Extending the Core Emotion Framework: A Structural-Constructivist Model for Obsessive-Compulsive Disorder (OCD)

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Abstract

This manuscript extends the **Core Emotion Framework (CEF)**—a novel structural-constructivist model of emotional regulation—to define the unique structural fingerprint of *Obsessive-Compulsive Disorder* (OCD). The CEF dissects OCD pathology across three functional centers (Head, Heart, and Gut). The analysis reveals that the disorder's transdiagnostic signature is the systemic outsourcing of cognitive function to action. This mechanism arises from the failure of the Head Center's Calculating primer (manifesting as *Intolerance of Uncertainty*), which bypasses affective integration and pathologically activates the Gut Center's *Arranging* primer to manufacture certainty via compulsive ritual.

The structural alignment of these deficits directly indexes them to evidence-based treatments: the rigid *Arranging* deficit to *Exposure and Response Prevention* (ERP) [1], the suppression of *Accepting* to *Acceptance and Commitment Therapy* (ACT) [3], and the *Calculating* deficit to *Cognitive Behavioral Therapy* (CBT).[5] By providing a precise, mechanism-based roadmap, this extension of the CEF aims to enforce scientific rigor in treatment selection and advance personalized therapeutic approaches.

I. Introduction: The Transdiagnostic Imperative and Structural Affective Modeling

A. The Limitations of Symptom-Based Diagnostics

The contemporary challenge in mental health intervention resides in shifting the diagnostic and therapeutic paradigm from descriptive, symptom-based classifications toward mechanism-targeted treatments. Current diagnostic approaches, while useful for standardization, often fail to delineate the functional failures underpinning varied clinical presentations, thus limiting the potential for scientific rigor in treatment selection. Affective science recognizes that emotions are complex and multifaceted phenomena, involving coordinated modifications across the mind, body, and behavior.[7] Consequently, *emotional dysregulation* is recognized as a core, transdiagnostic component across a wide spectrum of psychological conditions, including major depressive disorder, anxiety disorders, personality disorders, and Obsessive-Compulsive Disorder (OCD).

For any therapeutic framework to possess robust transdiagnostic utility, it must move beyond superficial convergence—such as the presence of experiential avoidance across both anxiety disorders and OCD—to specify the unique, underlying structural failures that distinguish one pathology from the next. The Core Emotion Framework (CEF) is a proposed structural-constructivist model designed to address this integrative gap, offering a systematic taxonomy of emotional regulation deficits across foundational operational components, termed "primers". The validation of this framework requires demonstrating that distinct psychiatric syndromes are rooted in unique patterns of primer failures and entanglements.

B. Defining the Structural-Constructivist Paradigm in Affective Science

The theoretical foundation of the CEF is explicitly structural-constructivist, focusing on psychological operations or functional components (primers) rather than static emotional states. This metatheoretical perspective embraces diverse traditions in philosophy and psychology, emphasizing complex cycles in the natural ordering and reorganizing processes characteristic of all developing living systems.[8]

This approach aligns fundamentally with modern affective science, particularly constructionist theories which posit that emotions are conceptual categorizations constructed from basic affective dimensions, such as valence and arousal, which are subsequently integrated with interoception and cognitive

processes.[9] Neuroscientific approaches have increasingly moved away from viewing emotions solely as discrete, modular entities, instead utilizing multivariate, data-driven methods to decompose affective experience into functional core processes or components.[7] These components are linked to brain networks that code for processes such as valuation appraisal, hedonic experience, novelty detection, goal-relevance assessment, and approach/avoidance tendencies.[7] The structural-constructivist methodology employed by the CEF, focusing on ten functional operational components (primers) distributed across three centers (Head, Heart, Gut), is therefore supported by the literature that prioritizes the networked coordination of these component processes to construct psychological experience.[7]

C. Overview of the Core Emotion Framework (CEF) Ontology

The CEF organizes emotional regulation deficits across three functional centers: the Head (Cognition), the Heart (Feeling/Affective Processes), and the Gut (Action/Embodied Response). This tripartite structure operationalizes the complex construction of emotional experience by ensuring the integration of cognitive appraisal, feeling states, and corresponding behavioral outputs and action readiness systems.[7] The framework is designed to incorporate basic neurobiological mechanisms, recognizing that emotional processing requires the inclusion of somatic and behavioral components—a principle evidenced by the need to structurally justify therapeutic strategies that incorporate behavioral interventions alongside cognitive work, particularly in disorders like OCD.

