

## Commentary

# Zad's 4-Dimensional Model of the Self: An Integrative Conceptualisation

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The psyche is an emergent, multilayered system. Neurons, hormones, and genes set the stage; experiences and relationships script the play; thoughts, feelings, and drives write the dialogue; self-reflection and culture direct the performance. Yet despite the wealth of theoretical frameworks, psychoanalytic, cognitive-behavioral, humanistic, biopsychosocial, and neuroscientific, psychiatric education often remains siloed, with each model illuminating only a facet of the human story. This article propose a 4-Dimensional Model of the Self, which unites four cross-domain dimensions (Thoughts, Feelings, Behaviors, and Biology) with a novel metaconscious evaluative layer. The framework honors prior theories while offering an integrated lens for psychiatric reasoning and clinical application, anchoring DSM-5 categories into intuitive, phenomenologically grounded domains, offering a practical heuristic for educators and clinicians to scaffold case conceptualization, and demonstrating its applicability through clinical vignettes in psychosis, depression, and addiction.

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Contemporary psychiatric practice often fragments human experience into a collection of checklists, obscuring the rich interplays that underlie mental distress. This article proposes a novel conceptual framework for understanding the human psyche, designed to enhance both clinical reasoning and educational clarity, especially for junior practitioners who may feel fragmented when overly relying on symptom-based reasoning. By organizing mental phenomena into four interrelated dimensions (Thoughts, Feelings, Behaviors, and Biology) with an overlaying Metaconscious evaluative layer, clinicians can approach diagnosis and treatment with greater coherence and compassion. This shift empowers us to understand that psychiatric disorders are not merely collections of symptoms; they are expressions of distress that unfold over time, alter emotion, distort perception, invade the body, or erupt in behavior. The

framework requests a developmental and phenomenological lens for understanding the suffering person rather than merely labeling the syndrome.

## 1. Theoretical Anchoring

1. **Thoughts** evolve from psychoanalytic and cognitive traditions, integrating Freudian unconscious drives<sup>[1]</sup> and Beck's schemas<sup>[2]</sup> but extending into metaconscious self-evaluation.
2. **Feelings** draw on affective neuroscience<sup>[3]</sup> and humanistic emphasis on authentic emotion<sup>[4]</sup>, while addressing regulation gaps in earlier models.
3. **Behaviors** build on behaviorism<sup>[5]</sup> and attachment theory<sup>[6]</sup>, linking ritual/action patterns to social scripting and personality structure.
4. **Biology** synthesizes modern neurocircuitry and epigenetic research<sup>[7]</sup>, bridging reductionist and systems approaches.

By juxtaposing these alongside the DSM-5's categories, our model transcends silos and illuminates cross-domain interactions.

## 2. Zad's 4D Model

### 2.1. Thoughts

1. *Conscious cognition*: real-time perception & awareness (e.g., attention networks)
2. *Subconscious schemas*: memory & mental frameworks (e.g., cognitive distortions)
3. *Unconscious drives*: impulses & defense mechanisms (e.g., Freudian id dynamics)
4. *Metaconscious evaluative self*: self-esteem, narrative identity, coherence (the "observer" that critiques inner dialogue)<sup>[8]</sup>

### 2.2. Feelings

1. *Needs-driven*: biological (hunger, sleep) & social motives (affiliation, power)<sup>[9]</sup>
2. *Experience-driven*: basic emotions (joy, fear, anger, sadness), attachment-related affect (like longing, shame, or contentment) and regulation (Bowlby's attachment emotions)<sup>[10]</sup>

### 2.3. Behaviors

1. *Personal tendencies*: approach/avoidance/ritualized actions (Skinnerian operants)<sup>[11]</sup>
2. *Interpersonal*: attachment patterns & social scripts (Ainsworth's styles)<sup>[12]</sup>

