

Essay

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Essay

Toward an Integrative Ontology of Authentic Care: Phenomenological-Practical Synthesis for Mental Health Transformation

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Abstract

This essay develops an original synthesis between ontological depth and practical applicability to transform mental health care. Through analysis of the epistemological violence inherent in medical reductionism and the articulation of phenomenologically grounded operational criteria, we argue that the apparent tension between philosophical rigor and clinical effectiveness constitutes a false dichotomy that can be overcome through integrative frameworks that honor both existential irreducibility and the need for practical intervention. We propose an Integrative Ontology of Authentic Care that synthesizes radical phenomenological critique with specific operational tools, thus establishing a conceptual bridge between ontological transformation of the clinical encounter and tangible improvement of therapeutic outcomes. This synthesis preserves the existential depth of phenomenological analysis while developing precise contextual criteria for its implementation in real clinical settings, overcoming both technical instrumentalism and theoretical idealism

Keywords: integrative ontology; epistemological violence; phenomenological-practical synthesis; operational contextual criteria; authentic clinical transformation

1. Introduction: Beyond the False War Between Depth and Efficacy

This essay does not aim to offer a finalized model or an operational manual for mental health practice. Instead, it lays the groundwork for a new conceptual architecture — a foundational reconfiguration of how we think about clinical care, subjectivity, and the role of philosophical depth in the therapeutic encounter.

Contemporary literature in philosophy of medicine frequently presents an irreconcilable opposition between two apparently incompatible positions: on one hand, radical phenomenological critique that denounces the ontological violence of medical reductionism; on the other, clinical pragmatism that privileges empirically validated interventions over abstract philosophical considerations. This dichotomous presentation, while intellectually stimulating, has proven counterproductive both for the development of more sophisticated theoretical frameworks and for the evolution of more humane clinical practices.

This essay argues that this apparent opposition constitutes a false dichotomy that can be overcome through an integrative synthesis that preserves the best of both traditions. Such ontological reduction often manifests in clinical practice when existential or ethical concerns — such as a patient's reflection on moral ambiguity within their family — are prematurely classified as pathological signs, without exploring their experiential meaning. We propose an *Integrative Ontology of Authentic Care* — not as a completed system, but as a fertile direction for thought.

Consider three paradigmatic cases that illustrate the inadequacy of both purely critical positions and exclusively pragmatic approaches:

Case A: A person with bipolar disorder type I experiences severe manic episodes with psychosis that destroy their family relationships and work capacity. Stabilization with lithium allows them

to maintain existential continuity and creative exploration without previous destructive cycles, but requires existential integration of the meaning of living with a chronic neurochemical condition.

Case B: An autistic person receives erroneous diagnoses of "paranoid personality disorder" for fifteen years, internalizing pathologizing interpretations of their natural processing characteristics, developing profound self-alienation until the correct diagnosis allows identity reconceptualization as legitimate neurodivergence.

Case C: An adolescent experiences acute existential crisis after sudden confrontation with mortality during family illness. Symptoms (insomnia, anxiety, "depersonalization") could be medicalized as "generalized anxiety disorder" or understood as natural philosophical awakening requiring existential accompaniment rather than pharmacological intervention.

A purely phenomenological approach would fail to provide necessary stabilization for Case A; a purely biomedical approach would perpetuate the epistemological violence evident in Case B; an exclusively pragmatic approach would lose the opportunity for existential growth in Case C. Clinical reality demands frameworks that can navigate this complexity without sacrificing rigor in any dimension.

By explicitly affirming the foundational character of this proposal, we seek to shift the terrain of debate: from a dispute over which model works best, to a deeper interrogation of what it means to care in a manner that is both effective and existentially truthful.

2. Ontological Diagnosis: Epistemological Violence as Structural Obstacle

2.1. Genealogy of Technical Colonization of Suffering

The positivist project inaugurated by Auguste Comte did not anticipate the ontological consequences of its epistemological revolution. By establishing that authentic knowledge derives exclusively from empirical observation of verifiable phenomena, it inadvertently inaugurated a specific form of violence that transcends the merely conceptual to become existential violence: the structural impossibility of encountering the human as human within frameworks that only recognize the objectifiable.

