

The Somatica Model

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Martial law of the Soma

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This is a model of chronic complex illness built from within.

It is still developing, but it is the clearest way I have found to explain what these conditions feel like mechanically: not as one symptom, one organ, or one diagnosis, but as a whole system changing how it governs energy, threat, recovery and capacity.

This is the first of two pieces.

This one is the map. It tries to explain the Somatica Model in a human-readable way: why ME/CFS, Long COVID, dysautonomia, fibromyalgia, chronic pain, neurodivergent burnout and trauma-shaped physiology can overlap without collapsing them into one thing.

The second piece will go deeper into the mechanisms: autonomic regulation, sleep, central sensitisation, immune signalling, energy limits, connective tissue load and the biokinetics underneath the map.

For now, the aim is simpler: to make the pattern easier to see.

Not to diagnose anyone. Not to replace medicine. Not to claim the final answer.

Just to offer a structure that might help others understand what is happening when the body still belongs to the same person, but access to energy, movement, thought and recovery has changed.

A lot of medicine is built to find the broken part. That makes sense when the problem is local: a fracture, tumour, infection, blocked vessel, autoimmune marker, structural lesion, or clear organ abnormality. The job is to locate the fault, name it, treat it, and monitor whether it resolves.

But many chronic complex illnesses do not behave like one broken part. They present as a pattern across systems.

Fatigue, pain, dysautonomia, brain fog, sensory intolerance, post-exertional crashes, non-restorative sleep, nausea, temperature instability, joint problems, migraines, shutdowns and cognitive slowing can all appear together, but not always in the same order or with the same intensity. One person enters through cardiology because standing sends their heart rate strange. Another enters through rheumatology because pain is the loudest feature. Another enters through neurology because cognition, sensation or migraines dominate. Another is sent toward psychiatry because the whole thing looks too distributed to be comfortably held as physiology.

Each doorway can contain a piece of truth. The problem is that the patient is left holding the whole pattern.

The Somatica Model starts from that whole pattern. It does not ask which single part has failed first. It asks what state the system has reorganised into. That is the central shift: chronic complex illness as governance reorganisation, not simply isolated damage. The longer Somatica document frames this directly: chronic multi-system illness may involve a lawful reorganisation of regulation across bodily infrastructure, nervous-system governance and predictive modelling, rather than dysfunction being reducible to one organ or subsystem.

The phrase I use for this is **martial law of the soma**.

"Soma" means the living body: the body as felt, regulated, inhabited and survived from inside. "Martial law" is not meant as drama. It is a governance image.

A city under emergency rule does not vanish. The roads are still there. The buildings are still there. The people are still there. But ordinary life changes. Movement is restricted. Resources are rationed. Repair is delayed. Signals are watched more closely. Small disturbances are treated as possible threats. The city may still function, but it is no longer

organised around flourishing. It is organised around preventing collapse.

That is the useful comparison.

In chronic complex illness, the body can enter a similar protective rule. The system becomes more conservative with energy, less tolerant of variation, quicker to react, slower to recover and more likely to treat ordinary activity as unsafe. In the short term, this kind of protection can be adaptive. Under acute stress, a body should mobilise. It should increase alertness, redirect energy, narrow priorities and protect survival.

The problem begins when the emergency setting becomes the baseline.

This is where reduced function gets misread as reduced personhood.

The person is still there. Their intelligence is still there. Their humour is still there. Their care, frustration, ambition, memory and wish to participate are still there. What changes is access.

A person can still care and not be able to reply. They can still understand and not be able to think clearly on command. They can still want to move and not have the circulatory stability to stand. They can still want to exercise and not have the recovery capacity to absorb exertion. They can still be emotionally present and not have access to the words, facial expression or energy that would prove it to someone else.

The route from intention to action has become unreliable.

That is one of the cruellest parts of these illnesses. They do not only take energy. They make the person look absent from choices they are still internally present for.

This is also why the phrase **Chronic Fatigue Syndrome** is such a damaging undersell. To someone who has not lived it, fatigue sounds like tiredness. Maybe severe tiredness. Maybe long-term tiredness. But still tiredness.

ME/CFS, especially when post-exertional malaise is present, is not just being tired for a long time. It is a state where exertion can produce delayed deterioration; where sleep can happen without restoration; where heart rate, cognition, pain and sensory tolerance can shift together; where the body may restrict output after demands that would be ordinary for someone else.

The name describes the surface feeling. It does not describe the system behaviour.