### 2.4. Biology

1. *Circuits*: reward (mesolimbic), fear (amygdala), stress (HPA axis)<sup>[13]</sup>
2. *Neurochemicals*: dopamine, cortisol, serotonin
3. *Plasticity*: epigenetic modulation & neuroadaptation<sup>[14]</sup>

## 3. Expanded Metaconsciousness

The metaconscious layer (“evaluative self”) mediates between cognition and identity. It is shaped by culture, trauma, and reflective practice:

1. **Culture** imparts narratives that shape life scripts and self-worth<sup>[15]</sup>
2. **Trauma** can fragment coherence, leading to dissociative defenses<sup>[16]</sup>
3. **Reflective practice** (e.g., mindfulness) enhances metacognitive control and emotional resilience<sup>[17]</sup>

### 3.1. Thoughts

#### *Cultural Schemas*

Cognitive frameworks do not develop in isolation; they are shaped by the cultural narratives, values, and belief systems that individuals absorb from an early age. For instance, in honor-based societies, thought patterns often prioritize reputation and social standing, whereas in more individualistic contexts, internal goals and personal achievement may dominate mental schemas. These cultural schemas influence attention biases, memory encoding, and interpretive styles—literature in cultural neuroscience demonstrates that neural networks for self-referential processing (such as the medial prefrontal cortex) respond differently depending on culturally ingrained self-construals<sup>[18][19]</sup>.

#### *Cross-Cultural Cognitive Distortions*

While core cognitive distortions—such as overgeneralization or catastrophizing—occur across populations, their content and triggers vary by culture. A clinician using our model would explore how

culturally specific beliefs (for example, fatalism in some communities or mindfulness in Eastern traditions) shape automatic thoughts and deeper schematic structures.

### *Metaconscious Evaluation*

At the metaconscious level, cultural narratives inform the "inner critic" and overarching life story. Cross-cultural research shows that narrative identity differs in collectivist versus individualist societies, affecting self-esteem and coherence <sup>[20]</sup>. Our framework invites assessment of how these culturally rooted narratives support or undermine reflective self-appraisal.

### *3.2. Feelings (Expanded)*

#### *Needs-Driven Affects*

Biological imperatives (hunger, sleep) and social motives (belonging, status) arise from hardwired drives. Culture shapes the needs that are foregrounded and how they are expressed. For example, some societies valorize stoicism while others encourage emotional disclosure.

#### *Experience-Driven Emotions*

Basic emotions (joy, fear, anger, sadness) interact with attachment-related affects (longing, shame, contentment). Affective neuroscience identifies the prefrontal–amygdala circuitry that underlies regulation; our model integrates these findings with humanistic ideals of authentic emotion, thereby filling gaps in prior frameworks that omitted neuronal pathways.

#### *Regulation Gaps*

Earlier models often left out the neural mechanisms of emotion control. We address this by linking dysregulation, such as rumination or affective inertia, to specific circuits (for instance, reduced prefrontal inhibition of limbic structures).

#### *Cultural Modulation*

Cultural norms guide how feelings are labeled and managed. For example, collectivist contexts may discourage overt anger, leading to somatic presentations; our model encourages clinicians to inquire about culturally sanctioned emotion rules.

### 3.3. Behaviors

#### *Culturally Scripted Rituals*

Behaviors often follow scripts learned through cultural practices—rituals that mark transitions, express belonging, or manage distress. For example, communal rites of passage may channel adolescent risk-taking into socially sanctioned activities, whereas in other settings, individuals may adopt solitary coping behaviors. Anthropological and social-psychological studies highlight how ritual enactment engages operant learning systems and symbolic meaning [\[21\]\[22\]](#).

#### *Social Roles and Norms*

Behavioral tendencies emerge from roles prescribed by family, religion, or profession. In collectivist cultures, deference and interdependence drive behavioral inhibition; assertiveness and self-expression are rewarded in more egalitarian contexts. Our model prompts clinicians to map patient actions onto these social scripts and consider how departures from expected roles may contribute to distress.

