress becomes disorder-like when high load plus rigid salience plus poor time-binding plus low enactment repeatedly shrinks life, relationships, learning and self-governance.

Evidence Backbone and Source Anchors

Nosology anchors
The disorder spectra are organized around contemporary psychiatric classification and clinical descriptions, especially DSM-5-TR and ICD-11 CDDR. These frameworks are used as external maps, not as proof that the new theory is correct.

Care anchors
WHO mhGAP and NICE-style guideline logic are used for safety principles: stepped care, assessment, risk triage, evidence-based interventions, medication by qualified professionals, and referral when danger or complexity exceeds the setting.

Information anchors
NIMH topic pages and other public clinical resources are used only for broad disorder education. This atlas avoids copying diagnostic criteria and avoids pretending to give complete treatment protocols.

Theoretical boundary
All constructs unique to this project - cumulative overlay, negative focus, neural-physical breadth, MCD and governance containers - are proposed as hypotheses. They need operational validation, reliability testing and outcome studies.

Research Program: How the Theory Can Be Tested

Prediction
For each spectrum, the theory must predict patterns in agency, salience, time-binding, body load and relapse that are not already explained by generic distress or symptom severity.

Measurement
Use repeated measures: daily MCD ratings, sleep timing, avoidance counts, functional goals, physiological proxies if available, ecological stressors, medication changes and clinician-rated scales.

Falsification
The model fails when its constructs cannot be rated reliably, do not predict outcomes, do not change with intervention, or add no explanatory value beyond established models.

Ethics
Participants must know the difference between validated care and experimental formulation. The theory should increase access, dignity and precision, never shame people or delay proven treatment.

Table of Contents

Each part is exactly 70 application pages. Front matter occupies pages 1-7.

Part 1 - Neurodevelopmental Spectrum pp. 8-77
ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

Part 2 - Anxiety, Panic and Fear Spectrum pp. 78-147
generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

Part 3 - Obsessive-Compulsive and Repetitive Loop Spectrum pp. 148-217
OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoug...

Part 4 - Trauma, PTSD and Dissociation Spectrum pp. 218-287
PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

Part 5 - Depression, Anhedonia and Burnout Spectrum pp. 288-357
major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grie...

Part 6 - Bipolar and Circadian-Activation Spectrum pp. 358-427
bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

Part 7 - Psychotic and Salience Dysregulation Spectrum pp. 428-497
schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative sym...

Part 8 - Eating, Body-Image and Somatic Control Spectrum pp. 498-567
anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and con...

Part 9 - Substance Use, Craving and Addictive Loop Spectrum pp. 568-637
alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered c...

Part 10 - Personality, Self-Boundary and Relational Regulation Spectrum pp. 638-707
borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dy...

Safety note

This PDF proposes a research architecture. It must not replace diagnosis, emergency care, medication management or psychotherapy by licensed professionals.

01. Nosological bridge

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies language design as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies family system as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies medication interface as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies substance interface as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies research design as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies case formulation as a systems integration problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 1 / 10

ADHD, autism spectrum, executive-function and sensory-motor developmental profiles

CLINICAL FIELD

In the neurodevelopmental spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes ADHD, autism spectrum, executive-function and sensory-motor developmental profiles. Its working profile is developmental variation in attention, sensory gating, social prediction, executive sequencing, motor timing, and environmental fit rather than a simple lack of will or intelligence. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a widened-but-unstable possibility field: many perceptual and action layers are active, while governance has difficulty ranking, sequencing, and protecting one dominant task-layer long enough for completion. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks attention variability, sensory load, transition cost, task initiation, social prediction, sleep, learning history, strengths, masking, family accommodation, and school or work ecology. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Neurodevelopmental Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: externalize time, reduce sensory overload, create cue-rich environments, use strengths-based coaching, train transition rituals, separate attention from self-worth, and coordinate evidence-based clinical care when impairment is high. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: higher MCD-alternative generation with lower enactment stability predicts creative divergence plus impairment under poorly structured environments. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid framing neurodevelopmental difference as laziness; avoid coercive normalization; do not use intense exposure or discipline when sensory overload is the primary driver. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks how relational...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks how identity...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies language design as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks how salience...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies family system as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies medication interface as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies substance interface as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks how inhibition...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies research design as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies case formulation as a systems integration problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks how attention...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 2 / 10

generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation

CLINICAL FIELD

In the anxiety, panic and fear spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes generalized anxiety, panic, phobias, social anxiety and chronic threat anticipation. Its working profile is over-protective threat prediction, safety behavior loops, interoceptive alarm, anticipatory worry and narrowed future simulation. The knowledge-base does not reduce the person to a label; it uses the label as a researched entry point, then asks...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as premature collapse of consciousness into a threat-container: the mind treats one possible danger as if it has already become the governing reality. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks worry chains, avoidance patterns, safety behaviors, panic sensations, intolerance of uncertainty, sleep, caffeine or substances, trauma cues and medical contributors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Anxiety, Panic and Fear Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: map the fear-container, restore uncertainty tolerance, train negative focus, use graded exposure when appropriate, build interoceptive literacy, and separate preparation from compulsive reassurance. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: anxiety severity rises when difference-resolution is high but time-binding is captured by catastrophic futures and enactment is limited to avoidance. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not reinforce reassurance dependence; screen for medical panic mimics and suicidality; exposure must be paced and clinically appropriate. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance.
Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies language design as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies family system as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies medication interface as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies substance interface as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies research design as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies case formulation as a systems integration problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 3 / 10

OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassura...

CLINICAL FIELD

In the obsessive-compulsive and repetitive loop spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes OCD, body-focused repetitive behaviors, hoarding-like accumulation, checking, intrusive taboo thoughts and compulsive reassurance. Its working profile is intrusive salience, doubt inflation, ritualized certainty seeking, mental checking, avoidance and sticky moral or contamination meanings. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as a meta-complexity trap: the system generates too many threat-interpretations but cannot close uncertainty without ritual, so compulsion becomes false governance. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks obsession themes, compulsions, mental rituals, avoidance, reassurance, family accommodation, insight, shame, tic-related patterns and depression risk. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Obsessive-Compulsive and Repetitive Loop Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use exposure and response prevention principles under clinician guidance, preserve uncertainty, interrupt ritual governance, distinguish thought from command, and rebuild value-driven action. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: OCD loops show high difference-detection with impaired negative focus: the person cannot let one possible meaning remain unchosen without compulsive closure. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not debate the obsession content endlessly; do not give repeated certainty; assess self-harm risk when taboo intrusions cause despair. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies language design as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies family system as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies medication interface as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies substance interface as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies research design as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies case formulation as a systems integration problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it uses...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 4 / 10

PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns

CLINICAL FIELD

In the trauma, ptsd and dissociation spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes PTSD, complex trauma, dissociation, shame-based threat memory and attachment trauma patterns. Its working profile is intrusive memory, hyperarousal, avoidance, emotional numbing, threat reactivity, shame, relational vigilance and disrupted identity continuity. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as trauma freezes a past danger-container into present governance: body, memory and identity continue to update as if the unsafe scene is still active. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks trauma exposure, current safety, dissociation, triggers, nightmares, avoidance, shame, attachment injury, substance use, suicidality and medical stabilization needs. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Trauma, PTSD and Dissociation Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: prioritize safety and stabilization, build dual awareness, titrate memory work, restore body ownership, rebuild relational choice, and use evidence-based trauma therapies with qualified clinicians. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: PTSD persists when internal time-binding fails: the nervous system cannot mark the traumatic container as past, so present perception is overwritten by survival memory. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid premature deep trauma processing without stabilization; monitor dissociation, self-harm, domestic violence and psychosis-like symptoms. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance, what alternative...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies language design as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies family system as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies medication interface as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies substance interface as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies research design as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies case formulation as a systems integration problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 5 / 10

