

Environmental Stabilization and Symptomatic Variability

1. Pre-Intervention State: Allostatic Load and Sensitization

The patient entered in a state of **acute autonomic crisis** exacerbated by psychosocial stressors (interpersonal loss) superimposed on a degenerative baseline pathology (MS).

- **Suggested Clinical Profile:** High sensory hyper-reactivity and persistent cognitive rumination ("intrusive thoughts").
- **Biological State:** The testimony describes an inability to self-regulate through traditional methods (meditation/yoga), suggesting a nervous system in a state of **persistent hypervigilance** (a survival mechanism likely linked to past trauma: terrorist attacks and accidents).
- **Symptom Burden:** Severe anxiety, lower extremity fatigue ("heavy legs"), and a cognitive "tunnel vision" centered on future disability.

2. During the Intervention: Response to Environmental Neutrality

Exposure to the practice model infrastructure (a low-entropy environment with partial visual sensory deprivation) induced physical responses reported as "intense":

- **Physical Phenomenology:** Sensations of rhythmic cranial pressure and vibrations. In a clinical context, this can be interpreted as **proprioceptive sensitization** occurring once external environmental noise is eliminated.
- **Measurable Deltas (Subjective):**
 - **Pressure Point Identification:** Recognition of previously unnoticed tension in the solar plexus.
 - **Post-Session Motor State:** Transient ataxia or heaviness in limbs, consistent with a profound relaxation of sympathetic muscle tone following a period of high tension.

3. Post-Intervention State: Stabilization and Function

The most significant shift was observed in the **reduction of thought variability** and the improvement of sleep architecture.

- **Sleep Architecture:** Report of 10 hours of continuous, uninterrupted sleep—a critical delta for patients with neurodegenerative diseases where sleep consolidation is vital for metabolic stability.
- **Cognitive Modulation:** A drastic reduction in mental "noise" and the need for external validation. The patient reports a transition from "hyper-vigilance" to "presence," indicating a temporary reduction in cognitive load.

4. Matrix of Deltas and Functional Improvements

Category	Pre-FSRL (Baseline)	Post-FSRL (Observed Delta)	Clinical Value
Cognition	Persistent rumination and over-analysis.	"Populating thoughts" nearly absent.	Reduction of allostatic load.
Sleep	Fragmented / Hypervigilant.	10 hours of restorative, continuous sleep.	Circadian rhythm stabilization.
Proprioception	Unidentified tension (solar plexus).	Recognition and release of somatic tension.	Improved interoception.
Social Interaction	Visual avoidance, insecurity.	Ability to maintain sustained eye contact.	Social Engagement System activation.

5. Clinical Explanation and Observational Rigor

The model did not act as a treatment for MS; rather, it functioned as **containment infrastructure**. By "outsourcing" the need to process volatile environmental variables (noise, thermal fluctuations, complex visual stimuli), the patient's nervous system was able to redirect metabolic resources toward internal regulation.

The transition from a state of "threat expectancy" to one of "presence" suggests that **structured environmental stability** can serve as a valuable non-pharmacological variable for refractory patients. These individuals have often exhausted conscious self-regulation tools because their "baseline" stress is too high for meditation or yoga to be effective.

6. Limitations and Openness to Results

It is fundamental to note that this report represents one of a case series with 96-hour follow-up results. The durability of this stabilization once the patient returns to an uncontrolled urban environment is unknown. The success of this pilot lies in the **identification of a physiological signal of settling** that was previously inaccessible to the patient.