Neuroregulatory Extension of the Behavioural Classification Model (BCBM): The DRFM-8 Framework

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Abstract- Background: The Behavioural Classification Model of Disease (BCBM), previously published in the *International Journal of Innovative Research in Technology (IJIRT)*, conceptualizes chronic disease—particularly cancer—as an adaptive behavioural–systemic state. However, a mechanistic pathway explaining *how* such behavioural states may be regulated at the brain-network level has remained unexplored.

Objective: To present the Distributed Resonance Fraction Model (DRFM-8) as a neuroregulatory extension of the published BCBM, based on large-scale observational therapy data.

Methods: An observational dataset comprising 45,000 pendulum-based neuroregulatory therapy sessions was analyzed. The dataset included 250 patients, each receiving three sessions per day over approximately two months (≈60 days). Observations focused on consistency of response patterns rather than isolated symptomatic endpoints.

Results: Across sessions, effective regulation of target-associated behavioural and cognitive states was consistently observed when approximately one-eighth (1/8) of the estimated target energy was delivered as a direct resonant input. The remaining energy appeared to distribute across interconnected neural networks, supporting systemic balance.

Conclusion: DRFM-8 functions as a mechanistic companion model to the BCBM, proposing that behavioural disease states described by BCBM may be modulated through fractional, distributed neuroregulatory resonance rather than high-intensity, target-only intervention.

Keywords- Behavioural Classification Model, DRFM-8, neuroregulation, fractional resonance, network brain, integrative medicine

I. INTRODUCTION

The Behavioural Classification Model of Disease (BCBM), published in *IJIRT*, reframed chronic disease as a manifestation of long-term behavioural and adaptive states rather than solely as a cellular or genetic malfunction. While BCBM addressed the etiological question (WHY disease forms), a corresponding regulatory mechanism (HOW such states may be modulated) remained to be articulated.

The present paper introduces the Distributed Resonance Fraction Model (DRFM-8) as a neuroregulatory extension of BCBM, grounded in repeated therapeutic observations and aligned with contemporary network neuroscience.

II. OBSERVATIONAL DATASET AND THERAPY PROTOCOL

2.1 Patient and Session Structure

- Total patients: 250
- Sessions per patient per day: 3
- Duration: ~60 days (2 months)

Total therapy sessions:
250 × 3 × 60 = 45,000 sessions

2.2 Therapy Characteristics

- Non-invasive pendulum-based neuroregulatory intervention
- Brain-network–oriented therapeutic intent (e.g., hippocampal–limbic–prefrontal regulation)
- Standardized session duration and practitioner protocol

No pharmacological agents were administered during the observation period.

III. THE DISTRIBUTED RESONANCE FRACTION MODEL (DRFM-8)

3.1 Core Formula

Drop Energy Frequency (DEF) = Target Energy Frequency (TEF) / 8

3.2 Conceptual Interpretation

- Target Energy Frequency (TEF): Theoretical resonant requirement associated with a specific behavioural–neural target identified via BCBM classification.
- Drop Energy Frequency (DEF): The effective fractional energy delivered through the pendulum-mediated process.

According to DRFM-8:

- Approximately 1/8th of TEF manifests as direct target resonance.
- The remaining fraction contributes to distributed neural regulation, consistent with network-based brain function.

IV. INTEGRATION WITH THE BEHAVIOURAL CLASSIFICATION MODEL (BCBM)

BCBM categorizes disease states based on behavioural and adaptive patterns (e.g., threat persistence, emotional suppression, withdrawal, or hyper-control). DRFM-8 provides a neuroregulatory pathway through which these behavioural states may be modulated:

1. BCBM identifies the dominant behavioural disease state
2. Corresponding brain-network stress patterns are inferred
3. Fractional resonant input (DRFM-8) is applied
4. Network-level regulation reduces behavioural persistence of disease

Thus, BCBM explains *what kind of disease behaviour exists*, while DRFM-8 explains *how that behaviour may be gently regulated at the neural level*.

V. OBSERVATIONAL OUTCOMES

Practitioners consistently noted:

- Emotional stabilization
- Reduced hyperarousal or withdrawal patterns
- Improved sleep and cognitive steadiness
- Gradual reduction in symptom volatility

These effects aligned more closely with behavioural state regulation than with isolated symptom suppression.

VI. DISCUSSION

This companion paper positions DRFM-8 not as a standalone therapeutic claim, but as a mechanistic extension of the already published BCBM framework.

6.1 Scientific Positioning

- Compatible with network neuroscience principles
- Extends behavioural disease theory into neuroregulatory application
- Avoids high-intensity intervention paradigms

6.2 Limitations

- Observational design
- Lack of direct instrumental neurophysiological measurements
- Practitioner-dependent assessments

VII. FUTURE DIRECTIONS

- Instrument-based validation (EEG, HRV, functional imaging)
- Controlled comparative studies aligned with BCBM categories
- Quantitative modelling of fractional resonance thresholds

VIII. CONCLUSION

The Distributed Resonance Fraction Model (DRFM-8) provides a coherent neuroregulatory extension to the Behavioural Classification Model of Disease (BCBM) previously published in *IJIRT*. Together, these models propose that chronic disease states may be understood and modulated as behavioural–neural network phenomena, opening new interdisciplinary pathways for integrative medical research.

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