major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse

CLINICAL FIELD

In the depression, anhedonia and burnout spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes major depression, persistent depressive disorder, anhedonia, learned helplessness, burnout and grief-related collapse. Its working profile is low mood, reduced reward, slowed agency, rumination, sleep and appetite change, self-criticism, hopelessness and diminished future simulation. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as collapse of possible futures and contraction of self-governance: the person can still perceive difference but cannot convert it into believable action or reward. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks mood, anhedonia, sleep, appetite, guilt, suicidality, medical contributors, bipolar history, grief, social defeat, burnout load and substance use. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Depression, Anhedonia and Burnout Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: restore micro-agency, behavioral activation, social reconnection, anti-rumination design, sleep regulation, meaning reconstruction and appropriate medical/psychological treatment. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: depression reflects low enactment energy plus low teleological credibility: the organism no longer believes that action can change its future state. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: always assess suicide risk; screen for bipolar disorder before antidepressant strategies; do not moralize low energy as weakness. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies language design as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies family system as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies medication interface as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies substance interface as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies research design as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies case formulation as a systems integration problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 6 / 10

bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability

CLINICAL FIELD

In the bipolar and circadian-activation spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes bipolar I, bipolar II, cyclothymic patterns, mixed states, activation instability and circadian vulnerability. Its working profile is episodic mood elevation or depression, sleep sensitivity, reward activation, impulsivity, racing thoughts, mixed agitation and relapse around rhythm disruption. The knowledge-base does not reduce the person to...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as governance bandwidth oscillates: in depression the future collapses; in hypomania or mania too many futures become immediately executable without sufficient inhibition. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks episode history, sleep loss, antidepressant activation, family history, psychosis, mixed features, spending or risk behavior, suicidality and substance triggers. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Bipolar and Circadian-Activation Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: protect sleep and rhythm, build early-warning maps, coordinate psychiatric medication care, reduce activation triggers, preserve relational feedback and design relapse contracts. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: bipolar activation reflects unstable coupling between alternative generation and enactment inhibition, with circadian disruption lowering the threshold for runaway agency. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not treat mania as mere creativity; avoid sleep deprivation; antidepressant monotherapy can be dangerous in bipolar presentations and requires specialist care. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies language design as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies family system as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies medication interface as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies substance interface as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies research design as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies case formulation as a systems integration problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base does not reduce the person to a...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 7 / 10

schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psych...

CLINICAL FIELD

In the psychotic and salience dysregulation spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes schizophrenia spectrum, delusional intensity, hallucinations, paranoia, disorganization, negative symptoms and attenuated psychosis states. Its working profile is aberrant salience, unusual beliefs, perceptual anomalies, suspiciousness, disorganized thought, social withdrawal and impaired reality testing. The knowledge-base...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as meaning-containers lose calibration: internal signals, coincidences and fears may be granted excessive external certainty and begin to govern reality-model construction. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks psychosis symptoms, duration, insight, functioning, mood episodes, substance use, sleep deprivation, medical causes, violence or self-harm risk and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Psychotic and Salience Dysregulation Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: stabilize sleep and safety, reduce stress, support reality testing without humiliation, coordinate antipsychotic and psychosocial care, family work and early-intervention services. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: psychosis emerges when salience assignment exceeds governance verification, causing possible meanings to harden into external certainties before social and sensory calibration. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: do not intensify metaphysical interpretation during active psychosis; avoid validating delusions as facts; urgent care is needed for command hallucinations or high risk. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies language design as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies family system as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies medication interface as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies substance interface as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies research design as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies case formulation as a systems integration problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 8 / 10

anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns

CLINICAL FIELD

In the eating, body-image and somatic control spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes anorexia nervosa, bulimia nervosa, binge eating, ARFID-like restriction, body-image distress and control-based eating patterns. Its working profile is disturbed eating patterns, body image overvaluation, control loops, interoceptive confusion, shame, binge-purge cycles and medical risk. The knowledge-base does not reduce the person...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the body becomes the dominant control-container: eating, shape or weight is used to govern uncertainty, identity, emotion or relational safety. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks weight trajectory, restriction, bingeing, purging, exercise, medical instability, body image, sensory food aversion, trauma, perfectionism and family context. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Eating, Body-Image and Somatic Control Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: medical safety first, nutritional rehabilitation, CBT-E or family-based principles where suitable, interoceptive repair, shame reduction and value beyond body-control. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: severity rises when body-control becomes the only reliable enactment channel for agency, while broader life-governance feels uncertain or impossible. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: eating disorders can be medically dangerous; avoid weight-loss framing; do not prescribe restrictive rules; urgent medical care is needed for instability. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies language design as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies family system as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies medication interface as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies substance interface as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies research design as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the person to a label; it...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies case formulation as a systems integration problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 9 / 10

alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops

CLINICAL FIELD

In the substance use, craving and addictive loop spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes alcohol, nicotine, cannabis, stimulants, sedatives, opioids, behavioral addictions and cue-triggered compulsive reward loops. Its working profile is craving, tolerance, withdrawal, cue-reactivity, habit loops, relief-seeking, narrowed reward systems and identity conflicts around control. The knowledge-base does not reduce the...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as the substance becomes an outsourced governance technology: it rapidly changes state when internal self-regulation cannot shift arousal, pain or meaning fast enough. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks substance pattern, withdrawal risk, triggers, co-occurring disorders, trauma, sleep, social network, medical risk, motivation, harm and protective factors. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost, rigidity and loss of freedom matters.

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Substance Use, Craving and Addictive Loop Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: use harm reduction and evidence-based addiction care, build craving maps, replace state-shift rituals, strengthen delay capacity, treat comorbidity and design relapse learning systems. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: addiction persists when a fast external state-switch repeatedly outcompetes slower internal governance learning, especially under stress or emptiness. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: withdrawal from alcohol, benzodiazepines or opioids can be medically dangerous; avoid moralizing relapse; coordinate professional support and medication options where indicated. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

01. Nosological bridge

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies nosological bridge as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. How DSM/ICD categories are used only as a map, while the theory studies the dynamic system beneath the label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=01; focus=Nosological bridge; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

02. Phenotype compression

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies phenotype compression as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The visible syndrome is compressed into a few repeating control problems: salience, time, body, relation and action. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=02; focus=Phenotype compression; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

03. Developmental history

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies developmental history as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Early learning, body constraints and social feedback shape which containers become dominant under stress. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=03; focus=Developmental history; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

04. Biological substrate

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies biological substrate as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The theory remains compatible with genetics, neurodevelopment, neurotransmission, inflammation, sleep and endocrine stress without reducing personhood to biology. The central clinical question becomes: which container has captured governance, what alternative containers remain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=04; focus=Biological substrate; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

05. Predictive processing lens

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies predictive processing lens as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Symptoms are treated as costly predictions that keep winning because they feel safer or more certain than alternatives. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=05; focus=Predictive processing lens; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

06. Attention architecture

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies attention architecture as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Attention is mapped as a scarce governance beam that can be captured, split, widened or protected. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=06; focus=Attention architecture; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

07. Salience economics

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies salience economics as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The mind pays salience to what it believes is urgent; disorder often begins when urgency becomes mispriced. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=07; focus=Salience economics; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

08. Interoceptive coupling

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies interoceptive coupling as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Body signals become evidence for fear, identity, control, reward or threat depending on the active container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=08; focus=Interoceptive coupling; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

09. Affective granularity

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies affective granularity as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Treatment must increase emotional precision, not merely reduce emotion. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=09; focus=Affective granularity; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

10. Memory binding

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies memory binding as a orientation and clinical mapping problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The past becomes clinical when memory governs the present instead of informing it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=10; focus=Memory binding; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

11. Internal time

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies internal time as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Symptoms often distort the relation between now, before, next and never. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=11; focus=Internal time; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

12. Agency bandwidth

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies agency bandwidth as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Agency is measured as how many viable actions remain available under load. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=12; focus=Agency bandwidth; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

13. Negative focus

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies negative focus as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Negative focus means not falling into a single thought-loop; it is active non-collapse, not suppression. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=13; focus=Negative focus; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

14. MCD metric

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies mcd metric as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Meta-Complexity Differentiation tracks difference-resolution, time-binding, alternative generation and enactment. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=14; focus=MCD metric; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

15. Governance layer

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies governance layer as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Governance is the capacity to rank competing layers without denying any one layer exists. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=15; focus=Governance layer; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

16. Teleology layer

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies teleology layer as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. A person needs a believable why; symptom reduction alone may not restore direction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=16; focus=Teleology layer; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

