When the Mind Gets Ahead of Reality

Why therapy, medication, exposure, and behavioral activation are not opposites

A Personal Starting Point

I came to this question partly through my own experience of the mind building a model faster than the outside world could confirm or correct. At times, I experienced my work, my importance, and my future as if a kind of validation had already arrived before the world had actually supplied it. That is an uncomfortable sentence to write, but it is the reason this question matters to me. I know what it feels like when the mind's model becomes larger, faster, and more certain than the evidence available to support it.

I am not using that experience here to prove that the model was true, and I am not asking the reader to accept my private interpretation of it. I am using it because it forced a harder question. How does the mind stabilize a meaning before the evidence is strong enough? What keeps that meaning open to correction? And what happens when correction arrives too slowly, too weakly, or not at all?

This article uses that personal question as a doorway, but the argument is not only about psychosis or grandiosity. The same perception-action loop appears in depression, anxiety, addiction, and other mental-health patterns. The difference is where the loop breaks, what kind of Productive Value is being misread, and what kind of treatment reaches that failure surface.

Opening Frame

We often talk about mental illness as if it must be one of two things: a chemical problem in the brain or a problem in how a person thinks. That split is too crude. A person does not move through the world as a detached mind riding on top of a body, and a body does not generate behavior without interpretation, memory, expectation, attention, and action. Mental life sits inside a loop. The world sends signals. The body receives and transforms them. The brain focuses, interprets, predicts, and acts. The action then changes the world, the body, and the next signal. This article is about that loop — and about how depression, anxiety, addiction, psychosis, personality patterns, and treatment may make more sense when we ask where in the loop the problem is occurring.

This article uses a behavioral framework I call the Productive Value-Productive Power framework, or PV-PP. In simple terms, it is a model of how people decide what they can do, what threatens them, what help or harm is moving toward them, and what actions seem worth taking. The framework matters here because it separates actual capacity from perceived capacity. A person can have real ability left and still experience the situation as impossible. Or a person can feel capable while the actual situation is more dangerous than they think.

The framework has two halves. Productive Value is what moves through interaction: help, harm, information, trust, money, injury, relief, opportunity, shame, obligation, danger, or repair. Productive Power is the capacity that remains or changes after those exchanges: what a person can actually do, tolerate, access, repair, or recover. A tiger can injure me. A friend can help me. A drink can provide short-term relief while damaging long-term capacity. Therapy can provide new information. Medication may change the body's ability to transition from stuck to active. The framework is about how the mind estimates these exchanges and then acts from that estimate.

This view is compatible with predictive-processing accounts of the brain, which describe perception as model-building and updating. PV-PP adds a practical question: once the mind has built a model, what does that model make possible or impossible for action and recovery? [1,2]

By “the mind gets ahead of reality,” I do not only mean psychosis, grandiosity, or spectacular breaks from ordinary experience. I mean any case where the working model runs faster than correction. Anxiety can project threat before danger is established. Addiction can project relief before the full cost is counted. Psychosis can stabilize percepts or meanings without enough support. Depression can sometimes do the opposite: it can make the mind lag behind reality by failing to register remaining capacity, help, or recovery corridors. The common problem is not that every condition is the same. It is that each condition can disturb the loop between reality, perception, action, and feedback.

We do not act on reality directly. We act on the reality our brain has built well enough to act from.

The Tiger in the Distance

That statement sounds abstract until you think about vision. Light enters the eye as electromagnetic radiation. The brain does not receive a label that says “tiger.” It receives patterns: color, motion, contrast, edge, distance, shape, and ambiguity. It compares those patterns with memory, expectation, context, and prior experience. If the scene is unclear, the system samples again. We turn our head. We focus our eyes. We move closer or step back. We listen. The mind keeps refining the scene until the object resolves: tiger, dog, person, trash bag, shadow.

The important point is that the brain is not a camera. It is an active model-builder. It samples the world, focuses on some signals more than others, fills in gaps, checks against memory, predicts what may happen next, and then prepares action.

A tiger in the distance is not just an object. It is a possible interaction. The mind does not only ask, “What is that?” It asks, “What can that thing do? What could it do to me? How far away is it? How fast can it move? Can I run, climb, hide, freeze, defend myself, or protect someone else?”

In other words, perception becomes practical. The scene resolves into a question of capacity.

The loop runs in both directions. The world sends signals, but the brain also queries the world. If something in the distance might be dangerous, we move our eyes, shift posture, listen harder, step back, look for a path, or search for other people. More information comes in. The mind focuses again. The model updates.

Constructed perception is not automatically false. Sometimes focusing improves contact with reality. The problem begins when the focusing loop overbuilds, underbuilds, or locks onto the wrong thing.