#### *Habitual and Impulsive Patterns*

Beyond formal rituals, culture shapes everyday habits—dietary customs, sleep-wake cycles, leisure activities—and even impulsive behaviors, such as substance use patterns that vary by community norms. Behavioral neuroscience links these patterns to reinforcement circuits, demonstrating that culturally patterned rewards modulate the striatum's activity [\[23\]](#).

### 3.4. Biology

#### *Gene–Culture Coevolution*

Biological processes are not solely determined by genetic endowment; they interact with cultural practices in shaping epigenetic marks and neural development. Studies of gene-culture coevolution reveal, for example, that cultural diets can influence microbiome-gut-brain signaling, affecting neurotransmitter synthesis [\[24\]](#).

#### *Epigenetic Modulation*

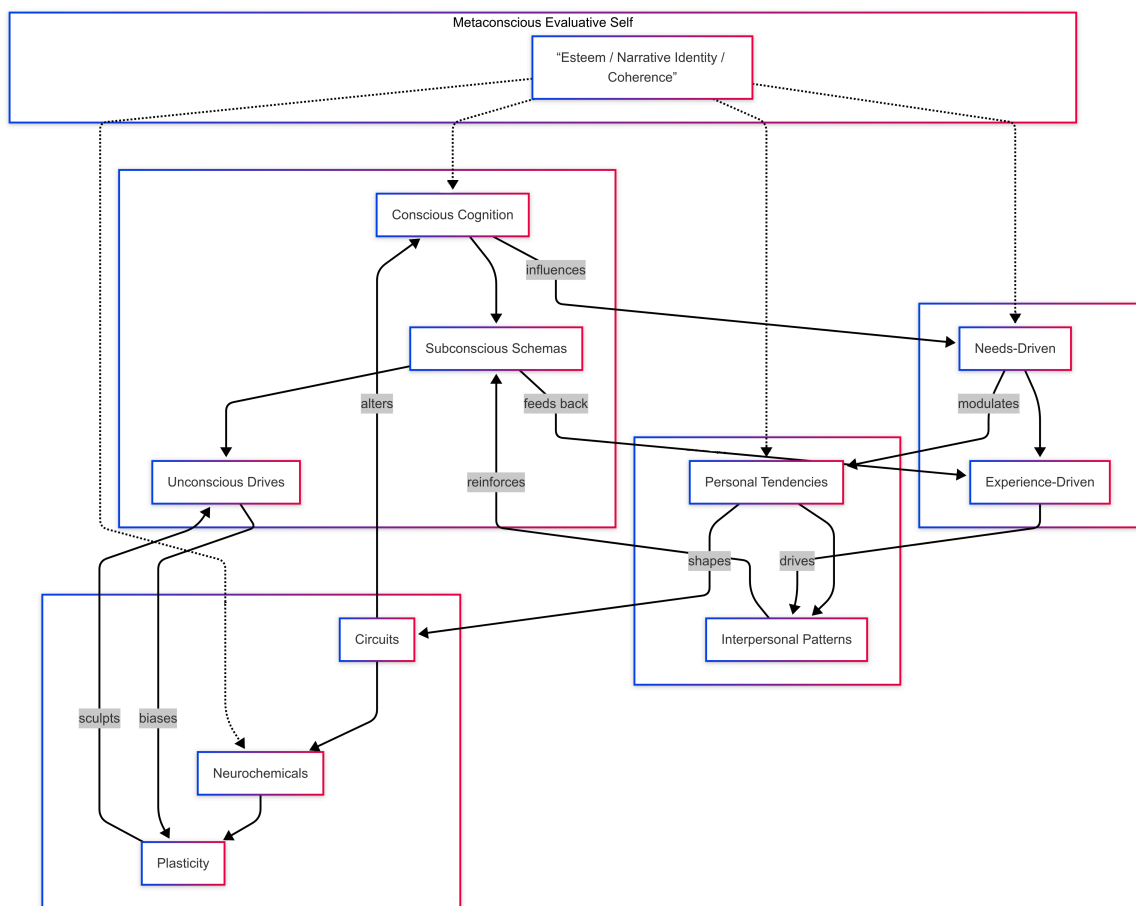
Exposure to cultural stressors—war, migration, discrimination—can leave epigenetic signatures on stress-regulation genes (such as FKBP5), altering HPA-axis responsiveness across generations [\[25\]](#). Our