17. Cognitive loop map

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies cognitive loop map as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The theory diagrams the loop from trigger to meaning to body to action to confirmation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=17; focus=Cognitive loop map; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

18. Somatic loop map

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies somatic loop map as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The body is not a side effect; it is a co-author of the symptom container. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=18; focus=Somatic loop map; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

19. Relational loop map

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies relational loop map as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Other people can become threat, mirror, regulator, judge, rescuer or arena. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=19; focus=Relational loop map; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

20. Environmental ecology

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies environmental ecology as a mechanism construction problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Symptoms worsen when the environment repeatedly rewards the disorder-loop. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=20; focus=Environmental ecology; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

21. Comorbidity logic

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies comorbidity logic as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Comorbidity is not noise; it often reveals shared collapse points across systems. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=21; focus=Comorbidity logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

22. Differential diagnosis

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies differential diagnosis as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The same surface behavior can arise from different governance failures. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=22; focus=Differential diagnosis; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

23. Risk stratification

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies risk stratification as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The first clinical question is safety: suicide, self-harm, violence, neglect, medical instability or psychosis. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=23; focus=Risk stratification; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

24. Stabilization layer

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies stabilization layer as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Before transformation, the system may need sleep, food, safety, medication review and predictable routines. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=24; focus=Stabilization layer; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

25. Mapping session

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies mapping session as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The clinician or researcher maps containers before trying to change them. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=25; focus=Mapping session; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

26. Trigger taxonomy

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies trigger taxonomy as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Triggers are classified as sensory, cognitive, relational, bodily, temporal, moral and existential. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=26; focus=Trigger taxonomy; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

27. Meaning audit

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies meaning audit as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The symptom is asked: what problem are you trying to solve, and what price do you charge? The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=27; focus=Meaning audit; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

28. Avoidance audit

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies avoidance audit as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Avoidance may protect short term survival while shrinking long term agency. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=28; focus=Avoidance audit; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

29. Safety behavior audit

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies safety behavior audit as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Safety behaviors are tested for whether they restore life or maintain the trap. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=29; focus=Safety behavior audit; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

30. Reassurance economy

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies reassurance economy as a assessment and differential formulation problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Repeated reassurance can become a drug of certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial, compulsion or collapse?

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=30; focus=Reassurance economy; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

31. Exposure logic

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies exposure logic as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Exposure is reframed as governed contact with the feared container without compulsive collapse. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=31; focus=Exposure logic; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

32. Behavioral activation

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies behavioral activation as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Action can precede belief when the governance system is too depleted to feel motivation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=32; focus=Behavioral activation; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

33. Cognitive restructuring

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies cognitive restructuring as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Thought work is useful when it increases degrees of freedom, not when it becomes endless debate. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=33; focus=Cognitive restructuring; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

34. Metacognitive training

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies metacognitive training as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The person learns to see a thought as an event inside consciousness, not the sovereign of consciousness. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=34; focus=Metacognitive training; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

35. Body regulation

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies body regulation as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Breath, posture, movement and sleep are treated as state-governance levers. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=35; focus=Body regulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

36. Social repair

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies social repair as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Relational repair is a nervous-system intervention, not only a moral conversation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=36; focus=Social repair; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

37. Values reconstruction

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies values reconstruction as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Values are used to choose between containers when all options contain discomfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=37; focus=Values reconstruction; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

38. Identity continuity

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies identity continuity as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Recovery requires a self that can survive state changes without becoming each state. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=38; focus=Identity continuity; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

39. Language design

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies language design as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The words used in therapy either widen or imprison the field. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=39; focus=Language design; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

40. Psychoeducation

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies psychoeducation as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Education is not information dumping; it is a new map that reduces shame and increases choice. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=40; focus=Psychoeducation; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

41. Skills ladder

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies skills ladder as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Skills are sequenced from state stabilization to choice expansion to meaning integration. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=41; focus=Skills ladder; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

42. Measurement ladder

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies measurement ladder as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Outcomes must include symptoms, function, agency, body load, relationship quality and relapse resilience. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=42; focus=Measurement ladder; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