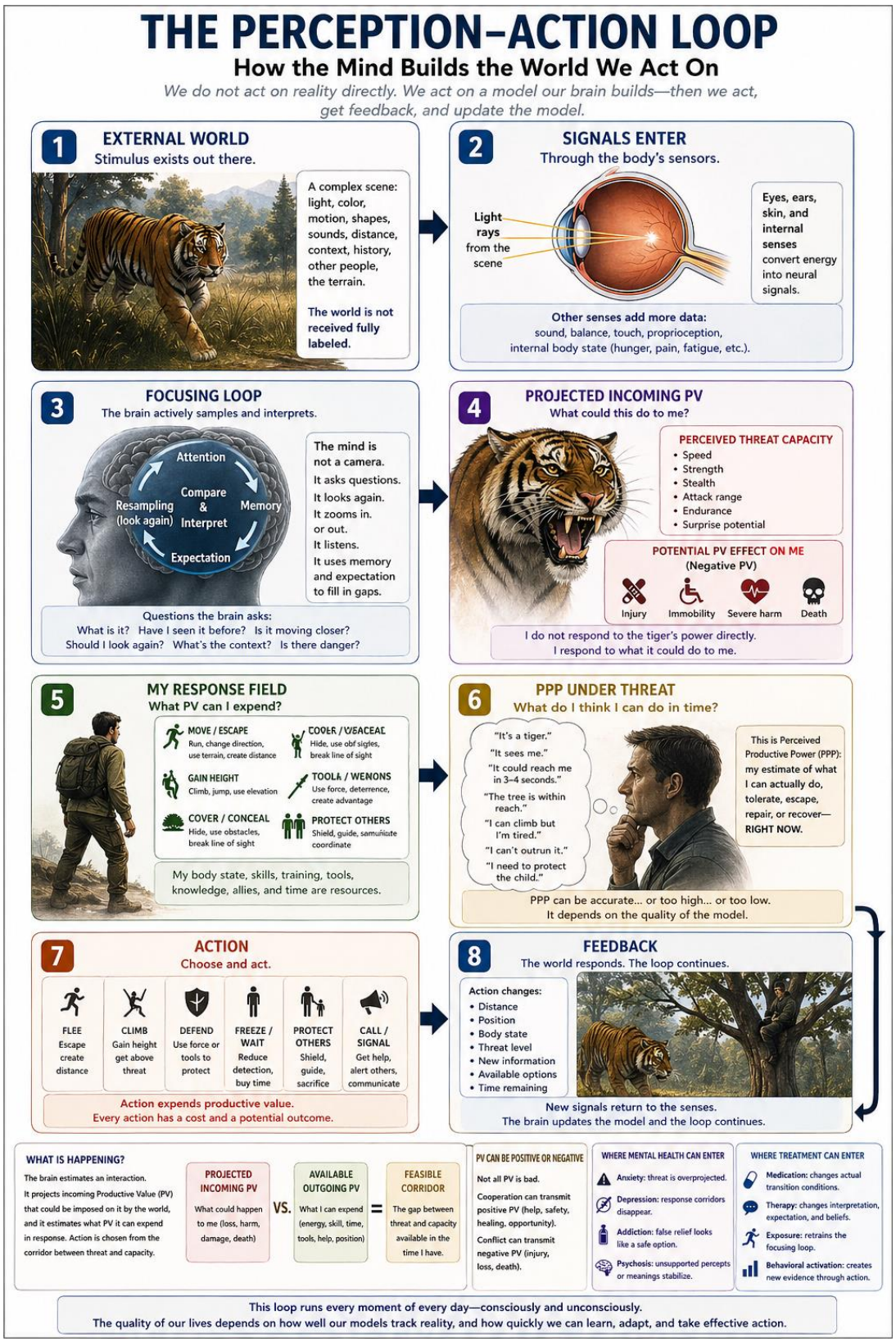

Figure 1. The perception-action loop. External signal is sampled, focused, interpreted, turned into a perceived situation, acted on, and then updated by feedback.

Actual Capacity and Perceived Capacity

This is where the Productive Value–Productive Power framework, or PV-PP, becomes useful. The framework separates what moves through interaction from the capacity that remains after interaction, and then separates actual capacity from perceived capacity.

Term	Plain meaning	Example
Productive Value (PV)	What moves through interaction: help, harm, information, relief, injury, support, cost, opportunity, repair.	A friend gives useful advice; a tiger imposes injury; a drink gives short-term relief.
Productive Power (PP)	The actual capacity that remains or changes: what I can do, tolerate, access, repair, or recover.	I can lift ten pounds; I have enough support to make the call; my sleep is too degraded to function well.
Perceived Productive Power (PPP)	My mind's working estimate of that capacity under the situation.	I think I can lift fifty pounds; I think I cannot make the call; I think there is no safe path. From here on, I will mostly use plain language: help or harm for Productive Value, actual capacity for Productive Power, and perceived capacity for Perceived Productive Power.

