

Coherence Capacity: A New Framework for Understanding Recovery

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Abstract

This concept paper examines coherence capacity: a new framework for understanding recovery. It develops an argument drawn from Applied Coherence Medicine, identifies the relevant biological or clinical mechanisms, and considers where that argument may fail. This is a narrative perspective, not a systematic review or an original clinical study.

The central problem

Coherence Capacity proposes that recovery requires at least three interdependent abilities: sufficient energetic availability, regulatory flexibility and integration across time. The book abbreviates these as E, R and T and writes $C = E \times R \times T$. This formulation expresses an intuitively valuable proposition: extremely poor performance in one domain can limit whole-person adaptation even when the others are relatively strong. It should be published as an exploratory construct rather than a validated clinical equation.

Mechanisms and causal architecture

Energetic capacity can involve sleep continuity, nourishment, oxygen delivery, activity tolerance and recovery from exertion; regulation involves responses to stressors and return to baseline; temporal integration concerns circadian regularity, maintenance of gains and incorporation of adaptation over days or months. None can be inferred from a single wearable score. HRV varies with context, fitness, age, medication and measurement method. The multiplicative formulation needs operational definitions and units: if E, R and T are scored differently, the product can change with arbitrary rescaling. A safer scientific representation is initially $C = f(E, R, T)$, with multiplication retained as a philosophical proposal.

A discriminating example

Two individuals can report identical symptom scores while differing substantially in sleep disruption, activity tolerance and recovery time after ordinary demands. The proposed E-R-T model asks whether those differences change the burden of treatment each can tolerate. Importantly, assigning values to E, R and T without validated measurement may create false mathematical precision. The concept should remain a clinical hypothesis until its scale properties are justified.

Competing explanations and limitations

Most conventional care already accounts for reserve, severity and timing in some settings. A new index must therefore demonstrate what it adds; it cannot claim originality merely because it integrates variables. The framework also risks moralizing illness if low capacity is mistaken for personal failure. Structural disease, social deprivation and medications may constrain all three dimensions. Numerical simplicity must not conceal these different causal mechanisms.

What evidence would change the interpretation?

A conceptual falsifier is straightforward: if an additive model or single existing functional measure predicts better than the multiplicative index, the equation should be revised. A clinical vignette can illustrate this without inventing clinical evidence: two people may report equal depressive symptom severity while differing in sleep, activity tolerance, autonomic symptoms and recovery time, leading to different feasible treatment burdens.

Implications for medical interpretation

The immediate value is a language for discussing treatment feasibility. The Institute should explicitly distinguish the observed domain, the proposed causal interpretation and the intervention chosen, while avoiding any claim that the index diagnoses a disease or replaces validated assessment.

Selected scientific reading

Kitano (2002), Systems biology: a brief overview, Science.
<https://doi.org/10.1126/science.1069492>

McEwen (1998), Protective and damaging effects of stress mediators, New England Journal of Medicine.
<https://doi.org/10.1056/NEJM199801153380307>

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