43. Digital tool design

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies digital tool design as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Apps and AI tools can support mapping, reminders and measurement, but cannot replace qualified care. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=43; focus=Digital tool design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

44. Family system

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies family system as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Families can reduce accommodation, increase safety and avoid turning symptoms into identity labels. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=44; focus=Family system; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

45. School/work adaptation

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies school/work adaptation as a intervention architecture problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Reasonable adjustments can turn impairment into manageable difference. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=45; focus=School/work adaptation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

46. Medication interface

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies medication interface as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Medication is framed as state-window support; prescribing belongs to qualified clinicians. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=46; focus=Medication interface; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

47. Substance interface

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies substance interface as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Substances can mimic treatment by producing rapid state change while weakening endogenous governance learning. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=47; focus=Substance interface; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

48. Sleep interface

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies sleep interface as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Sleep is treated as the nightly re-indexing of containers, salience and emotional memory. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=48; focus=Sleep interface; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

49. Nutrition interface

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies nutrition interface as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Nutrition is handled as basic biological support, not as magical cure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=49; focus=Nutrition interface; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

50. Exercise and movement

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies exercise and movement as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Movement expands bodily degrees of freedom and interrupts frozen loops. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=50; focus=Exercise and movement; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

51. Spiritual/existential layer

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies spiritual/existential layer as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Existential meaning can support recovery when it increases humility, agency and compassion rather than delusional certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=51; focus=Spiritual/existential layer; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

52. Culture and stigma

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies culture and stigma as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Culture shapes symptom meaning, help-seeking, shame and family interpretation. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=52; focus=Culture and stigma; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

53. Research design

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies research design as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The theory must generate falsifiable hypotheses and measurable predictions. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=53; focus=Research design; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

54. Biomarker ideas

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies biomarker ideas as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Possible biomarkers are framed as exploratory: sleep regularity, HRV, reaction time, language entropy and behavioral variability. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=54; focus=Biomarker ideas; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

55. Case formulation

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies case formulation as a systems integration problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. A case is written as a dynamic map, not as a frozen label. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=55; focus=Case formulation; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

56. Micro-intervention

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies micro-intervention as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. A small intervention is designed to weaken one loop without destabilizing the whole person. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=56; focus=Micro-intervention; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

57. Macro-intervention

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies macro-intervention as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. A macro plan redesigns environment, identity, relationships and long-term purpose. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=57; focus=Macro-intervention; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

58. Relapse model

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies relapse model as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Relapse is studied as a return of old governance under load, not as moral failure. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=58; focus=Relapse model; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

59. Failure mode

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies failure mode as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Every theory needs a map of how it can harm when misused. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=59; focus=Failure mode; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

60. Ethics and consent

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies ethics and consent as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The person must understand what is experimental, established, optional and risky. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=60; focus=Ethics and consent; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

61. Clinician stance

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies clinician stance as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through container and negative focus. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The stance is precise, humble, non-shaming, trauma-aware and reality-based. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=61; focus=Clinician stance; constructs=container, negative focus; primary dimension=salience; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

62. Data schema

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies data schema as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through cumulative overlay and neural-physical breadth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The knowledge base stores observations as containers, loops, triggers, interventions and outcomes. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=62; focus=Data schema; constructs=cumulative overlay, neural-physical breadth; primary dimension=body state; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

63. Algorithmic triage

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies algorithmic triage as a research and implementation design problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through governance and salience pricing. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Decision support must prioritize danger signals and referral thresholds before elegance. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=63; focus=Algorithmic triage; constructs=governance, salience pricing; primary dimension=time-binding; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

64. Training curriculum

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies training curriculum as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through negative focus and internal time. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Practitioners learn the model by mapping cases, testing hypotheses and receiving supervision. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=64; focus=Training curriculum; constructs=negative focus, internal time; primary dimension=relational context; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

65. Outcome dashboard

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies outcome dashboard as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through neural-physical breadth and teleology. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. A dashboard shows symptom intensity, agency, avoidance, sleep, social function and meaning traction. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=65; focus=Outcome dashboard; constructs=neural-physical breadth, teleology; primary dimension=attention; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