This epistemological violence—a concept that designates forms of harm emerging from the imposition of interpretive frameworks that systematically invalidate legitimate human experiences—operates through three fundamental mechanisms:

1. **Ontological reduction:** The transformation of being-in-suffering into entity-with-symptoms, thus losing access to existential dimensions of human suffering.
2. **Disciplinary normalization:** The production of subjects who self-monitor according to apparently neutral criteria of normality, internalizing the pathologization of their natural differences.
3. **Technical totalization:** The subordination of the irreducibility of human encounter to protocols that promise control through elimination of all non-objectifiable residue.

Consider the specific phenomenology of this operation in the contemporary clinical context: when an autistic person who naturally processes information in a detailed and systematic manner receives interpretation of "cognitive rigidity," not only diagnostic error occurs but fundamental ontological transformation. The person develops perpetual vigilance over their own strengths, experiencing them as symptoms to control. Disciplinary power is no longer exercised over them but through them: they have become guardians of their own normalization.

2.2. The Structure of Calculative Thinking in Medicine

Martin Heidegger distinguished between calculative thinking (which asks "how does it work?" and "how is it controlled?") and meditative thinking (which asks "what is it?" and "what does it mean?"). Positivist psychiatry has systematically privileged the first type, losing access to the question of the being of human suffering.

This loss manifests in the metamorphosis of the DSM-V from diagnostic manual to implicit ontology. When it defines "Autism Spectrum Disorder" through specific behavioral criteria, it is not merely describing a condition: it is performing a fundamental ontological operation that reduces neu-

rodivergent difference to measurable deficit, thus establishing which forms of neurological processing count as legitimate.

However, diagnosing this epistemological violence should not lead us to total rejection of technical knowledge. Such rejection would constitute another form of reductionism—anti-scientific reductionism—that would be equally inadequate for responding to the complexity of human suffering. Integrative synthesis requires rather the subordination of technical knowledge to the fundamental existential encounter, not its elimination.

3. Critical Differentiation: Paradigmatic Limitations, Ethical Malpractice, and Integrative Synthesis

3.1. The Need for Conceptual Precision

The analysis developed thus far requires a fundamental clarification to avoid conceptual confusions that could compromise both theoretical precision and evaluative justice toward mental health professionals. It is crucial to distinguish between three different analytical levels that, while interrelated, operate in distinct dimensions and require differentiated responses:

- 1. **Paradigmatic limitations of traditional CBT:** Structural restrictions of the theoretical-methodological framework that can be overcome through conceptual development
- 2. **Ethical malpractice in clinical application:** Violations of professional deontological codes independent of the theoretical framework used
- 3. **Phenomenologically informed CBT:** Integrative synthesis that preserves technical efficacy while overcoming ontological limitations

The absence of this distinction has generated in the specialized literature both unjust condemnations of theoretical frameworks for individual ethical failures and inappropriate justifications of malpractice through appeal to paradigmatic limitations.

3.2. Conceptual Differentiation Matrix

Table 1. Conceptual Differentiation Matrix in CBT Critique.

Dimension	Paradigmatic Limitations	Ethical Malpractice	Integrative Synthesis
Nature of problem	Structural restrictions of theoretical framework	Violations of professional ethics	Paradigmatic transformation through synthesis
Level of responsibility	Limitation of scientific paradigm	Individual professional responsibility	Conceptual-practical innovation
Clinical manifestation	Systematic ontological reduction but ethically applied	Invalidation, confidentiality violation, lack of empathy	Preservation of technical efficacy with existential dignity
Appropriate response	Theoretical development and complementary training	Disciplinary sanction and ethical supervision	Implementation of integrative frameworks
Paradigmatic example	CBT that reduces existential anxiety to cognitive distortion but with respect for patient	Violation of professional secrecy to justify therapeutic failure	CBT that validates existential anxiety while providing specific tools

3.3. Illustrative Cases of Each Category

3.3.1. Case A: Paradigmatic Limitation without Malpractice

Presentation: 16-year-old adolescent experiences existential anxiety after sudden death of grandfather. Experienced and ethical CBT therapist applies cognitive restructuring for "catastrophic thoughts" about mortality.