Long COVID makes this easier for more people to see. Someone can be functioning normally, then an infection happens. The acute illness passes, but the system does not return to baseline. Now there is fatigue, post-exertional malaise, dysautonomia, brain fog, poor sleep, pain, sensory intolerance or reduced tolerance for normal activity.

That sequence makes it harder to dismiss the whole pattern as personality, weakness or anxiety. Long COVID and ME/CFS are not identical in every cause or subtype, but they can overlap in the state they produce. The CAN dysregulation document describes ME/CFS and Long COVID as sharing a multi-system defensive state involving autonomic control, arousal gain, sleep fragmentation, central sensitisation and an energy-governor clamp around PEM.

Different doors. Similar room.

That does not mean every case is the same. It means different triggers may push people toward overlapping defensive system states.

The body, nervous system and mind are all involved in that state, but not in a simplistic "it is all connected" way. The body is the physical infrastructure: connective tissue, muscles, fascia, blood vessels, joints, immune signalling, hormones, organs and cellular energy. This is where cost is paid. If joints are unstable, the body pays. If blood pressure regulation is poor, the body pays. If muscles are guarding all day, the body pays. If immune signalling is elevated, the body pays. If sleep does not restore, the body pays.

The nervous system is the control layer. It regulates threat, energy, pain, movement, heart rate, digestion, temperature, sleep and shutdown. It decides what gets amplified, what gets ignored, what gets protected, what gets restricted and what counts as safe enough. This layer does not always respond to conscious reasoning. You can know a room is safe and still have a body acting like it is not. You can understand pacing and still overshoot. You can know a symptom is not immediately dangerous and still have the system amplify it.

The mind is the modelling layer. It predicts, plans, remembers, worries, interprets and simulates. This is not separate from biology. Thinking costs energy. Masking costs energy. Monitoring symptoms costs energy. Trying to explain yourself to doctors costs energy. Trying to appear normal while calculating whether standing up will ruin the afternoon costs energy.

These layers continuously feed into one another. A body signal can become a threat prediction. A threat prediction can increase autonomic output. Autonomic output can change body state. That changed body

state gives the mind more unstable information to interpret.

Round and round.

This is why “mind or body?” is often the wrong question. The issue is not whether one causes the other in a clean line. The issue is that the whole system can become tightly coupled under pressure. When the system is stable, a stressful thought, a posture change, a noisy room or a mild pain signal may remain local. When the system is under emergency governance, the same input can spread.

A conversation can worsen pain. Standing can reduce thinking. Poor sleep can destabilise heart rate. Pain can increase vigilance. Vigilance can tighten muscles. Muscle tension can increase pain. The loops are not imaginary just because they cross categories.

Sleep sits near the centre of this. Not because sleep is a lifestyle variable, but because sleep is maintenance.

Deep sleep is when the repair crews are supposed to enter the city. Waste is cleared. Signals are reset. Memory is processed. Immune tone shifts. Pain thresholds can soften. The alarm system gets a chance to lower its volume.

But in these illnesses, sleep can occur without maintenance completing. A person can be unconscious for hours and wake up feeling poisoned, wired, heavy, sore, foggy or already in debt. That is not normal tiredness. That is failed restoration.

The CAN model treats slow-wave sleep as a major bottleneck: high arousal and autonomic instability can prevent deep maintenance states, while poor maintenance leaves the system noisier and more reactive the next day. This matters because sleep failure is not just another symptom on the list. It can become the condition that prevents the whole system from standing down.

If the alarm state fragments sleep, and fragmented sleep prevents repair, then the next day begins from an already compressed baseline. Pain is louder. Cognition is slower. Heart rate is more volatile. Sensory tolerance is lower. The person has not started from neutral. They have started from unfinished maintenance.

This is where the five-stage descent becomes useful.

It is not a diagnostic ladder. It is a way of seeing how the state deepens. I picture it less as a straight line and more as a pyramid opening downward. At the top, the system is still relatively narrow. By the

bottom, more and more systems are involved. The deeper the descent, the less it looks like one symptom and the more it looks like a whole organism operating under emergency rule.

The first stage is threat sensitisation. The person may still look functional. They may still work, study, socialise, mask, joke, perform and push through. But the cost is rising. Sleep is lighter, stress responses sharpen, recovery is less complete, and ordinary pressure starts taking more out of the system than it used to. This is often the stage where people are praised for resilience while the margin is quietly being spent.