66. Contraindications

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies contraindications as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through salience pricing and agency bandwidth. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Some methods should pause during mania, psychosis, intoxication, medical instability or unsafe environments. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=66; focus=Contraindications; constructs=salience pricing, agency bandwidth; primary dimension=identity; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

67. Integration with CBT/DBT

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies integration with cbt/dbt as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through internal time and MCD. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. Existing therapies are integrated as tools inside a broader governance model, not replaced by slogans. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=67; focus=Integration with CBT/DBT; constructs=internal time, MCD; primary dimension=reward; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

68. Integration with neuroscience

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies integration with neuroscience as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through teleology and container. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The model remains translational: brain mechanisms inspire hypotheses but do not pretend certainty. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=68; focus=Integration with neuroscience; constructs=teleology, container; primary dimension=inhibition; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

69. Long-term mastery

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies long-term mastery as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation...

THEORY TRANSLATION

The theory reads the syndrome through agency bandwidth and cumulative overlay. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The final goal is flexible self-governance across changing states, not permanent emotional comfort. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=69; focus=Long-term mastery; constructs=agency bandwidth, cumulative overlay; primary dimension=meaning; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.

70. Open questions

Part 10 / 10

borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relat...

CLINICAL FIELD

In the personality, self-boundary and relational regulation spectrum, this page studies open questions as a failure analysis and mastery problem. The spectrum includes borderline, narcissistic, avoidant, dependent, obsessive-compulsive personality traits, attachment dysregulation and chronic relational self-instability. Its working profile is stable-yet-maladaptive patterns in self-image, emotion regulation, attachment, interpersonal expectation, defense...

THEORY TRANSLATION

The theory reads the syndrome through MCD and governance. Here the disorder is modeled as self-containers and relational containers remain fused or brittle: the person cannot flexibly hold self, other, past wound and present choice in the same governed field. The chapter ends by naming what could break the model and how to test it. The central clinical question becomes: which container has captured governance, what alternative containers remain available, and how can the person regain enough breadth to choose without denial...

ASSESSMENT LENS

Assessment tracks identity continuity, attachment triggers, emotion storms, impulsivity, self-harm, interpersonal cycles, empathy, boundaries, trauma history and functional impairment. In MCD language, record D for difference-resolution, T for internal time-binding, A for alternatives generated, and E for effective enactment. Also score load signals: sleep disruption, social cost, avoidance, bodily arousal, shame, functional impairment and safety risk. A high score is not automatically pathology; the pattern of cost...

KNOWLEDGE-BASE OBJECT

KB tags: spectrum=Personality, Self-Boundary and Relational Regulation Spectrum; page=70; focus=Open questions; constructs=MCD, governance; primary dimension=enactment; source anchor=DSM/ICD/WHO/NICE/NIMH.

APPLICATION PROTOCOL

A practical application begins with safety and stabilization, then draws the trigger-to-container loop. The practitioner identifies the state shift, names the governing meaning, tests whether the behavior expands or narrows life, and introduces one small experiment. For this spectrum the main intervention direction is: DBT, MBT, schema and psychodynamic principles may help; train self-other differentiation, rupture repair, boundary rituals, delayed reaction and values-based identity continuity. The experiment must be measurable, paced and reversible.

RESEARCH HYPOTHESIS

Hypothesis for this page: relational dysregulation reflects weak meta-containment: the person cannot keep multiple models of self and other active without collapsing into threat, fusion or defense. Operationalization: compare baseline MCD patterns with symptom intensity, ecological stress, sleep regularity and functional outcome over repeated daily observations. The theory is strengthened only if it predicts changes beyond generic distress; it is weakened if simpler models explain the same data better.

FAILURE AND SAFETY BOUNDARY

Boundary condition: avoid blame labels; manage self-harm risk; therapy requires consistency, boundaries and crisis planning; coercive confrontation can worsen shame or rupture. The theory must never become a grand explanation that ignores medical assessment, social danger or established care. When risk is acute, the correct move is not deeper interpretation but escalation to appropriate clinical or emergency support.

MCD MICRO-SCORE TEMPLATE

D: difference-resolution | T: internal time-binding | A: alternatives generated | E: enactment | Load: sleep/body/shame/social risk | Output: one reversible experiment.