If my body can lift ten pounds and I think I can lift ten pounds, perception is aligned. If my body can lift ten pounds and I think I can lift fifty, I may overreach. If my body can lift ten pounds and I think I can lift nothing, I may shut down even though action remains possible.

The tiger example adds one more step. In a threat case, the mind does not only estimate my own capacity. It also estimates incoming impact. The question is not only "What can I do?" It is also "What can this thing do to me?" A tiger's speed, force, teeth, and attack range matter because they project possible harm in my direction: injury, immobility, death. My response field then becomes the set of productive value I can expend in time: run, climb, hide, defend, call for help, protect someone else, or wait.

So the brain is estimating an interaction. It is asking: what could come toward me, what can I send back or do before it arrives, and is there a feasible corridor between threat and response?

Actual State, Perceived State, and Decisions

In the framework's technical language, Layer 1 means actual state: body condition, tools, support, danger, constraints, and real capacity. For a general reader, it is enough to think of this as the actual situation the person is living inside.

Perception and focusing turn that situation into perceived capacity: the mind's working estimate of what is possible, dangerous, tolerable, blocked, or recoverable.

The decision system then operates from perceived capacity, not from perfect reality. A decision can make sense inside the perceived world even when that perceived world is incomplete, distorted, overfocused, or under-corrected.

That is why symptoms can be hard to change. The person may not simply be choosing badly; they may be acting from a world-model that has already lost access to the evidence it needs for correction.

