PSA · ESF SERIES

But There Are Already Lots of Models

The nonlinear test — the existing frameworks, what they often operationalize as, and what hasn't yet consolidated.

Q *Aren't there already lots of non-medical-model frameworks?*

A Yes. Biopsychosocial. Ecological. Developmental. Trauma-informed. Recovery-oriented. Psychosocial rehabilitation. Network medicine. Social determinants of health. Precision medicine. Systems biology. And from disability literature, social justice traditions, and neurodivergent and autistic communities: the social model of disability, the neurodiversity paradigm, mad studies, crip theory, autistic self-advocacy frameworks, among others. They exist, they do real work, and the critique here is not that they don't.

The question is narrower, and more structural: how many of these models are genuinely *nonlinear* in their underlying assumptions? Not multifactorial. Not holistic. Not 'many variables interacting.' Genuinely nonlinear.

The nonlinear test (what an underlying nonlinear architecture requires)

- No single normative architecture against which all configurations are evaluated.
- Context-dependent emergence.
- Dynamic state shifts across time.
- Path dependence — history shapes current state.
- Equifinality (same outcome from different paths) and multifinality (different outcomes from the same path).
- Architecture-environment interaction as constitutive, not as modifier.
- Distributed causation across scales.
- Regulatory systems operating across cellular, autonomic, behavioral, and social levels at once.
- Outcomes shifting with timing, load, and recovery state.
- Heterogeneity treated as expected system behavior, not noise around a mean.

Why existing models often miss the test

Most frameworks ultimately collapse back into linear assumptions when operationalized: a norm, a deviation, a risk factor, a dysfunction, a predictor, a severity gradient, an intervention target. Even the biopsychosocial model is most often operationalized as *biological factor* + *psychological factor* + *social factor* = *outcome* — additive causation, not emergence.

Many ‘systems’ approaches use systems language while preserving fundamentally linear architectures underneath. The vocabulary modernizes faster than the explanatory structure does. That gap is part of why the same problems keep recurring across reform cycles — the new framework arrives, gets implemented inside the old architecture, and reproduces the same limitations under a new name.

What we do have (fragments of a genuinely nonlinear clinical architecture)

- Complexity science.
- Allostasis (Sterling & Eyer; McEwen).
- Predictive processing.
- Developmental systems theory.
- Network medicine.
- Cybernetics.
- Ecological physiology.

Each contributes load-bearing pieces. None has consolidated into a unified clinical architecture capable of replacing the linear default at the level of routine practice. The work is real, distributed, and ongoing — but the consolidation isn’t there yet.

BOTTOM LINE

The question isn’t whether alternatives to the medical model exist. They do, and the work being done across disability, social justice, and neurodivergent-led frameworks is substantive. The question is whether any has consolidated a genuinely nonlinear architecture — one capable of treating heterogeneity, dynamic regulation, and architecture-level variation as foundational, rather than as secondary complications to be managed inside fundamentally linear logic.

That’s what the second model has to become — not a softer pathology medicine, and not a vocabulary refresh inside an existing linear frame, but a model where nonlinearity is the architecture, not an afterthought.

Companion to The Wrong Fight (evostress.blog) and the ESF PSA series — Neurodiversity-Lite, Words Worth Defending, Single-Source or Regulatory?, Where the Cost Lives, and Stigma Keeps Shifting.

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