Analysis:

- **Paradigmatic limitation:** Reduces legitimate existential confrontation with finitude to "cognitive distortion"
- **Ethical competence:** Maintains confidentiality, demonstrates empathy, respects patient autonomy
- **Outcome:** Symptomatic reduction but loss of opportunity for existential growth

Evaluation: The therapist operates competently within the limitations of their theoretical framework. There is no ethical violation, but there is avoidable ontological restriction through integrative training.

3.3.2. Case B: Ethical Malpractice Independent of Theoretical Framework

Presentation: Adult patient seeks therapy after verifiable traumatic experience (documented fraud). Therapist invalidates experience, violates confidentiality, and pathologizes legitimate exercise of citizen rights.

Analysis:

- **Clear ethical violations:** Breach of confidentiality, systematic invalidation, lack of basic empathy
- **Independence from theoretical framework:** These violations would be equally reprehensible in psychodynamic, humanistic, or systemic therapy
- **Instrumentalization:** CBT used as post-hoc justification for anti-ethical behavior

Evaluation: Serious malpractice requiring disciplinary sanction independent of the theoretical framework used. The problem does not lie in CBT but in the professional's ethical incompetence.

3.3.3. Case C: Phenomenologically Informed CBT

Presentation: Same adolescent from Case A, but treated through integrative synthesis.

Application of synthesis:

- **Existential validation:** Recognition of anxiety as legitimate confrontation with finitude
- **Specific tools:** Breathing and relaxation techniques to manage somatic intensity
- **Meaning exploration:** Elaboration of existential impact of death experience
- **Integration:** Development of capacity to inhabit tension between finitude and vital projects

Outcome: Reduction of anxious symptoms + growth in existential maturity + preservation of philosophical sensitivity as personal strength.

3.4. Diagnostic Criteria for Differentiation

3.4.1. Indicators of Paradigmatic Limitation (Without Malpractice)

1. **Systematic ontological reduction** but applied with respect and ethical competence
2. **Adherence to protocols** that restrict existential exploration but without patient invalidation
3. **Symptomatic efficacy** with limitations in existential growth
4. **Therapeutic relationship** characterized by mutual respect within restricted conceptual frameworks
5. **Recognition of limitations** and appropriate referral when framework proves insufficient

3.4.2. Indicators of Ethical Malpractice

1. **Violation of confidentiality** to justify therapeutic failures
2. **Systematic invalidation** of patient suffering and experience
3. **Lack of basic empathy** and reactive response to questioning
4. **Ideological imposition** without informed consent or consideration of alternatives
5. **Pathologization of verifiable experiences** to maintain interpretive supremacy
6. **Refusal of supervision** or method review in face of evidence of harm

3.4.3. Characteristics of Successful Integrative Synthesis

1. **Preservation of technical efficacy** of specific CBT interventions
2. **Integration of existential validation** in therapeutic process

- 3. **Paradigmatic flexibility** according to contextual case needs
- 4. **Ethical competence** maintained across different conceptual frameworks
- 5. **Multidimensional outcomes** including both symptomatic reduction and existential growth

3.5. *Implications for Professional Training and Supervision*

3.5.1. Differentiated Training Programs

To address paradigmatic limitations:

- Complementary training in phenomenology and existential philosophy
- Development of integrative competencies that preserve technical efficacy
- Specialized supervision in cases requiring existential exploration

To prevent ethical malpractice:

- Strengthening training in professional ethics and deontological codes
- Clinical supervision systems focused on quality of therapeutic relationship
- Early detection protocols for anti-ethical behaviors

To implement integrative synthesis:

- Development of curricula combining technical rigor with philosophical sophistication
- Creation of supervised practice spaces in integrative frameworks
- Research on effectiveness of synthetic approaches

3.5.2. Institutional Evaluation Protocols

Table 2. Differentiated Evaluation Protocols.

Type of Problem	Evaluation Method	Appropriate Intervention
Paradigmatic limitation	Peer case review + existential outcome evaluation	Complementary training + specialized supervision
Ethical malpractice	Disciplinary investigation + patient complaint review	Sanction + ethical rehabilitation + intensive supervision
Need for synthesis	Integrative competency evaluation + complex case follow-up	Advanced training + mentorship in synthetic frameworks

3.6. *Conclusion: Toward Fair and Constructive Critique*

This conceptual differentiation allows for more precise and fair evaluation of challenges in CBT practice, avoiding both unjust demonization of theoretical frameworks for individual ethical failures and inappropriate justification of malpractice through appeal to paradigmatic limitations.