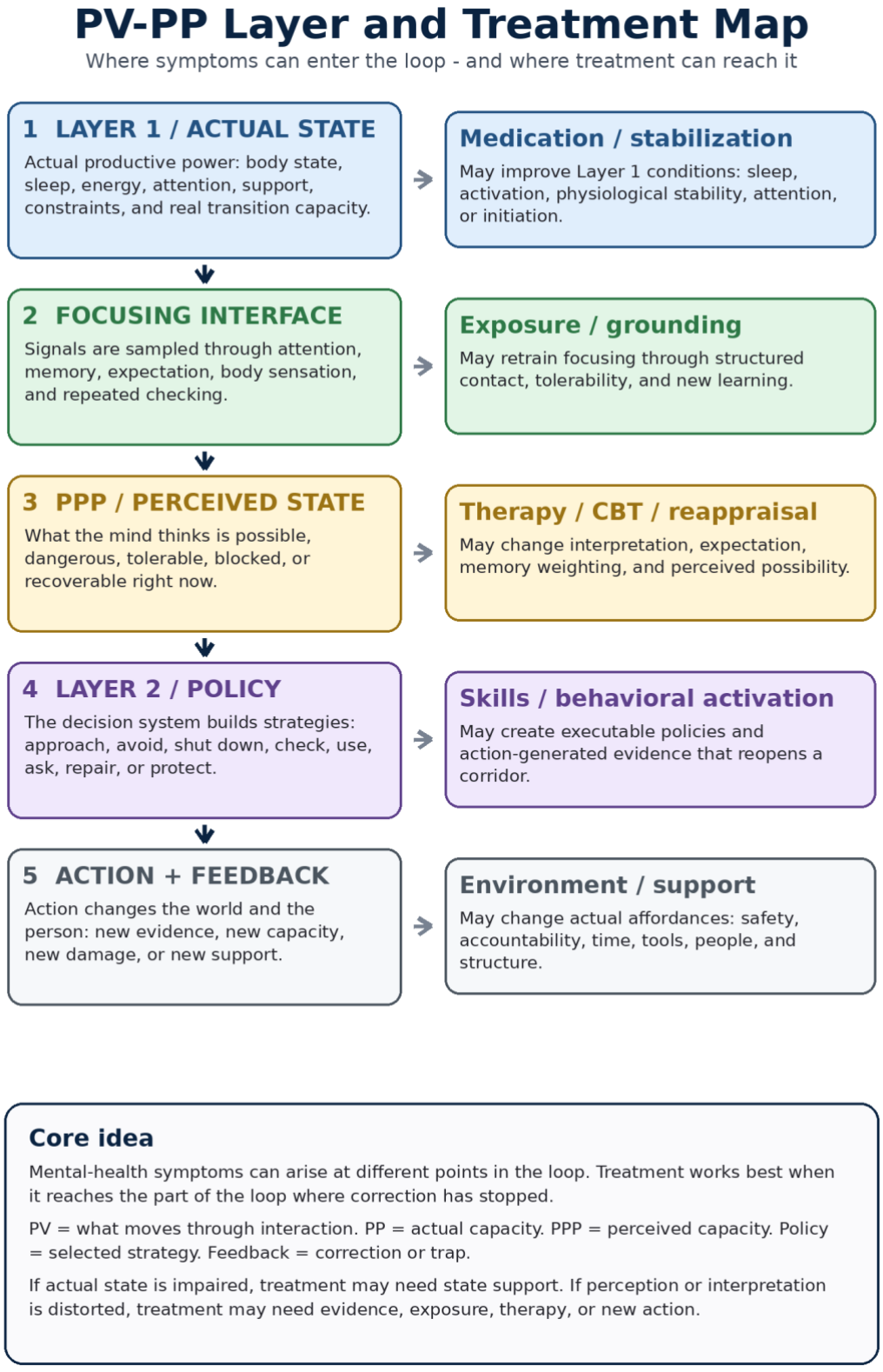

Figure 2. PV-PP layer and treatment map. Different symptoms can enter the loop at different surfaces, and different treatments can reach different parts of that loop.

When the Loop Breaks

Many mental-health symptoms can be understood as unwanted features of the same loop that normally lets us perceive and act. The problem may appear in actual state, perceived state, focusing, interpretation, policy selection, or feedback after action.

Anxiety can overproject threat. Depression can under-resolve recovery paths. Addiction can make immediate relief look like a safe corridor while delayed damage accumulates. Psychosis can stabilize percepts or meanings without enough support. Personality patterns can harden into repeated interpersonal strategies.

The conditions are not the same. The point is that each may disturb a different surface of the loop. Once that is visible, treatment becomes less mysterious: medication, therapy, exposure, behavioral activation, support, skills, and environmental change reach different parts of the system.

Depression: When Transition Capacity and Recovery Corridors Collapse

Consider a person lying in bed with the dishes in the sink, a phone call unanswered, and a short walk available outside. From the outside, each action looks small. From the inside, none of them feels small. The phone call feels like a wall. The walk feels pointless. The dishes feel like proof of failure rather than a task. The person may even know, abstractly, that action could help, but the action does not feel reachable.

That moment is where depression becomes easier to misunderstand. The problem is not simply laziness, and it is not always a single false thought. The actual ability to initiate transition may be impaired, while the perceived model of recovery also contracts. The person is caught between reduced transition capacity and a world-model that says no available action will matter.

Depression is not simply sadness. In this framework, many depressive shutdown states are coupled failures in actual transition capacity and perceived recoverability. The person may have real burden: low energy, poor sleep, reduced action initiation, narrowed attention, reduced social contact, and less ability to register positive feedback. At the same time, the mind may read the future as more closed than it actually is. There may be remaining help, remaining ability, or remaining repair paths, but they do not feel available.

By transition capacity, I mean the real ability to move from one state to another: from bed to standing, silence to making the phone call, craving to waiting ten minutes, panic to tolerating the room, isolation to contacting another person. Depression matters structurally because it can reduce this capacity while also changing the person's perceived estimate of it.

That means depression can operate on both sides of the loop. Actual transition capacity may be degraded, and the perceived model of future transition may become worse than the actual state requires. The person does less, sees less, receives less feedback, and has fewer chances to discover that some action remains possible. Withdrawal then reduces incoming support, activity, social contact, and corrective evidence. The model of no-path begins to stabilize itself.

This is why the phrase "just think differently" is inadequate. If actual transition capacity has collapsed far enough, the person may not be able to use cognitive correction effectively. But the opposite simplification is also inadequate: medication alone may improve state without rebuilding interpretation, expectation, action, social repair, or environmental support.

In this framework, antidepressant medication can be modeled, when effective, as actual-state transition-capacity support. This is a structural interpretation, not a claim that PV-PP explains serotonin or brain chemistry. Clinical sources already treat medication as one recognized part of depression and broader mental-health treatment. [3,4,5] The PV-PP claim is narrower: medication does not directly prove that the person's negative beliefs are false, and it does not itself supply a new life interpretation. Rather, when it works, it may alter the actual-state conditions under which transition becomes possible: getting out of bed becomes

reachable, rumination becomes less absorbing, action initiation has less friction, sleep or recovery may improve, positive feedback can register, and behavioral activation becomes executable. The decision system then receives better input conditions. Policies that previously seemed out of reach may become visible, testable, or sustainable.