model encourages attention to these epigenetic factors as part of the biological dimension.

## Cultural Neuroscience Foundations

Neuroimaging research demonstrates that culturally shaped behaviors and beliefs leave discernible traces in brain structure and function. For instance, cultural meditation practices correlate with increased cortical thickness in attention networks [26]. Incorporating such findings, the 4D Model situates biology within an interplay of genetic predispositions and culturally mediated environmental inputs.

## 4. Visual Framework



**Figure 1.** Schematic of Zad's 4D Model with bidirectional inter-domain arrows and the metaconscious evaluative overlay.

*Depicting the self as a four-string instrument, if one string is off-tune, the whole melody changes. Biology can influence Feelings, which in turn shape Behaviors; Behaviors reinforce Thoughts; Thoughts modulate Behaviors;*

## **5. Clinical Vignettes**

### *5.1. Applying the 4D Model in Assessment and Treatment*

To translate theory into practice, we propose a four-step clinical flow:

#### *1. Mapping Symptoms to Domains*

Clinicians begin by categorizing presenting issues, such as insomnia or self-criticism, under Thoughts, Feelings, Behaviors, or Biology.

#### *2. Identifying Domain Interactions*

Next, practitioners trace how disturbances in one area (for example, thought distortions) amplify others (such as sleep-avoidant behaviors or HPA-axis activation).

#### *3. Formulating a Multi-Modal Plan*

Interventions are selected for each domain: cognitive restructuring for maladaptive beliefs, emotion-regulation skills for affective instability, habit reversal or behavioral activation for dysfunctional actions, and pharmacotherapy or neuromodulation for biological dysregulation.

#### *4. Monitoring and Refinement*

Progress is tracked across all domains, using standardized measures or brief checklists. Adjustments are made when one domain lags, for example, adding mindfulness exercises to bolster metaconscious regulation if narrative coherence remains poor.

#### **Vignette A: Psychosis (Schizophrenia)**

*A 24-year-old university student presents with auditory hallucinations, social withdrawal, and disorganized speech. He reports that “the television sends him messages” and that “people can hear [his] thoughts.” Academic performance has declined, and hygiene has deteriorated.*

1. **Thoughts:** The patient demonstrates disorganized thinking and persecutory delusions, reflecting a breakdown in coherent cognition. Internal speech is misattributed as external voices, and schemas

about others are distorted by threat-related bias. Abstract reasoning and executive functioning are impaired, suggesting deficits in prefrontal circuitry related to goal-directed thought.

2. **Feelings:** Blunted affect and reduced emotional expressiveness are prominent. While overt distress is minimal, negative symptoms such as anhedonia and emotional flattening suggest an underlying affective disconnection. Interpersonal mistrust may be fueled by misinterpreted affective cues, creating a feedback loop that isolates the patient further.
3. **Behaviors:** Behavioral disorganization is evidenced by poor grooming, mutism, and erratic pacing. Social withdrawal appears driven by both cognitive disarray and affective blunting. Speech becomes tangential and circumstantial, reflecting disrupted self-monitoring and semantic drift.
4. **Biology:** Neuroimaging studies in similar patients often reveal hyperactivity in mesolimbic dopamine pathways (e.g., ventral tegmental area to nucleus accumbens), which may contribute to aberrant salience attribution and hallucinations. Additionally, hypofunction in prefrontal cortical regions may underlie executive dysfunction and cognitive fragmentation.
5. **Metaconscious (Evaluative Self):** The patient exhibits a collapse in narrative identity. He cannot coherently explain the timeline of his symptoms or his sense of self. His internal voice has become alien, perceived as external and threatening. Self-reflection is fragmented and lacks integration. The “observer self” is overwhelmed, unable to contextualize his thoughts as his own. Metaconscious collapse: fragmented narrative identity → cognitive remediation + antipsychotics <sup>[27]</sup>