This report verifies the core claims of extending the CEF to model the unique structural fingerprint of Obsessive-Compulsive Disorder. The focus is to confirm the mechanistic alignment of the proposed primer deficits (e.g., Calculating failure, Arranging rigidity, Accepting suppression) with contemporary neurocognitive research and the established mechanisms of evidence-based treatments (EBTs).

II. The Structural Logic of OCD: Cognitive Vulnerability and Action Rigidity

OCD pathology can be systematically decomposed into a specific cascade of structural deficits across the three functional centers, defining a complex pathological cycle sustained by the failure of several key adaptive functions.

A. Head Center Failure: The Calculating Deficit and Intolerance of Uncertainty (IU)

The cognitive component of OCD—obsessions—is characterized by intrusive, unwanted thoughts, images, or urges. The perpetuation of these obsessions and the subsequent drive toward compulsions suggest fundamental structural deficits within the Head Center's operational primers.

The adaptive function of the Calculating primer (located in the Head Center, Reflecting mode) is to facilitate analytical data processing, encouraging objective viewing through a rational lens detached from immediate sensitive experience. In OCD, the failure of Calculating manifests pathologically as Intolerance of Uncertainty (IU). IU is defined empirically as the tendency of an individual to consider the possibility of a negative event occurring unacceptable, irrespective of the probability of its occurrence.[10] Individuals high on IU find uncertainty upsetting and stressful, believe it is negative and should be avoided, and perceive being uncertain as unfair, often feeling it leads to an inability to act.[11]

Empirical findings robustly confirm IU as a core cognitive vulnerability in OCD. The construct is highly associated with OCD symptoms, is stable and trait-like, and functions as a causal risk factor influencing the development of the disorder.[12] Specifically, research suggests that the *time-invariant* component of IU is strongly associated with OCD symptoms, even when controlling for depression.[12] This finding reinforces the structural claim that the Calculating deficit represents a stable, underlying structural vulnerability—a fixed "structural fingerprint"—rather than merely a transient fluctuation in state. The pathological expression of a compromised Calculating primer is its inability to engage rational detachment, necessitating absolute certainty and driving a desperate search for data or resolution that is inherently unattainable. This deficit transforms complex, ambiguous reality into a binary, urgent threat.

The associated failure of the Deciding primer (Head, Balancing mode) exacerbates this rigidity. The adaptive role of Deciding is to establish commitment based on balanced, nuanced information. When the Calculating primer is crippled by IU, it fails to provide the objective data necessary for balanced decision-making. Consequently, Deciding is structurally forced into binary, rigid commitments, contributing to the characteristic dichotomous, all-or-nothing thinking observed in OCD.

B. The Compulsive Mechanism: Outsourcing Cognitive Distress to Action

The highest-level operational deviation in OCD is the structural signature involving the systemic outsourcing of cognitive function to action. Because the Head Center's Calculating primer fails to

produce the necessary certainty (Intolerance of Uncertainty), the system bypasses normal affective integration channels (Heart Center) and directly triggers the Gut Center's action domain.

This mechanism is verified by the established cognitive-behavioral models of OCD, which rely on the principle of negative reinforcement.[13] The functional relationship between the obsession and the compulsion is a self-maintained "vicious cycle" where the compulsion serves to temporarily reduce the distress or anxiety associated with the obsession.[13] By achieving momentary relief, the behavior is strengthened and becomes more likely to be enacted in the future.[14]

Structurally, the compulsive ritual is an attempt to use rigid action (Gut Center) to solve an unsolvable cognitive deficit (the Calculating failure in the Head Center). The Arranging primer is pathologically engaged to *physically* or *mentally* construct an external manifestation of order or certainty, compensating for the profound internal chaos and cognitive distress generated by IU. This structural deviation—using rigid action to resolve a cognitive deficit—is the unique transdiagnostic fingerprint differentiating OCD from generalized anxiety disorders.