Therapy works at a different surface. It can challenge the perceived impossibility of action, inspect the evidence for learned futility, separate actual incapacity from perceived incapacity, and help the person test whether the corridor is really closed. Behavioral activation adds another surface: it creates evidence through action. The person does not merely think differently; the person acts in a bounded way and discovers whether the world answers differently than the depressive model predicted. Mayo Clinic describes psychotherapy and medication as common depression treatments, supporting the article's claim that multiple treatment surfaces are already recognized in practice. [4]

Depression is therefore a central example of why medication and therapy are not opposites. Medication may change the actual transition surface, allowing cognitive, behavioral, and environmental repair to become reachable. Therapy and action then help rebuild the model, the expectation, and the corridor.

Anxiety: When the System Focuses on Threat

Imagine walking into a meeting and noticing one face that looks bored or irritated. Ten other faces are neutral or friendly, but the mind keeps returning to the ambiguous one. The room begins to resolve around that signal. The person is no longer responding to the whole room. They are responding to the room their focusing loop has built.

That is one reason anxiety can feel so convincing. The threat is not always invented from nothing. It may begin with a real signal, but the signal is selected, amplified, resampled, and treated as more governing than the rest of the scene.

Anxiety is often described as fear without enough danger, but that description is too thin. In PV-PP terms, anxiety is not only a threat-appraisal problem. It is a mismatch between projected incoming negative Productive Value and perceived outgoing response Productive Value. The person's model says: something bad may come toward me, and I do not have enough capacity, time, support, or recovery power to meet it. Clinical sources also treat anxiety disorders as conditions commonly addressed through psychotherapy, medication, or both, which the article later interprets structurally. [7]

In the tiger example, this focusing pattern would be adaptive if the tiger were real and close. It would be dangerous to underread the signal. Anxiety becomes a problem when the same structure is applied too broadly: a facial expression becomes rejection, uncertainty becomes disaster, a bodily sensation becomes catastrophe, an ordinary task becomes a threat, or a future possibility becomes an immediate governing danger.

The error does not always begin as a conscious belief. It may begin in the focusing loop. The person keeps sampling the same class of cue: the heartbeat, the look on another person's face, the possible mistake, the possible loss, the possible contamination, the possible embarrassment. The more the system samples that cue, the more evidence it seems to have that the cue matters. Attention itself starts producing confirmation.

This is the PV-PP addition to the familiar cognitive account. The question is not only "Is the feared event likely?" It is also: what negative Productive Value do I expect the world to impose, what outgoing Productive Value can I expend in response, how much time do I have, and could I recover if the event happened? Anxiety can overproject incoming harm, underproject response capacity, and underread recovery. Once that perceived world is built, avoidance can look rational.

Avoidance is therefore not just a symptom. It is a decision strategy selected from the world the person currently perceives. If the perceived world says the situation is dangerous and the self cannot tolerate it, avoidance may appear to preserve safety. The problem is that avoidance also blocks corrective help, information, skill, and embodied experience. The person never receives the evidence that might have shown the situation was tolerable or recoverable.

This is why exposure-based treatment can make sense for some anxiety conditions. Structured exposure is not simply "doing the scary thing." NIMH describes exposure therapy as a type of CBT for anxiety disorders in which a person spends brief periods in a supportive environment learning to tolerate distress, and NICE recommends CBT as a psychological intervention for panic disorder while also recognizing antidepressant medication as an option in some cases. [6,7] In PV-PP terms, structured exposure is a controlled way to let the focusing loop sample the feared cue under conditions that permit new learning. The system gets a chance to discover that the feared cue, action, or situation does not produce the expected catastrophe.

Cognitive therapy works at a related but distinct surface. It asks whether the constructed model is overreading danger, underreading capacity, or treating possibility as certainty. It can help distinguish "this could happen" from "this is happening," "this would be unpleasant" from "this would be unsurvivable," and "I feel unable" from "I have no capacity."

Medication, when useful, may operate differently. It need not prove that anxiety is purely biological. Clinical sources recognize medication as one treatment option for anxiety disorders, alongside psychotherapy and exposure-based approaches. [5,7] In PV-PP terms, medication may reduce the actual activation, panic intensity, sleep disruption, or threat-salience pressure that keeps the focusing loop locked onto danger. In that sense, medication can change the conditions under which attention and interpretation operate without itself supplying the long-term correction.

Trauma-related anxiety requires extra care. VA and APA materials describe prolonged exposure and related PTSD treatments as structured, trauma-focused psychotherapies, not casual repetition of safe contact. [8,9]

So anxiety is not merely a thought error, and it is not simply a chemical state. It is often a disturbance in how the mind focuses threat, estimates incoming harm, estimates response capacity, and selects policies such as avoidance, checking, reassurance-seeking, or escape. That is why anxiety treatment often combines cognitive correction, structured exposure, state support, and behavioral practice. Each reaches a different part of the same loop.