**- Intervention Plan:**

Treatment begins with antipsychotic medication to address dopamine dysregulation (Biology). Concurrently, cognitive remediation targets working memory and reasoning deficits (Thoughts). Narrative therapy and guided self-reflection are introduced gradually to reconstruct identity and metaconscious coherence. Behavioral activation and social skills training help restore daily structure and interpersonal engagement. Family psychoeducation provides a stabilizing context. The 4D Model ensures each intervention aligns with a specific disrupted domain, while continuously monitoring how improvements in one area (e.g., reduced delusions) facilitate healing in others (e.g., restored identity or emotional trust).

**Vignette B: Depression (Major Depressive Disorder)**

*A 45-year-old reports persistent sadness, anhedonia, and fatigue. Mapping onto:*

1. **Thoughts:** negative cognitive triad (self-blame, hopelessness)



2. **Feelings:** pervasive sadness, anhedonia
3. **Behaviors:** social withdrawal, psychomotor slowing
4. **Biology:** HPA axis hyperactivity, monoamine deficits
5. **Metaconscious:** self-criticism, cyclical hopeless narrative → SSRI + mindfulness [28]

#### **Vignette C: Addiction (Opioid Use Disorder)**

*A 30-year-old with opioid misuse shows compulsive rituals (Behaviors) and reward-circuit hijacking. The model guides DBT-informed behavior modification and neurobiological adjuncts*

1. **Thoughts:** craving schemas (“just one more dose”)
2. **Feelings:** dysphoria between use episodes
3. **Behaviors:** compulsive drug seeking, ritualized consumption
4. **Biology:** reward-circuit sensitization (ventral tegmental dopamine surge)
5. **Metaconscious:** conflict between self-ideal and actions → DBT + MAT [29]

#### **Vignette D: Borderline Personality Disorder**

*A 28-year-old presents with chronic feelings of emptiness, intense interpersonal conflicts, and recurrent self-harm urges. Applying the 4D Model:*

1. **Thoughts:** “Others will abandon me,” rigid splitting schemas
2. **Feelings:** Rapid-onset anger and despair, difficulty soothing intense affect
3. **Behaviors:** Impulsive spending, self-injurious actions during crises
4. **Biology:** Heightened stress-axis reactivity (elevated cortisol), dysregulated serotonergic tone
5. **Metaconscious:** Fragmented self-narrative, alternating idealization and devaluation of self
  - **Intervention Plan:** Dialectical behavior therapy modules for emotion regulation (Feelings), schema-focused work to modify splitting (Thoughts), distress-tolerance skills to curb impulsivity (Behaviors), and SSRIs to address biological hyperarousal.

### **5.2. Disorders of the Self: Applying the 4D Model to Identity Disintegration**

Disorders such as schizophrenia, dissociative identity disorder (DID), Capgras, Fregoli, and Cotard’s syndromes present a fundamental challenge to the coherence and continuity of the self. The 4D Model allows clinicians to track how such disruptions emerge across interacting psychological and biological domains.

In schizophrenia, for instance, metaconscious coherence may fragment, leading to disturbances in thought content (delusions), perceptual boundaries (hallucinations), and affective expression. Vignette A reflects this breakdown, where persecutory delusions distort cognitive schemas, mesolimbic dopamine dysregulation alters salience attribution (Biology), and social withdrawal reflects impaired behavioral organization. Importantly, narrative self-fragmentation contributes to a sense of alienation, requiring interventions that integrate cognitive remediation with identity-supportive psychotherapy.