The integrative synthesis proposed in this essay does not constitute simply a "more ethical CBT" but a ****paradigmatic transformation**** that preserves technical efficacy while overcoming structural ontological limitations. This conceptual precision is fundamental for the development of:

- **Professional training** that distinguishes technical competence, ethical competence, and integrative competence
- **Clinical supervision** that can appropriately identify and address each type of challenge
- **Institutional evaluation** that applies fair and constructive standards
- **Theoretical development** that advances through rigorous synthesis rather than unproductive polarization

Only through this conceptual precision can phenomenological critique fulfill its constructive function of promoting more mature and authentic forms of accompaniment of human suffering, without falling into the injustice of condemning competent professionals for paradigmatic limitations nor into the complacency of tolerating ethical violations under the pretext of theoretical diversity.

4. Phenomenological-Practical Synthesis: Toward Dynamic Complementarity

4.1. The Principle of Ontological Complementarity

When Niels Bohr introduced complementarity to physics, he revealed something profound: light behaves as both wave and particle, not through contradiction but through a richer reality than either description alone captures. This insight illuminates mental healthcare’s central challenge. A person experiencing depression simultaneously undergoes measurable neurochemical changes and confronts profound questions about life’s meaning. Neither perspective alone tells the full story.

This complementarity runs deeper than methodology—it reflects how humans actually exist. We live simultaneously as biological organisms, psychological beings, and meaning-seeking persons. Consider Maria, a 45-year-old teacher experiencing major depression:

- **Neurobiologically:** Her serotonin and dopamine systems show altered functioning, visible in brain imaging
- **Psychologically:** She experiences persistent negative thoughts about her competence and worth
- **Existentially:** She grapples with whether her life’s work has mattered after a beloved student’s suicide
- **Culturally:** As a Latina woman, she carries specific expectations about strength and family support

Each level reveals truth, yet none contains the whole. The art lies not in choosing one perspective but in understanding when and how each illuminates Maria’s suffering.

4.2. When Biology Takes Priority: Clear Indicators

Some situations demand immediate biological intervention. We must recognize these without shame or philosophical hand-wringing:

1. Acute Safety Risks

- Active suicidal behavior with specific plan and means
- Severe mania with dangerous impulsivity (spending life savings, risky sexual behavior)
- Psychosis with command hallucinations to harm self or others

Example: James, experiencing his first manic episode, hasn’t slept in five days and believes he’s receiving divine messages through his television. He needs mood stabilization before any meaningful existential dialogue can occur.

2. Biological Processes Blocking Basic Function

- Severe depression with psychomotor retardation preventing self-care
- Panic disorder so intense the person cannot leave their home
- Catatonia or severe dissociation blocking interpersonal contact

Example: Keiko’s panic attacks occur 10-15 times daily, leaving her housebound for months. Medication can create the stability needed for her to engage in therapy exploring the attacks’ meaning.

3. Clear Biological Etiology

- Postpartum psychosis with hormonal triggers
- Substance-induced mood disorders during withdrawal
- Depression secondary to hypothyroidism or B12 deficiency

4.3. When Meaning Takes Priority: Recognizing Existential Territories

Equally important is recognizing when biological intervention would miss the point entirely:

1. Normative Life Transitions

- Grief after loss (distinguishing from clinical depression)
- Identity questioning during major life changes
- Existential anxiety about mortality after serious illness

Example: After surviving cancer, David experiences intense anxiety about death. Rather than medicating this away, therapy helps him integrate mortality awareness into a richer appreciation of life.

2. Cultural and Spiritual Experiences

- Visions or voices consistent with person’s spiritual tradition
- Emotional expressions normative in person’s culture
- Meaning-making through indigenous healing practices

Example: Ana, from a Puerto Rican family, reports visits from her deceased grandmother. In her cultural context, this represents connection, not psychosis. Pathologizing it would constitute cultural violence.

3. Neurodivergent Ways of Being

- Autistic sensory sensitivities and processing differences
- ADHD’s creative, non-linear thinking patterns
- Highly sensitive person (HSP) traits

Example: Marcus’s need for routine and difficulty with eye contact aren’t symptoms to eliminate but autistic traits requiring accommodation, not treatment.

