Trapped Navigation: Addiction, Trauma, and OCD as Conscious Suppression of Intelligent Correction [A] (2026)

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Paper 2 in a series on conscious suppression; see [Paper 1: Intelligence Without Consciousness](#) for the full taxonomy of intelligence and consciousness.

Abstract

Why do people with addiction, trauma-related avoidance, or obsessive-compulsive disorder often know their behavior is maladaptive yet cannot stop? Standard explanations – impaired executive control, habit dominance, weak insight – are incomplete. This paper applies the attractor framework's suppression mechanism. In each disorder, the person *detects* the discrepancy between behavior and goals (insight is intact), but **phenomenal, identity-constitutive investment** – the felt urgency of craving, the necessity of avoidance, the compulsion to ritualize – deepens the attractor basin relative to corrective perturbations. The suppression is not a failure of intelligence; it is a dynamical competition between attractors. The paper distinguishes this account from dual-process and executive-control theories, provides falsifiable diagnostic criteria, and discusses treatment implications (why insight alone fails). Acknowledgment is made that for addiction, the relationship between incentive

salience (*wanting*) and phenomenal consciousness remains contested; the model targets the subset of craving states that patients report as felt urgency.

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1. Introduction: The Paradox of Insight Without Change

A person with alcohol use disorder knows that drinking damages their health, relationships, and future. Yet when a craving arises, they drink. A trauma survivor knows that the parking garage is safe, yet they avoid it. A person with OCD knows that the ritual is irrational, yet they perform it.

Standard explanations invoke **impaired executive control** (Volkow et al., 2016), **habit dominance** (Balleine & Dickinson, 1998), or **lack of insight** (Amador et al., 1994). But these accounts do not explain why the person can articulate the harm, describe counterarguments, and intend change, yet the behavior persists. Executive control may be intact in non-trigger contexts; habits may be sensitive to goal-level knowledge; insight may be partial or oscillating.

The attractor framework provides a model of **motivational competition** where a conscious, identity-binding urge temporarily overrides the correction signal. In *Intelligence Without Consciousness* (Galida, 2026), we introduced **conscious suppression**: phenomenal, identity-constitutive commitment deepens an attractor basin, making it resistant to corrective perturbations. This paper applies that mechanism to addiction, trauma-related avoidance (PTSD), and OCD. It does not deny executive or habit deficits; it proposes that in many cases, a conscious-level attractor competition is the primary obstacle to change.

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2. Defining Conscious Suppression (Self-Contained Glossary)

For readers unfamiliar with Paper 1:

- **Attractor basin** – the set of states from which a system returns to a stable pattern. A deeper basin resists larger perturbations.
- **Corrective permeability (κ)** – responsiveness to error signals; $\kappa = 1/\tau$, where τ is return time to baseline after a perturbation.
- **Conscious suppression** – a process where the person *experiences* an urge, fear, or compulsion as felt, identity-relevant, and *not chosen* (non-deliberative), yet the depth of that attractor prevents escape from the maladaptive behavior. This corresponds to **Level 3** in Paper 1: detection of error + suppression via basin depth. Level 2 (automatic bias without error detection) and Level 1 (unfamiliarity) are not the target.

On sealing mechanisms: The paper treats sealing mechanisms (e.g., rationalizations) as *attractor-consistent outputs* generated by the basin state, not as deliberate strategic choices. Although they may *feel* deliberate to the patient, the model treats them as expressions of the attractor's depth, not as independent volitional acts. This resolves the tension between "non-deliberative urgency" and the deployment of rationalizations.

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3. Empirical Grounding

Addiction:
Volkow et al. (2016) demonstrate that chronic substance use impairs prefrontal executive function in a state-dependent manner — deficits emerge under craving or stress, not at all times. Individuals can maintain intact verbal knowledge of consequences and express intention to stop (Goldstein et al., 2009). The craving state has been modeled as a competing attractor (Redish, 2004; Gutkin et al., 2006). **Incentive-salience theory** (Robinson & Berridge, 1993, 2008) distinguishes *wanting* (which can be non-conscious) from *liking*. The present model targets the subset of craving states that are *phenomenally accessible* — the patient's reported felt urgency. This is a narrower claim; the paper does not assume that all incentive-salience processes are conscious.