In DID, disruptions in memory encoding and retrieval (Thoughts), disjointed affect regulation (Feelings), and state-dependent behavior (Behaviors) unfold alongside trauma-induced neurobiological changes (Biology). Here, the metaconscious self—typically the site of autobiographical integration—splits into compartmentalized self-states.

Therapy may prioritize grounding strategies (Behavior), emotion labeling (Feelings), and narrative reconstruction (Metaconscious), before addressing trauma physiology (Biology).

Misidentification syndromes like Capgras (believing loved ones are imposters) or Fregoli (seeing strangers as familiar) illustrate failures in person recognition and emotional tagging, traceable to disrupted face-affect associations (Feelings), aberrant salience (Biology), and metaconscious misinterpretation of internal confusion as external threat. Cotard's syndrome, characterized by nihilistic delusions ("I do not exist"), reflects an extreme collapse of self-reference across domains, most starkly in Metaconscious disintegration. These conditions require careful reassembly of relational coherence and biological modulation, often via combined pharmacological and psychotherapeutic approaches.

### *5.3. Narcissistic Traits and Ego-Syntonic Personality Disorders: A 4D Application*

Ego-syntonic disorders, such as narcissistic or antisocial personality traits, differ from more overtly distressing conditions in that the patient often lacks internal conflict or insight. Yet the 4D framework offers structured access points for clinical engagement, even when subjective suffering is minimal.

#### **Vignette E: Narcissistic Personality Traits**

A 35-year-old male presents with interpersonal conflict at work and strained family relationships, yet reports no personal distress. He describes himself as "highly competent" and blames others for misunderstandings.

1. **Thoughts:** Core cognitive schemas center on superiority, entitlement, and perfectionism. These beliefs often function as compensatory defenses, protecting a fragile internal self-image.

2. **Feelings:** Emotional life is dominated by envy, defensiveness, and suppressed shame. Affect may be blunted, misattributed, or denied, contributing to poor emotional granularity.
3. **Behaviors:** Interpersonal patterns include dominance, dismissal of others' needs, and validation-seeking behaviors. These are reinforced through social scripting and learned relational dynamics.
4. **Biology:** Functional imaging suggests heightened reactivity in the default mode and reward circuits, potentially underpinning self-focus and status-seeking behavior.
5. **Metaconscious:** The evaluative self is rigid and grandiose, with impaired reflective capacity. Feedback is either dismissed or experienced as narcissistic injury, inhibiting growth.

**Treatment Plan:** Work begins not by confronting distortions directly, but by building therapeutic alliance and subtly encouraging reflective practice. Schema therapy may soften maladaptive beliefs, while metacognitive interventions increase tolerance for internal complexity. Mindfulness and compassion-focused techniques can gradually destabilize rigid identity defenses, while SSRIs or modulatory agents may assist with irritability or impulse control when present.

This application demonstrates that even in ego-syntonic states, the 4D Model provides clinicians with entry points for engagement, highlighting the interplay between social cognition, neurobiology, and identity processes.

## 6. Discussion

### 6.1.

Zad's 4D Model offers an integrative architecture that both synthesizes and transcends existing psychological schools. By explicitly mapping Freudian drives, Beckian schemas, affective neuroscience, behaviorist operants, attachment patterns, neurocircuitry, and epigenetics into four cohesive domains, anchored by a metaconscious evaluative layer, our framework provides a unified language for describing human experience. This model addresses a key limitation of siloed theories: the lack of a shared ontology that accommodates dynamic, cross-domain interactions. In practice, clinicians can use the model to trace presenting symptoms through multiple levels of analysis, from neurotransmitter imbalances to narrative identity disruptions, thereby avoiding reductionism or over-reliance on any single paradigm.