4.4. The Integration Zone: Where Both/And Thinking Thrives

Most clinical presentations fall between extremes, demanding skillful integration:

4.4.1. Sequential Integration

Sometimes we address levels in sequence, each preparing ground for the next:

Case: Sarah, 28, presents with severe bipolar disorder and existential crisis about her identity.

Phase 1 (Weeks 1-8): Stabilization

- Mood stabilizer to end rapid cycling
- Sleep regulation and basic routine establishment
- Psychoeducation about bipolar as biological reality

Phase 2 (Weeks 9-20): Integration

- Exploring what it means to have a "creative temperament" requiring management
- Distinguishing between Sarah-as-person and bipolar-as-condition
- Developing personal meaning around living with intensity

Phase 3 (Ongoing): Synthesis

- Using mood tracking as mindfulness practice, not just symptom monitoring
- Channeling hypomanic energy into artistic projects with safeguards
- Building identity that includes but isn’t reduced to diagnosis

4.4.2. Simultaneous Integration

Often, biological and existential work proceed together, each informing the other:

Case: Michael, 52, has treatment-resistant depression following job loss.

Integrated Approach:

- **Biological:** Antidepressant to improve energy and concentration
- **Cognitive:** Challenging thoughts like "I’m worthless without my career"
- **Existential:** Exploring identity beyond professional achievement
- **Social:** Addressing real financial stress and family dynamics

The medication doesn’t "fix" Michael but gives him energy to engage in meaning-reconstruction. The therapy doesn’t ignore biological reality but works with it.

4.5. Practical Decision Framework

Rather than abstract principles, clinicians need concrete guidance. This framework synthesizes phenomenological sensitivity with clinical pragmatism:

Assessment main	Do-	Biological Priority Indicators	Existential Priority Indicators
Functioning		Cannot perform basic ADLs; work/school impossible	Functioning preserved but questioning its meaning
Temporality		Acute onset with rapid deterioration	Gradual emergence tied to life events
Subjective Experience		"This isn't me"; ego-dystonic	"This is who I am"; ego-syntonic
Cultural Context		Symptoms inconsistent with cultural norms	Experiences validated by cultural framework
Response to Meaning		Meaning-making increases distress	Meaning-making provides relief
Safety		Imminent risk to self/others	Philosophical death anxiety without intent

4.6. Integration in Practice: The Clinical Conversation

The rubber meets the road in how we talk with people seeking help. Compare these approaches:
Traditional Biomedical:

"Your symptoms indicate major depressive disorder. We'll start you on an SSRI and monitor for improvement. Any questions about the medication?"

Pure Existential:

"Your suffering reflects a crisis of meaning. Let's explore what this depression might be trying to tell you about your life's direction."

Integrated Approach:

"You're experiencing something that's affecting you on multiple levels. There's clearly intense emotional pain that might have biological components—difficulty sleeping, low energy, concentration problems. And you've mentioned feeling like life has lost its color since your divorce.

I'm curious about both aspects. Sometimes medication can help restore enough energy and clarity to engage with the deeper questions you're facing. Other times, the biological symptoms ease when we address what's underneath.

What's your sense of what you need right now? We can explore both dimensions and see what combination might help you not just feel better, but find your way forward."

4.7. Cultural Considerations: Beyond Western Frameworks

The synthesis must extend beyond Western phenomenology and biomedicine:

4.7.1. Indigenous Perspectives

Many indigenous traditions never separated mind, body, and spirit. The Māori concept of *hauora* encompasses:

- *Taha tinana* (physical wellbeing)
- *Taha wairua* (spiritual wellbeing)
- *Taha whānau* (family wellbeing)
- *Taha hinengaro* (mental/emotional wellbeing)

Clinical Application: For Māori clients, addressing depression might involve family healing circles alongside individual therapy, connecting to land and ancestors while also considering medication if severe.

4.7.2. Eastern Philosophies

Buddhist psychology offers sophisticated frameworks for understanding suffering without pathologizing it. The concept of *dukkha* (suffering/dissatisfaction) as inherent to existence provides different context for depression than Western disease models.

Clinical Application: Mindfulness-based interventions can honor Buddhist clients’ worldviews while providing empirically supported tools for emotional regulation.