PTSD & avoidance:
Extinction recall deficits (Milad et al., 2006) are well documented, but they do not fully account for conscious fear as *necessary* even when safety is known. Meta-analyses confirm vmPFC–amygdala decoupling in PTSD (e.g., Etkin & Wager, 2007, and subsequent reviews). Ecological momentary assessment (EMA) studies in representative samples show that individuals with PTSD often report high certainty of safety before trigger environments yet avoidance persists (see, e.g., reviews of EMA in PTSD). The attractor account adds the role of identity-binding schemas ("the world is dangerous") as basin-deepening factors.

OCD:
The DSM-5-TR includes an insight specifier: *good/fair*, *poor*, or *absent*. Approximately 25–30% of individuals with OCD have poor insight (Catapano et al., 2010). This paper targets the **good-insight subgroup** (where the person recognizes irrationality). For poor-insight patients, the mechanism may

be closer to Level 2 (automatic compulsion without error detection).

Recent literature (2015–2025):

- EMA studies of craving show that momentary urge strength predicts relapse better than global insight (Serre et al., 2015; Shiffman et al., 2020).
- OCD outcome studies confirm that poor insight predicts worse response to ERP (García-Soriano et al., 2021). Good-insight patients still show substantial residual symptoms, consistent with a competition model.
- Identity-shifting interventions for addiction (Best et al., 2016) support the importance of decoupling selfhood from "addict" identity.

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4. Three Clinical Patterns

4.1 Addiction

- **Mechanism:** Craving as a state-dependent attractor that overrides goal-directed control when triggered. Identity fusion ("I am an addict") deepens the basin where present, but is not universal.
- **Suppression signature:** The person can articulate reasons to quit, has attempted to quit, but during craving, corrective signals are suppressed.
- **Sealing mechanisms:** Cognitive rationalizations ("just this once," "I need it to cope") that block the error signal from updating the basin — treated as attractor-consistent outputs, not deliberate choices.

4.2 Trauma-Related Avoidance (PTSD)

- **Mechanism:** Conditioned fear creates an avoidance attractor. Safety knowledge may be intact, but felt necessity dominates.
- **Suppression signature:** “I know it’s safe, but I can’t go in.”
- **Identity fusion:** “The world is dangerous” as a self-defining schema.

4.3 Obsessive-Compulsive Disorder (OCD — Good Insight Subgroup)

- **Mechanism:** Anxiety drives compulsions that temporarily reduce distress, despite knowledge of irrationality.
- **Suppression signature:** “I know it doesn’t make sense, but I have to do it.”
- **Sealing mechanisms:** “Better safe than sorry,” “It’s a small price to pay for certainty.”

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5. Transdiagnostic Table

Disorder	Error signal detected	Conscious investment	What maintains basin depth (mechanism)
Addiction	Knowledge of negative consequences	Craving (felt urgency)	Reinforcement schedule + state-dependent executive impairment + (sometimes) identity fusion

Disorder	Error signal detected	Conscious investment	What maintains basin depth (mechanism)
Trauma avoidance	Safety knowledge (cognitive)	Fear (felt necessity)	Extinction resistance + hyperarousal + schema of danger
OCD (good insight)	Knowledge of irrationality	Anxiety (felt urgency)	Negative reinforcement via distress reduction + certainty-seeking belief

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6. Diagnostic Criteria for Clinical Fantasy Attractors (Operationalized)

A patient’s presentation is a **candidate** clinical fantasy attractor if it meets **three of five** criteria (provisional threshold; empirical validation required). The Level 2/3 distinction requires momentary assessment (see §7).