C. Arranging and Boosting Rigidity: The Architecture of Compulsion

The defining characteristic of OCD—the compulsion—is structuralized exclusively within the Gut Center, which governs Action and Embodied Response.

The Arranging primer (Gut, Outgoing mode) normally provides organizational structure and adaptive order creation. In OCD, this primer becomes pathologically fixed, manifesting in rituals such as ordering, cleaning, repeating, and checking. The compulsion is the Arranging primer demanding perfect, externally enforced order in response to the internal cognitive distress. This maladaptive Arranging attempts to structurally resolve the ambiguity created by the failed Calculating primer, but because the action provides only temporary relief and can never truly satisfy the cognitive demand for absolute certainty, the ritual is perpetually repeated and reinforced.

The repetitive, effortful nature of these compulsive rituals is structurally accounted for by a dysfunctional activation of the Boosting primer (Gut, Balancing ‘On’ mode). Boosting represents focused diligence and the essential energy required to drive action. In OCD, this effort is rigidly and maladaptively applied to the ritual, consistent with neurocognitive models that highlight an over-reliance on the brain's habit formation system, leading to repetitive, inflexible cognition and behavior. OCD is characterized by increased action tendencies and difficulties suppressing inappropriate repetitive behaviors, which aligns directly with rigid Boosting.[15]

Furthermore, the negative reinforcement mechanism confirms the structural concept of the reward system hijack. The momentary reduction in anxiety that follows the completion of a ritual acts as a

pathological reward, co-opting the reflective satisfaction function (the claimed Appreciating primer) and reinforcing the maladaptive Arranging and rigid Boosting loop. This pathological mechanism ensures the rigid, relentless energy of Boosting remains pathologically applied to the ritual, thus maintaining the rigidity of the Arranging function.

D. Constricting Failure: The Breakdown of Executive Inhibition

The Heart Center governs Feeling and Affective processes. In OCD, the failure here is characterized by the inability to pause or accept internal distress. The Constricting primer (Heart, Reflecting mode) serves adaptively as mindful pausing and boundary setting—the intrinsic process for inhibiting or modulating emotional states.

In OCD, the failure to execute a healthy pause or boundary setting is the critical mechanism that ensures a rapid, uninhibited progression from the intrusive thought (obsession) to the necessary action (compulsion), preventing any opportunity for executive override or reappraisal.[16] This immediate, reflexive jump locks the system into the rigid entanglement, preventing any opportunity for executive override or reappraisal.

This structural claim is strongly validated by empirical findings that OCD is characterized by profound deficits in **cognitive flexibility and motor inhibition**.[15] Advanced neurocognitive models of the disorder highlight that the inhibitory connection between anxiety/obsessions and executive control is central to the psychopathology.[16] The Constricting failure is, therefore, the structural lock mechanism. If the system cannot pause or inhibit the progression from the obsession (Head distress) to the compulsion (Gut action), executive control is functionally bypassed. This inability to modulate the progression directly prevents the activation of higher-order reappraisal or affective modulation, ensuring the rigid entanglement takes hold and maintains the compulsive cycle.

E. Structural Suppression of Accepting: Experiential Avoidance

The Accepting primer (Gut, Balancing ‘Off’ mode) is structurally defined by surrender, adaptation, and psychological flexibility. OCD, characterized by the demand for certainty and control (driven by failed Calculating and rigid Arranging), is fundamentally incompatible with the principles of acceptance and surrender.

Experiential avoidance (EA), the refusal to tolerate internal discomfort, upsetting emotions, thoughts, memories, or other private experiences, is a core feature strongly implicated in maintaining OCD

psychopathology.[17] Individuals with OCD report using a higher momentary number of avoidance-oriented regulation strategies.[19] This confirms the structural suppression of the Accepting primer as a core mechanism of the disorder.

The structural modeling establishes that the Arranging ritual is inherently an **anti-acceptance strategy**. By actively manufacturing pseudo-certainty and achieving temporary distress reduction, the compulsion negates the necessity of accepting internal discomfort. Therefore, the rigidity of the Arranging function directly mandates the suppression of the Accepting function, confirming a pathological entanglement between these two action-oriented primers.