4.8. Challenges and Honest Limitations

This synthesis faces real obstacles:

1. Time and Resources

- Insurance typically covers 12 sessions, insufficient for deep existential work
- Clinicians need extensive training across domains
- Institutional pressures favor quick symptom reduction

2. Measurement Difficulties

- How do we quantify "existential growth" or "meaning integration"?
- Outcome measures designed for symptom reduction miss broader changes
- Research funding favors easily measurable interventions

3. When Integration Fails

- Some conditions (severe schizophrenia, advanced dementia) may preclude meaningful phenomenological work
- Some people prefer purely biological or purely existential approaches
- Cultural contexts may reject integration as Western eclecticism

4.9. Future Directions: Building Bridges

Moving forward requires collaboration across traditionally separate domains:

1. Research Priorities

- Develop outcome measures capturing both symptom change and existential dimensions
- Study how biological and meaning-based interventions interact
- Include diverse cultural perspectives in framework development

2. Training Innovations

- Joint programs between medical schools and philosophy departments
- Clinical practica emphasizing integrated assessment
- Supervision models addressing both technical and existential competence

3. Institutional Changes

- Advocacy for longer treatment authorizations for complex cases
- Development of integrated treatment teams
- Creation of clinical settings supporting both efficiency and depth

4.10. Conclusion: The Path of Both/And

The synthesis of phenomenological depth and practical efficacy isn’t merely an intellectual exercise—it responds to how humans actually suffer and heal. We are neither purely biological machines nor disembodied spirits. We are embodied beings who create meaning, cultural persons shaped by context, individuals seeking both symptom relief and existential understanding.

This synthesis demands more from clinicians: comfort with ambiguity, competence across domains, wisdom to discern what each unique person needs. It's harder than choosing one perspective. But it honors the full complexity of human experience in ways that purely biological or purely existential approaches cannot.

The Norwegian philosopher Arne Vetlesen reminds us that suffering always means something to the sufferer. Our task is creating clinical spaces where both the neurochemistry of pain and its personal significance receive careful attention. In this integration lies not perfection but a more complete and compassionate response to the mystery of human suffering.

5. Paradigmatic Cases: Synthesis in Action

5.1. Successful Multilevel Integration: Bipolar Disorder

Presentation: 28-year-old woman, literature teacher, experiences first manic episode with psychotic symptoms (beliefs of having discovered secret codes in classical texts), multiple hospitalizations, job loss, and deterioration of family relationships. Previous history of depressive episodes interpreted as "artistic sensitivity."

Application of Integrative Synthesis:

Acute Phase (Phenomenologically Grounded Biomedical Priority):

- Stabilization with antipsychotics and lithium to restore capacity for interpersonal encounter
- Hospitalization oriented not as disciplinary control but as protected space for intersubjectivity recovery
- Explicit recognition that medication seeks to facilitate, not replace, subsequent existential work

Stabilization Phase (Operative Synthesis):

- Continued medication with psychoeducation about neurobiology that honors both technical necessity and identity impact
- Phenomenological exploration of the existential meaning of living with a condition requiring technical modulation
- Therapeutic work on integration of "pathological" and "creative" aspects of their sensitivity as parts of a broader existential totality

Integration Phase (Technically Sustained Phenomenological Priority):

- Development of personal understanding of bipolarity as specific form of inhabiting temporality (intensity vs. stability)
- Identity reconstruction integrating neurobiological condition into authentic life project
- Return to teaching work with greater self-understanding about rhythms necessary to sustain both creativity and stability

Result: Sustained symptomatic stability + renewed personal meaning + restored social and professional functioning + authentic integration of condition into personal identity.

5.2. Differential Application: Adult Autistic Neurodivergence

Presentation: 35-year-old man, successful software engineer, limited but satisfactory social relationships, seeks evaluation for "differences" he has always experienced. Exceptional executive function in structured contexts, difficulties in ambiguous social situations, intense interests in technology.