The second stage is autonomic dysregulation. The automatic systems become less automatic. Heart rate, blood pressure, temperature, digestion, sweating, sleep-wake rhythm and posture become more unstable. Standing up starts to matter. Heat starts to matter. Meals start to matter. Stress has direct body consequences. This can look like anxiety from the outside because the symptoms are adrenaline-shaped, but adrenaline-shaped does not mean imaginary. It means the autonomic system is involved.

The third stage is central sensitisation and guarding. The system's volume knob turns up. Pain spreads. Light gets harsher. Sound gets more invasive. Touch can become unpleasant. Muscles brace. Fascia tightens. The body begins protecting against input that may not have been dangerous before. This is where fibromyalgia-like patterns make more sense. Pain is not always telling you about one damaged place. Sometimes pain is telling you that the signal-processing system itself has become sensitised.

The fourth stage is circulatory and regulatory instability under demand. Standing can reduce thinking. Blood flow changes can create brain fog. Heart rate becomes less predictable. Heat, posture, exertion or stress can trigger disproportionate symptoms. The system struggles to regulate circulation, arousal and cognition at the same time. You can have enough intelligence and still not have enough stability to access it. You can have enough motivation and still not have the physiological permission to act on it.

The fifth stage is the energy-limiting protective state. This is the deep clamp. The system restricts output to prevent further destabilisation. Post-exertional malaise becomes central here. You do something physical, cognitive, emotional or sensory. During the activity, compensation may hide the cost. Afterwards, the debt appears. Hours later. A day later. Sometimes longer.

Fatigue deepens. Pain increases. Thinking narrows. Noise tolerance collapses. Heart rate becomes unstable. Sleep may worsen despite

exhaustion. The system drops into low-power mode.

This is why "fatigue" misses the point. It is not just tiredness. It is an energy restriction state. The body is not saying, "I am a bit sleepy." It is saying, "Spending is closed until further notice."

The stages stack. Threat sensitisation can remain underneath autonomic dysregulation. Autonomic dysregulation can remain underneath central sensitisation. Central sensitisation can remain underneath circulatory instability. Sleep failure can run through all of it. By the time the energy clamp is active, the presentation can look chaotic because it is not one thing anymore. It is layered.

This also explains why treatment can be unstable. Pain treatment may reduce pain without restoring capacity. Sleep support may help sleep without restoring orthostatic tolerance. Psychological therapy may reduce threat appraisal without fixing mechanical instability. Exercise may help a system with margin and harm a system in clamp. The intervention is not judged only by what it is. It is judged by the state it enters.

That is one of the practical points of Somatica: the right intervention at the wrong layer can become the wrong intervention.

Recovery, then, is not optimisation. It is not forcing output. It is not becoming a productivity machine. It is not pretending mindset can override physiology. Recovery means helping the system stand down from emergency governance.

That starts with stabilisation. Reduce the background noise. Support the body mechanically. Reduce repeated pain signalling. Protect sleep. Lower uncertainty. Coordinate care. Stop making the patient spend half their remaining energy proving the pattern exists.

Then the system needs less amplification. Signals have to stop arriving at emergency volume. That does not mean sedation or numbing the person. It means restoring proportion: body sensations that do not immediately become threat, exertion that does not immediately become debt, sleep that performs maintenance, activity that does not constantly trigger defensive restriction.

Only then does expansion make sense. Pacing is not avoidance. Pacing is staying inside the recoverable region long enough for recovery capacity to rebuild. Once margin returns, activity can widen. But forcing expansion before stabilisation may simply teach the system that ordinary life is still dangerous.

That is the difference between rehabilitation and escalation.

Somatica does not claim all chronic illness is the same. It does not deny structural disease, autoimmune pathology, endocrine dysfunction, infection, vascular problems, connective tissue disorders or neurological disease. It does not reduce Long COVID or ME/CFS to psychology. It does not claim trauma causes everything. It does not replace diagnosis or medicine.

It is a governance-level map.

It asks what state the system is in, what loads are acting on it, what is being amplified, what recovery is being blocked, which layers are active, and what would allow the body to loosen emergency rule.

The central image remains simple.

The person is still inside the city.

The city is under martial law.

The roads exist, but movement is restricted. The repair crews exist, but sleep does not always let them work. The power grid exists, but access is rationed. The control centre is trying to prevent collapse, but its own protection has become part of the problem.

This is not the whole truth of chronic illness.

But it is a useful map.

Not lazy.

Not weak.

Not inconsistent.

Not just tired.

A system under sustained constraint.

A body under emergency governance.

A person still there, trying to live through changed rules.





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