Addiction: When Relief Looks Like a Corridor

A drink, pill, bet, or hit does not usually first appear as destruction. It appears as relief. It says: this will get me through the next hour. It will lower the pressure, quiet the body, stop the fear, make sleep possible, make the room tolerable, or make the day survivable.

That is why addiction cannot be understood only as bad preference or weak will. The first thing the mind sees may be a local corridor. The tragedy is that the corridor may relieve the present moment while damaging the future conditions needed for recovery.

Addiction is one of the clearest examples of a loop that begins as a perceived solution and becomes an actual trap. In ordinary language, people often describe addiction as weakness, craving, bad judgment, or chemical dependency. Each of those descriptions may catch part of the phenomenon, but none of them is complete. In PV-PP terms, addiction is especially interesting because it can move through several surfaces of the loop at once: perceived relief, learned expectation, policy selection, actual-state degradation, and feedback.

The first mistake is often not that the person believes the substance or behavior is harmless in some abstract way. The first mistake may be more local and more persuasive: this will help now. Alcohol may reduce anxiety tonight. A drug may blunt pain. Gambling may create the feeling of recovery after a loss. Pornography, food, shopping, gaming, or scrolling may provide escape from pressure, loneliness, shame, or boredom. The behavior enters the model as a relief corridor.

A relief corridor is not the same thing as a recovery corridor. That distinction matters. A relief corridor reduces immediate pressure. A recovery corridor preserves or restores the conditions needed for future function. Addiction becomes structurally dangerous when the mind treats relief as if it were repair.

Early in the loop, the perceived model may say: this works. The behavior changes the immediate state, and if nothing obviously catastrophic happens right away, the system may learn the wrong lesson: I can do this and still be fine. Near misses can become false evidence of safety while delayed costs remain undercounted.

In PV-PP language, the problem is not only craving. The problem is that the action model becomes miscalibrated. The incoming pressure is real. The relief is real. But the long-run effect is misread. The behavior appears to preserve viability while quietly consuming it.

Over time, the loop moves from perceived relief to actual-state degradation. Sleep worsens. Health declines. Money becomes less stable. Trust erodes. Legal exposure may increase. Work reliability changes. Family roles weaken. Attention, impulse control, and stress tolerance can degrade. At that point, the issue is no longer just that the person is misreading the situation. The actual transition surface has changed. The person may now have less real capacity to tolerate discomfort, repair damage, sustain abstinence, or enter ordinary recovery work.

That is why addiction becomes coupled. The decision system selects the relief policy. The policy worsens actual state. The worsened actual state increases distress, withdrawal, shame, pain, or instability. That degraded state then makes the relief policy look even more necessary. The loop tightens.

The person may say, sincerely, I need this to function. In a narrow moment, that may even be true. The substance or behavior may temporarily restore enough relief to get through the next hour. But the broader model is false because the policy that supplies local relief is also damaging the future capacity that real recovery requires.

This is why addiction treatment is rarely just one thing. SAMHSA describes multiple treatment options for substance-use disorders, including evidence-based medications for alcohol and opioid use disorders, while SAMHSA's group-therapy guidance describes psychoeducational, skills-development, cognitive-behavioral, support, and interpersonal process groups used in substance-abuse treatment. [10,11] If the addiction is mild or early, cognitive and behavioral correction may be enough: the person learns to see the real cost, builds alternative policies, changes cues, and stops treating relief as repair. But as the loop deepens, treatment often has to address withdrawal, craving, environment, support, medical risk, and social structure.

Medication may help in some addictions by reducing withdrawal, craving, or physiological instability. Therapy may change the expectation model: what the person thinks the substance will do, what relapse means, and what alternatives are actually available. Support groups may supply external corrective structure, accountability, and social Productive Value that the person cannot yet generate alone. Environmental change may remove cues, restrict access, alter routines, and rebuild actual affordances. Recovery often requires not just saying no to the old policy, but constructing a different corridor that can actually carry the person's life. This article treats those treatment elements as acting on different PV-PP surfaces rather than as rival explanations of addiction. [10,11]

In this sense, addiction is not merely a failure of willpower. It is a case where the perception-action loop has learned a false corridor. The behavior seems to solve a problem because it solves one part of the problem quickly. But it does so by damaging the conditions needed to solve the larger problem. The treatment task is to make that full loop visible, interrupt the false relief corridor, and build a recovery corridor strong enough to compete with it.

Psychosis: When Unsupported Percepts or Meanings Stabilize

Psychosis is the place where the title of this article becomes most literal. A voice, a coincidence, a pattern, a private sense of mission, or a feeling of special significance may harden before ordinary reality has supplied enough support. From the outside, the belief may look obviously unsupported. From the inside, the mind has already organized the world around it.