1. **Insight intact:** The patient can state, unprompted, the discrepancy between behavior and goals. *Operationalization:* Score ≥ 4 on the Brown Assessment of Beliefs Scale (BABS) insight item, or equivalent.
2. **Conscious urgency:** The maladaptive behavior is preceded by a felt, urgent state (craving, fear, anxiety) rated by the patient as “overwhelming” or “necessary.” *Operationalization:* Momentary ecological assessment (EMA) rating > 7/10 before the behavior.
3. **Identity fusion:** The patient endorses that the behavior or its avoidance is central to selfhood (e.g., “I am an addict,” “I must do this to be safe”). *Operationalization:* Endorsement of at least one identity statement on a structured interview.

4. **Low corrective permeability in trigger contexts:** Repeated corrective information (psychoeducation, feedback) does not reduce the behavior. *Operationalization:* No significant reduction after three sessions of evidence-based psychoeducation alone.
5. **Sealing mechanisms:** The patient spontaneously uses rationalizations that neutralize corrective input. *Operationalization:* Qualitative coding of patient speech (inter-rater reliability to be established; currently a research gap).

Counter-criteria (exclude if any present):

- The patient cannot state the discrepancy (insight absent) – then Level 2 or 1.
- The behavior stops entirely after receiving corrective information alone – then basin depth was shallow.

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7. The Detection Problem (Level 2 vs. 3) in Clinical Practice

Distinguishing automatic compulsion without error detection (Level 2) from conscious suppression with error detection (Level 3) requires:

- **Momentary assessment of doubt** during urge episodes (EMA protocols; Serre et al., 2015).
- **Reaction time paradigms** (e.g., Gillan et al., 2014, for goal-directed vs. habitual control in OCD; note that the specific link to error detection latency remains an active area).
- **Physiological markers** (dissociation between cognitive

knowledge and fear response suggests Level 3).

These methods are promising but not fully validated; the paper specifies directions for needed research.

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8. Implications for Treatment

Insight-only interventions (psychoeducation, cognitive restructuring alone) often fail in these disorders because the basin depth is maintained by conscious urgency, not lack of knowledge.

Effective treatment must **reduce basin depth** or **increase corrective force**:

- **Addiction:** Pharmacological reduction of craving (e.g., naltrexone; emerging evidence for GLP-1 agonists — see recent reviews, e.g., Klausen et al., 2022, for GLP-1 receptors and alcohol, and emerging clinical reports), contingency management, and identity-shifting interventions (Best et al., 2016).
- **Trauma:** Exposure therapy (increasing corrective force) combined with arousal reduction. The mechanism is basin reshaping, not insight.
- **OCD:** Exposure and response prevention (ERP) directly targets the basin by preventing the compulsion while the patient experiences urgency. The inhibitory learning account (Craske et al., 2014) is compatible; this paper reframes it as increasing corrective force against a competing attractor.

The prediction: treatments that solely enhance insight will be less effective for patients meeting the diagnostic criteria than treatments that directly target basin depth or corrective

force.

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9. Open Questions

- **Measuring basin depth in clinical settings:** Subjective urgency scales, behavioral persistence tasks, heart rate variability. A Clinician Basin Depth Scale (CBDS) is a research priority.
- **Level 2 vs. 3 differentiation:** Can EMA and reaction time methods reliably classify patients? Pilot studies needed.
- **Diagnostic threshold validation:** The “three of five” criterion requires empirical ROC analysis against treatment response.
- **Disorders where suppression is purely Level 2:** Some impulse control disorders or psychotic conditions may not meet the conscious detection criterion.

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10. Conclusion

Addiction, trauma-related avoidance, and OCD (good insight subtype) are not failures of intelligence. They are cases where conscious, identity-constitutive investment deepens an attractor basin relative to corrective perturbations. The person detects the error – they know the behavior is harmful or irrational – but the felt urgency overrides intelligent navigation.

This diagnosis explains why insight alone fails and why treatments that target basin depth succeed. The clinical fantasy attractor is a trapped navigator: intelligent, aware, but unable to escape.

The dance of recovery is not about knowing the way out. It is about reshaping the attractor landscape so that the path to safety becomes shallower than the pull to stay.

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