Clinically, the 4D Model serves as a heuristic for case conceptualization, treatment planning, and interprofessional communication. For example, in depression, pharmacotherapy may target HPA-axis dysregulation (Biology) while cognitive interventions modify negative schemas (Thoughts), mindfulness

builds metacognitive awareness (Metaconscious), and behavioral activation addresses withdrawal patterns (Behaviors). Training programs can incorporate the model to help trainees recognize how a single symptom, such as insomnia, may arise from intertwined dysfunctions across domains (e.g., stress-circuit hyperactivity, ruminative thought loops, affective dysregulation, maladaptive sleep habits). By doing so, it cultivates comprehensive, personalized care rather than one-size-fits-all protocols.

From a research perspective, the 4D Model invites quantitative and qualitative studies that measure domain-specific disturbances and their interactions. Factor-analytic work could validate whether questionnaire and neuroimaging metrics cluster into the four proposed domains plus a metaconscious factor. Longitudinal designs could test how shifts in one domain (e.g., improved emotion regulation through therapy) precipitate changes in others (e.g., reduced reward-circuit sensitization or modified self-narrative coherence). Moreover, the model's explicit inclusion of culture and trauma as modulators of metaconsciousness opens avenues for cross-cultural and lifespan research.

## *6.2. Improvements over DSM-5 and ICD-11*

### *1. Integrated Ontology*

Rather than separate symptom lists, our model offers a unified structure that links diagnostic categories to underlying domains.

### *2. Cross-Domain Interaction*

DSM-5 and ICD-11 treat symptoms in isolation. By mapping how Thoughts, Feelings, Behaviors, and Biology influence one another, the 4D Model accounts for dynamic processes, such as how chronic rumination (Thoughts) sustains HPA-axis activation (Biology).

### *3. Developmental and Cultural Context*

Standard nosologies pay limited attention to cultural variation or developmental trajectories. Our framework embeds cultural scripts within each domain and emphasizes how early attachment experiences shape emotion regulation and narrative self.

### *4. Treatment Sequencing*

Current classifications do not guide intervention order. Based on domain severity and interaction patterns, the 4D Model explicitly suggests when to prioritize biological treatments over cognitive or behavioral

strategies. By addressing these four gaps, the 4D model enhances diagnostic clarity and informs personalized, multi-modal treatment planning.

Several limitations warrant acknowledgement. First, the 4D Model remains a conceptual framework and requires empirical validation; the boundaries between domains may blur in practice, and certain phenomena (e.g., somatic symptom disorders) straddle multiple domains. Second, integrating such a broad model into routine clinical workflows demands practical tools, such as domain-specific assessment checklists or visual mapping software, that we have yet to develop. Finally, the relative weighting of each domain in different disorders (or even within subtypes of a single disorder) needs systematic study to avoid nominal “domain overload.”

Future directions include (1) operationalizing domain constructs into standardized assessment batteries; (2) designing training modules that teach clinicians to apply 4D mapping in real time; (3) piloting digital tools that allow patients to self-report domain-specific experiences, thereby enhancing shared decision-making; and (4) exploring how metaconscious interventions (e.g., narrative therapy, mindfulness-based cognitive therapy) specifically bolster coherence and identity integration. Ultimately, by providing a shared, multidimensional framework, Zad’s 4D Model aspires to bridge theory and practice, enriching both psychiatric education and patient-centered care.

## **Footnote1 (Etymology of "Zad")**

The name "Zad" comes from the Arabic root **زاد**, which refers to provisions or sustenance carried on a journey, whether physical supplies, knowledge, deeds, or essential resources for growth and survival. Metaphorically, we invoke "Zad" to signify the inner reserves and developmental nourishment, across thought, feeling, behavior, and biology, that support the self’s ongoing growth and resilience.

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### *Conflicts of Interest*

None declared.

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## Author Contributions

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