This is where my own stake in the subject belongs. My experience was not primarily a story about seeing a tiger that was not there. It was closer to a story about meaning, importance, and future possibility becoming too stable too soon. The mind did not simply ask, “What evidence do I have?” It began to live inside a model that felt ahead of the evidence. The point is not whether a large model is always wrong. Ambition also outruns present evidence. The clinical danger begins when the model stops allowing reality to answer back.

This is why I do not want to treat psychosis as merely bizarre thinking. The deeper issue is model stability. A mind can build a model and then reason from inside that model. The question becomes whether new evidence can still enter, whether contradiction can still matter, and whether the model remains correctable.

Psychosis gives the article its sharpest example of the mind getting ahead of reality, but it should not be treated as the only example. The broader point is that the brain’s model of the world can become insufficiently corrected by external signal, social feedback, memory quality, or later evidence. Psychosis is the dramatic case because the constructed world may differ sharply from the shared world other people are using.

Clinically, psychosis is commonly described in terms of symptoms such as hallucinations, delusions, and disorganized thought, and antipsychotic medication is often part of treatment for schizophrenia-spectrum psychosis. [12] NIMH’s psychosis materials similarly describe treatment as commonly including antipsychotic medication along with coordinated care and psychosocial support. [15] Those clinical facts do not prove the PV-PP framework, but they are consistent with the framework’s prediction that persistent psychosis often involves more than a downstream reasoning error.

In PV-PP terms, the important question is where the perceived world becomes unstable. A hallucination is closer to a bottom-up perceptual construction problem: the system generates or stabilizes perceived content without enough external support. A person may hear a voice, see a figure, smell smoke, or experience a presence even though the shared external signal does not support that content. Predictive-processing and source-monitoring accounts of psychosis are directly relevant here because they examine how internally generated or ambiguous experience may be misattributed or over-stabilized. [17] Layer 2 may then reason from that perceived world. If the voice is present in PPP, the decision system may ask what the voice means, whether it threatens the person, whether it commands action, or whether it must be obeyed.

A delusion is different. It is closer to a top-down interpretive stabilization problem. The perceived or remembered material may be organized into a fixed meaning, identity, threat, mission, or causal story that remains stable despite insufficient corrective support. Clinical sources define delusions as fixed false beliefs that persist despite contrary evidence and are not explained by the person’s cultural or religious background. [16] PV-PP does not need to improve on that clinical definition. It adds a structural interpretation: the belief has become a stabilized model from which the person’s decision system operates.

This distinction can be stated simply: hallucinations are more bottom-up; delusions are more top-down. Hallucinations concern unsupported perceptual content. Delusions concern unsupported meaning. In both cases, the result can be a contaminated perceived world. Layer 2 may still process the world with internal coherence, but it is processing from a model that is no longer adequately tethered to shared correction.

Grandiosity is an especially useful example because it shows how a model can supply identity support before the world has supplied enough evidence. Research on grandiose delusions notes that they can be experienced as meaningful and can provide purpose, belonging, or self-identity. [18] PV-PP would describe this as a perceived role or self-capacity model becoming stabilized ahead of adequate support. The problem is not simply that the belief is large. Ambition also builds models ahead of present evidence. The harder question is whether the model remains correctable: Can it accept contradiction, narrow itself, produce artifacts, respond to feedback, and let reality answer back?

This is where the title of the article does real work. “When the mind gets ahead of reality” does not mean every unusual idea is psychosis. It means the mind can build a model faster than evidence, feedback, and correction

can stabilize it. Sometimes that model is threat. Sometimes it is hopelessness. Sometimes it is relief. Sometimes it is identity or mission. The clinical danger rises when the model becomes too closed to correction.

This also explains why medication and therapy are not opposites in psychosis. If unsupported percepts or unstable salience are being generated upstream, medication may help by changing the actual transition conditions of the perceptual-cognitive system. But meaning, trust, functioning, relationships, and correction discipline are still not automatically repaired by medication. Psychosocial support, therapy, family education, structured routines, and coordinated care remain relevant because the person still has to live, interpret, decide, relate, and rebuild action from the world that treatment helps stabilize. [15]

The framework's prediction is therefore not that psychosis is "all biology" or "all belief." The prediction is more exact: persistent psychosis often involves substrate or perception-generation instability that contaminates perceived reality before ordinary reasoning begins. Treatment must therefore reach the state conditions, the perceived world, and the person's ability to test and live inside that world.

Why Treatment Looks the Way It Does

If mental-health symptoms can arise at different parts of the perception-action loop, then treatment should not be one kind of thing. Medication, therapy, structured exposure, behavioral activation, social support, skills training, and environmental change differ because they intervene at different surfaces.