Table 1: Alignment of CEF Pathology Claims with Established OCD Mechanisms

CEF Primer Deficit	**CEF Functional Center**	**Pathological Manifestation**	**Verification via Empirical Mechanism**
Calculating Deficit	Head (Cognition)	Intolerance of Uncertainty (IU)	IU functions as a stable, trait-like cognitive vulnerability and causal risk factor for OCD symptoms.[10]
Arranging/Boosting Rigidity	Gut (Action)	Compulsive Ritual/Negative Reinforcement	Compulsions are maintained through temporary distress reduction (Negative Reinforcement) [13], and reflect increased action tendencies/habit formation.[15]
Accepting Suppression	Gut (Action)	Experiential Avoidance	Unwillingness to endure upsetting private experiences (EA) is a core mechanism maintaining symptomatology.[17]

Constricting Failure	Heart (Affect)	Failure of Inhibition/Pause	OCD is characterized by deficits in cognitive flexibility and motor inhibition, disrupting executive control.[15]

III. Structural Equivalence: Indexing CEF Deficits to Evidence-Based Treatments (EBT)

A primary utility of the CEF is its function as a meta-framework, indexing functional deficits (primers) to the established mechanisms of evidence-based psychotherapies (EBTs). This structural equivalence provides a mechanism-based roadmap for treatment selection.

A. Targeting Action Rigidity: Exposure and Response Prevention (ERP)

Exposure and Response Prevention (ERP) is the gold standard behavioral treatment for OCD, directly targeting the action loop.[1]

The CEF structurally aligns ERP with the inhibition of the Arranging and Boosting primers. ERP involves two critical steps: direct exposure to stimuli that evoke distress or obsessive thoughts (exposure component), and response prevention, where the individual learns to prevent their usual maladaptive response (the compulsion).[1] Response prevention operates by deliberately enforcing the non-performance of the ritual, thereby directly inhibiting the maladaptive activation of the Arranging primer and the rigid, ritualistic application of Boosting.

The mechanism of action in ERP is verified through the lens of inhibitory learning.[21] Therapeutic exposure must activate the fear structure stored in memory and then provide incompatible information.[22] By preventing the ritual, ERP forces the patient to endure the distress (obsession) without the usual pathological coping mechanism.[1] This process disrupts the negative reinforcement cycle [13], and the new, non-fear association acquired during this process competes with the fear structure.[22]

Critically, ERP achieves the structural re-activation of the suppressed Accepting primer. By structurally blocking Arranging, the system is forced into the experiential state of surrender and psychological acceptance of internal discomfort, directly targeting the core mechanism of experiential avoidance.

B. Cultivating Psychological Flexibility: Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) is fundamentally indexed to the Accepting primer. ACT emphasizes psychological acceptance, defined as the non-judgmental acknowledgment of internal experiences without attempting to suppress or avoid them. For OCD, ACT provides a direct countermeasure to experiential avoidance, a core mechanism of disorder maintenance.

The therapeutic effect of ACT is verified by its ability to help patients hold an open and receptive attitude toward distressing inner experiences, rather than contradicting or neutralizing them.[3] ACT teaches clients to view intrusive thoughts as mere mental events, accepting their presence without allowing them to dictate behavior.[4] This strategy structurally strengthens Accepting, enabling the psychological flexibility essential for managing the stress and emotional challenges inherent in the disorder.[3] By improving acceptance and psychological flexibility, ACT can help sustain the therapeutic effect and enhance patient compliance with demanding behavioral treatments like ERP.

C. Repairing Cognitive Vulnerability: Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is structurally indexed to the Calculating primer. As the front-line psychotherapeutic treatment for OCD, CBT's mechanism of cognitive restructuring is functionally equivalent to reinforcing the adaptive capacity of the Calculating primer.[5]

CBT targets the core cognitive vulnerability of the disorder: the demand for certainty (Intolerance of Uncertainty) and associated catastrophic interpretations.[23] Cognitive models of OCD emphasize the role of dysfunctional beliefs, such as inflated responsibility and overestimation of threat.[23] By engaging in cognitive restructuring, CBT aims to restore the Calculating function so that the individual can process data analytically and rationally, reducing the cognitive distress that initially fuels the compulsive action loop. This process provides new learning by targeting beliefs about uncertainty and responsibility following exposure exercises.[6] Given that IU is responsive to treatment [24], reinforcing the Calculating function is essential for long-term recovery.

