# Full Governance Risk Containment Framework

Nervonic Acid Self-Experimentation in AMN

**1. Purpose**

This document accompanies the scientific rationale and clinical reference materials for nervonic acid (NA) self-experimentation.

Its purpose is to:

• Acknowledge both promise and uncertainty
• Identify personal psychological risk factors
• Establish structural safeguards
• Prevent escalation driven by fear or emotional investment
• Clarify boundaries regarding any prophylactic consideration for my daughter

*This is not a cure claim.*
*It is a structured exploratory intervention governed by predefined constraints.*

**2. Scientific Positioning: Three Layers**

All decisions in this project must distinguish between three layers:

1. Scientific plausibility
2. Clinical evidence
3. Emotional necessity

I am strongest in Layer 1.
Layer 2 remains limited.
Layer 3 is powerful.

When emotional necessity begins driving scientific decisions, escalation risk rises.

This framework exists to prevent that.

**3. Recognized Strengths of This Project**

The following increase rigor:

• Phenotype-specific reasoning (central long-tract conduction fragility without peripheral neuropathy)
• Clear separation between regeneration versus preservation goals
• Explicit distinction between biomarker change and clinical outcome
• Independent laboratory verification plan
• Defined budget and supply limits
• Recognition of translational limits between mouse and human data
• Absence of cure language

My phenotype may allow clearer detection of functional signal due to preserved motor units and identifiable conduction variability.

**It does not strengthen prophylactic inference for others.**

Strengths are acknowledged to demonstrate competence.
Weaknesses are acknowledged to demonstrate discipline.

Trust requires both.

**4. Evidence Gaps (Explicitly Acknowledged)**

- No human NA trials in AMN
- No adult dose-response data
- No evidence of prevention of cerebral inflammatory conversion
- Biomarker improvement does not guarantee clinical effect
- Long-term high-dose isolated NA exposure is not studied
- Translational models may not apply to chronic adult disease

**If after sustained observation at 1 g:**

- VLCFA decreases
- No adverse biological drift occurs
- No measurable functional gain appears

The correct interpretation is:

Biochemical engagement confirmed. Clinical effect undetermined.

Continuation at 1 g may be defensible as monitored maintenance.

Escalation is not automatically justified.

**5. Personal Bias and Psychological Risk Factors**

I recognize that the following psychological dynamics may influence my interpretation of outcomes:

- Strong response to novelty and expectation
- Early subjective improvement with new interventions
- High emotional investment due to limited medical support
- Fear of cerebral inflammatory conversion amplifies urgency
- My daughter’s carrier status increases perceived pressure
- Tendency toward fixation under uncertainty
- Significant identity investment in this work

These are not flaws. They are risk variables.

The strength is not introspection itself.
The strength is:

• Detecting bias
• Tolerating critique
• Admitting uncertainty
• Pre-committing to constraints
• Delaying action despite discomfort

Self-governance is more important than the compound itself.

**6. Existential Threat Management**

When existential threat is present, the brain:

1. Seeks control through action
2. Distrusts passive monitoring

This project must not become threat containment disguised as optimization.

Dose escalation is not control.
It can become the illusion of control.

Real control is:

• Structured review intervals
• Defined boundaries
• Non-reactivity to fear spikes
• Separation of transplant anxiety (stem cell transplant) from lipid dosing logic

**7. Experimental Structure**

Phase Separation

Phase 1: Biological engagement
Phase 2: Functional signal
Phase 3: Long-term trajectory observation (12–24 months total trajectory)

These phases must not be conflated.

**Dose Framework**

• Fixed starting dose: 1 g daily
• No escalation before 9 months under any circumstance
• Formal review at 9 months
• Escalation strongly discouraged before 12 months
• Escalation sequence limited to: 1 g → 1.5 g → 2 g
• Absolute ceiling: 2 g

If I increase dose without measurable change beyond baseline variability, I am reacting to uncertainty rather than data.

That is chasing signal.

**Evaluation Gates**

• First 30 days considered contaminated by novelty response
• Structured review at 9 months
• Extended review at 12 months

Escalation requires:

• Completion of at least 9-12 months at current dose
• Stable laboratory markers
• Stable imaging, if available
• ≥10–15% measurable improvement beyond baseline variability sustained for at least 3 months
• Confirmation by repeatable functional measures
• No unresolved external safety, oversight, or compliance concerns

• Absence of confounders

**Confounder Stability Requirement**

Escalation may occur only when confounding variables are stable, documented, and unlikely to be the primary explanation for observed changes.

For the purpose of this protocol, a confounder is considered destabilizing if it includes:

• Acute infection or inflammatory illness
• Medication changes within the prior stabilization window
• Recent steroid dose adjustments
• Significant sleep disruption
• Major psychological stress event
• Acute pain flare outside baseline variability

Escalation is not required to wait for complete absence of symptoms. In a chronic neurological condition, baseline variability is expected.

Instead, escalation requires:

• No active destabilizing confounders
• At least X weeks of relative physiological stability
• Sustained functional change beyond expected baseline fluctuation
• Clear documentation of concurrent variables

If improvement occurs during a destabilizing phase, escalation is deferred until stability is re-established and the signal persists.

Biochemical marker movement alone does not justify escalation. (VLCFA Blood Test)

**8. External Constraint Requirement**

Escalation must require friction.

Options include:

• Written agreement requiring third-party review
• Signed self-contract with dated escalation criteria
• Specialist consultation acknowledging absence of evidence for higher dosing
• Objective worsening beyond baseline variability

If escalation is easy, escalation will occur.

Friction protects the experiment.

**9. Daughter Boundary (Prophylactic Consideration)**

I cannot eliminate all risk for my daughter.

No parent can.

What I can provide:

• A model of disciplined thinking
• Calm monitoring rather than panic
• Structure over intensity

There will be:

• No prophylactic intervention for a minimum of 12 months of stable pilot data
• No action based solely on theoretical protection
• No decision driven by fear of future absence

NA is not insurance.

It is a theoretical hedge.

Those are not equivalent.

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10. Stabilizing Principle

For me:

Run the experiment cleanly.
Do not escalate emotionally.

For her:

Delay.
Observe.

Act only if data justifies it.

There is no current clock requiring acceleration.

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11. Final Commitment

I recognize both promise and bias and have built structure around both.

If at any point:

• Hope becomes central
• Escalation becomes identity-driven
• Fear overrides thresholds

The intervention must be reevaluated.

This project remains contained, disciplined, and reversible.