The payoff is simple: PV-PP does not prove that existing treatment practice is correct, but it explains why treatment practice is often mixed. A person may need state support because actual transition capacity is impaired. They may need therapy because the perceived model is overbuilt or underbuilt. They may need behavioral activation because only action can generate certain kinds of corrective evidence. They may need environmental change because the actual world is not supplying enough support, safety, or access.

This is why medication and therapy should not be treated as philosophical opposites. They may work on different parts of the same system. Medication may change transition capacity. Therapy may provide new information and change interpretation, expectation, and perceived possibility. Support groups may supply social help and accountability. Behavioral activation may create new evidence that could not be obtained from thought alone.

The treatment question is therefore not simply "chemical or psychological?" A better question is: where is the loop failing, and what intervention reaches that surface?

Treatment surface	Where it enters the loop	What it may change	Limit
Medication / state stabilization	Actual-state transition conditions	Sleep, activation, attention, affect regulation, craving, psychotic substrate instability, or action-initiation friction	Does not by itself supply interpretation, meaning, skills, or repaired relationships
Therapy / CBT / reappraisal	Perceived capacity, interpretation, memory weighting, expectation	What the person believes is dangerous, possible, tolerable, recoverable, or blocked	May underperform if actual transition capacity is too impaired to use the work
Structured exposure	Focusing loop and prediction error	How the system samples feared cues and learns from safe or tolerable contact	Must be structured; trauma-related conditions are not solved by simple repetition alone
Behavioral activation	Action-generated evidence and policy re-entry	Whether action is still possible and whether feedback can reopen a corridor	One action is not full recovery; it must connect to a real recovery path
Environmental restructuring / support	Actual affordances, constraints, and feedback	Available help, safety, accountability, access, routines, and social correction	External support can become dependency or false corridor if not tied to recovery
Skills training / scaffolding	Action planning and execution	New executable policies: routines, reminders, planning, communication, distress tolerance	Skills do not help if the person cannot access them under the active state

This treatment-surface view explains why combined treatment can be coherent without being vague. Depression may require both transition support and no-path correction. Anxiety may require threat re-learning and sometimes state support. Addiction may require relief-loop interruption, environmental change, and new recovery corridors. Psychosis may require medication, reality testing, support, and meaning repair. These are not random mixtures. They are attempts to reach different failure surfaces in the same loop.

Severe depression makes the coherence claim concrete. This framework would not predict that behavioral activation alone always works if actual transition capacity is too low for action to start. It also would not predict that medication alone always works if improved capacity does not repair learned futility, withdrawal, or a false no-path reading. The combined pattern is therefore structurally sensible: medication may support transition capacity, therapy may correct interpretation, behavioral activation may generate new evidence, and social or environmental repair may reopen real corridors.

The same logic extends beyond the four examples developed here. ADHD may involve actual-state attention and executive-control burden with learned adaptations. PTSD may involve trauma memory, threat focusing, and body-state burden in a coupled loop, which is why trauma-focused treatment requires more than ordinary reassurance. OCD may involve a threat-and-safety-policy lock. Personality disorders may involve stable interpersonal policies: repeated ways of resolving other people, threat, status, attachment, and control that become self-confirming through feedback. ADHD treatment guidance often includes both medication and behavioral or management supports [13], while borderline personality disorder treatment guidance centers psychological therapies, with medication generally used for associated symptoms or specific problems rather than as the core treatment [14].

That is the practical value of the framework: it does not ask whether a condition is simply chemical or psychological. It asks where correction has stopped and what kind of intervention can reach that part of the loop.

Correction, Not Certainty

The point of this article is not that one framework explains all of mental health. It does not. The point is more modest and more useful: mental-health problems can often be described by asking where the loop between reality, perception, action, and feedback has stopped correcting itself.

Medication may change actual transition conditions. Therapy may change interpretation, expectation, and perceived possibility. Structured exposure may help the system learn from feared cues under safer and more controlled conditions. Behavioral activation may create new evidence through action. Social support and environmental change may alter the actual world the person is trying to act inside.

The mind will always get ahead of reality. That is not a defect by itself. Prediction is how we move through the world. We act before everything is known. We fill gaps. We focus. We infer. We build models quickly enough to survive.

The danger is not that the mind builds models. The danger is losing correction. Mental health may depend less on having a perfect model of reality than on keeping the model open enough for reality to answer back.

A note on scope

This article is a framework essay, not clinical advice and not a replacement for diagnosis or treatment. Its claim is structural: different symptoms may enter the perception-action loop at different surfaces, and different treatments may act on different surfaces. The references below support external background claims about perception and treatment practice. They do not independently validate the PV-PP framework.

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