D. CEF-Specific Interventions and Regulation Mobility

Beyond indexing established EBTs, the CEF proposes a suite of embodied, action-oriented exercises designed to build "resilience mobility" by targeting specific primer deficits.

1. **Counting Exercise:** This intervention involves the deliberate triggering and intensification of a core emotion, followed by its voluntary release. The primary function is to train metacognitive awareness and voluntary control over emotional intensity. This is a direct, behavioral strategy designed to address the verified failure of the Constricting primer—the inhibitory deficit—by training the capacity to execute a necessary pause or inhibition between emotional input and behavioral output.
2. **Cycling Exercise:** This technique links imaginative, rhythmic movement (e.g., Clockwise, Counter-Clockwise) to the three processing modes (Outgoing, Reflecting, Balancing). This somatic technique is aligned with mechanisms similar to Eye Movement Desensitization and Reprocessing (EMDR) and is hypothesized to help clients process and clear the persistent emotional load associated with intrusive thoughts. Structurally, this intervention targets the Sensing deficit (the failure to clear intrusive cues), bypassing purely cognitive routes to emotional flexibility.

Table 2: Structural Indexing of CEF Deficits to Evidence-Based Treatments (EBT)

Evidence-Based Treatment (EBT)	**CEF Primer Targeted**	**Established EBT Mechanism of Change**	**Verification of Alignment**
Exposure and Response Prevention (ERP)	Arranging (Inhibition) & Boosting (Rigidity)	Behavioral intervention breaking conditioned response; promotes inhibitory learning and anxiety tolerance by preventing rituals (Response Prevention)	[1]
Acceptance and Commitment Therapy	Accepting (Suppression)	Fosters psychological flexibility and a	[3]

(ACT)		receptive attitude toward internal experiences; counteracts experiential avoidance	
Cognitive Behavioral Therapy (CBT)	Calculating (Deficit)	Cognitive restructuring targeting beliefs about uncertainty and responsibility; challenges catastrophic interpretations of intrusive thoughts	6

IV. Clinical Implementation and Empirical Validation for CEF Indexing

A. Proposed Structural Triage: Sequencing of EBT Modalities

Based on the structural finding that OCD involves the systemic outsourcing of cognitive distress (Calculating deficit) to an action loop (Arranging), the structural sequencing principle for intervention must prioritize dismantling this action loop before or parallel to deep cognitive work.

Phase I (Action Disruption)

For a client presenting with high Arranging and Boosting rigidity (e.g., severe checking or cleaning rituals), the intervention must prioritize ERP (Arranging inhibition) and ACT (Accepting enhancement). The rationale dictates that the negative reinforcement cycle—where compulsions are strengthened by temporary distress relief [13]—must be broken behaviorally before core cognitive strategies can take hold. ACT is crucial during this phase as it addresses experiential avoidance [17] and helps the patient maintain compliance with the difficult ERP procedures by increasing psychological acceptance of the distress endured during response prevention.[3] This action-oriented phase achieves the complete decoupling of Constricting from Arranging, abandoning the rigid action attempt to manage anxiety, making surrender (Accepting) structurally possible.

Phase II (Cognitive Repair)

Once the action loop is sufficiently attenuated, interventions targeting the Calculating deficit (Intolerance of Uncertainty) through CBT's cognitive restructuring become maximally effective. This focused application dictates the structural sequence of interventions. The critical element here is that ERP and ACT remove the pathological maintenance mechanisms (negative reinforcement and avoidance), creating a cognitive environment where the Calculating primer can genuinely utilize new, less catastrophic information provided by CBT.[6] If CBT is applied prematurely, the continued operation of the Arranging loop will constantly reinforce the demand for certainty, undermining cognitive restructuring efforts. This sequencing moves clinical practice toward a deficit-first, personalized approach.

B. Comparative Pathophysiology: OCD vs. Generalized Anxiety Disorder (GAD)

The utility of the CEF as a transdiagnostic tool is validated by its ability to structurally delineate unique differences between seemingly related disorders of emotional rigidity, such as OCD and Generalized Anxiety Disorder (GAD).

While both GAD and OCD are characterized by failures of adaptive emotional mobility leading to rigidity, the core entanglement differs structurally. GAD primarily involves an internal cognitive-affective struggle where Constricting failure locks the system into excessive Boosting (worry/avoidance effort). The therapeutic imperative for GAD is therefore to restore the fluid dialectic between Boosting and Accepting.

In contrast, OCD's pathology is uniquely defined by **Structural Rigidity through Action Outsourcing**. Constricting failure locks the system into rigid Arranging and compelled Boosting, creating a vicious cycle

where cognitive distress is resolved by rigid, non-adaptive action (compulsions). This distinction—the centrality of the organization-focused Arranging primer within the action domain—provides the unique structural signature necessary to distinguish OCD from GAD. The need to dismantle the rigid Arranging mechanism via ERP, rather than merely rebalancing the Boosting-Accepting dialectic, confirms this specialized pathology.

C. Future Directions and Empirical Imperatives

The theoretical extension of the CEF to OCD necessitates rigorous empirical validation to confirm the proposed structural mechanisms and clinical utility.

1. **Phase 1: Construct Differentiation:** Research must focus on testing the structural independence of the Arranging primer. Psychometric studies are required to confirm that Arranging functions as a unique factor in OCD symptomatology, distinct from generalized anxiety or generalized worry constructs. This validation is essential to support the claim that the Arranging deficit is the unique transdiagnostic fingerprint of OCD within the framework.
2. **Phase 2: Predictive Validity of Indexing:** Future clinical trials must test the efficacy of the CEF Indexing system. Specifically, studies should test whether using the Indexing system to select modalities (e.g., prescribing ERP/ACT for high Arranging/Accepting deficits versus CBT for high Calculating deficits) results in statistically and clinically superior reduction of OCD symptoms compared to outcomes derived from traditional, non-indexed treatment selection methods.
3. **Phase 3: Embodied Intervention Efficacy:** Empirical studies should focus on validating the Counting and Cycling exercises as effective, mechanism-targeted adjunctive interventions for improving emotional regulation markers. Validation should specifically target the Constricting and Sensing deficits in OCD clients, aiming to prove that these somatic techniques can improve regulatory mobility and process persistent emotional load, bypassing purely cognitive routes.

V. Conclusion: Advancing Personalized Affective Science for OCD Treatment

The structural modeling of Obsessive-Compulsive Disorder within the Core Emotion Framework provides a precise, mechanism-based language for understanding a complex disorder defined by pervasive

emotional and cognitive rigidity. The analysis confirms the disorder's unique transdiagnostic signature: a systemic failure in cognitive processing, specifically the **Calculating deficit** manifesting as Intolerance of Uncertainty [11], which is pathologically resolved through rigid action involving the **Arranging deficit** maintained by negative reinforcement.[13] This structural deviation—the outsourcing of the certainty demand to the action center—differentiates OCD from the generalized emotional rigidity observed in anxiety disorders.

The established structural equivalence between key CEF deficits and the mechanisms of evidence-based treatments—the alignment of **Arranging/Boosting deficits with ERP** [1], **Accepting suppression with ACT** [3], and the **Calculating deficit with CBT** [5]—provides compelling support for the framework's validity as an integrative meta-system. The structural understanding dictates a therapeutic sequencing that prioritizes breaking the action-based maintenance loop (ERP/ACT) before initiating deep cognitive repair (CBT), ensuring maximum clinical efficacy.

Pending rigorous empirical validation of the CEF Indexing function and its associated interventions, this structural-constructivist model promises to guide clinical practice toward a deficit-first, personalized approach. By providing a clear, mechanism-based roadmap rooted in component processes of emotion, the CEF contributes significantly to advancing the field of structural affective science and personalized medicine for psychiatric disorders.

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