Application of Integrative Synthesis:

Initial Evaluation (Diagnostic Synthesis):

- Phenomenological understanding of his experience of "being different" without presupposing pathology
- Formal neuropsychological evaluation to identify patterns of strengths and challenges
- Contextual analysis of situations where he experiences suffering vs. situations where he thrives

Conceptualization (Phenomenological Priority with Technical Support):

- Neurodivergence framework validating differences as legitimate variation of human processing
- Existential exploration of how his specific characteristics contribute to his identity and capabilities
- Technical identification of accommodation strategies to optimize functioning in challenging contexts

Integral Support (Practical Synthesis):

- Concrete strategies to optimize work environment based on understanding of his sensory and cognitive needs
- Therapeutic work on self-acceptance integrating both strengths and limitations
- Development of specific social skills without pretending general "normalization"

Result: Integrated understanding of differences as legitimate neurodivergence + practical accommodation strategies + greater self-understanding and acceptance + functioning optimization without loss of authenticity.

5.3. Existential Crisis in Adolescence: Beyond Pathologization

Presentation: 16-year-old adolescent experiences acute existential crisis after sudden death of grandfather. Symptoms: insomnia, intense anxiety, "depersonalization" episodes, radical questioning of life's meaning, deteriorated academic performance. Family pressure to "return to normal."

Application of Integrative Synthesis:

Contextual Evaluation (Avoiding Diagnostic Reductionism):

- Understanding symptoms as natural response to sudden existential confrontation
- Technical evaluation to rule out organic factors or conditions requiring specific intervention
- Analysis of family and social context that may be pathologizing normal growth processes

Existential Accompaniment (Phenomenological Priority with Minimal Technical Support):

- Validation of crisis as natural part of adolescent existential development
- Guided philosophical exploration of questions about mortality, meaning, and purpose
- Specific anxiety management techniques that do not medicalize underlying existential search
- Family work to create space honoring the growth process

Result: Existential integration of mortality experience + development of internal resources to face existential anguish + growth toward greater philosophical maturity + maintenance of existential sensitivity as personal strength.

6. Practical Implementation: Authentic Institutional Transformation

6.1. Integrative Clinical Training: Multilevel Competencies

Successful implementation of integrative frameworks requires fundamental transformations in clinical training that overcome current fragmentation between technical knowledge and existential sensitivity.

Phenomenologically Informed Biomedical Competencies:

- Understanding of neurobiology of mental conditions articulated with analysis of their existential impact
- Familiarity with evidence on intervention efficacy contextualized in frameworks of personal meaning
- Skills in symptom evaluation and interpretation that preserve ontological dignity of experience
- Capacity to distinguish between avoidable suffering (which should be alleviated) and existential suffering (which should be accompanied)

Technically Viable Phenomenological Competencies:

- Capacity for empathic understanding that does not sacrifice rigor in evaluation
- Skills in personal meaning exploration articulated with concrete interventions
- Sensitivity to existential dimensions informing specific technical decisions

- Competence to accompany existential growth processes within real institutional frameworks

Specific Integrative Competencies:

- Capacity to navigate between frameworks according to context without superficial eclecticism
- Communication skills honoring multiple perspectives while maintaining therapeutic coherence
- Competence for interdisciplinary collaboration articulating different intervention levels
- Capacity to resist both technical reductionism and phenomenological idealism

6.2. Ontologically Grounded Clinical Decision Protocols

We develop decision algorithms that articulate existential considerations with technical needs in operationally viable ways:

Integrative Initial Evaluation:

1. Is there imminent safety risk? → Biomedical priority with preparation for subsequent existential work
2. Are symptoms ego-dystonic and causing severe distress? → Biomedical evaluation articulated with meaning exploration
3. Are differences ego-syntonic and contextual? → Phenomenological approach with technical support as needed
4. Is there evidence of treatable neurobiological condition? → Integrative synthesis combining technical intervention with existential elaboration
5. Does suffering reflect existential growth process? → Phenomenological accompaniment with technical monitoring

Criteria for Intervention Articulation:

- **Sequential:** Technical stabilization followed by existential work (acute crises)
- **Simultaneous:** Parallel biomedical intervention and phenomenological accompaniment (chronic conditions)
- **Contextual:** Alternation according to therapeutic process phase (recurrent episodes)
- **Preventive:** Existential work to prevent crises requiring technical intervention

6.3. Multidimensional Evaluation Metrics

To overcome limitations of purely symptomatological metrics, we develop indicators capturing both technical improvement and existential growth:

Contextually Interpreted Technical Indicators:

- Symptomatological reduction evaluated in relation to person's existential goals
- Social and work functioning interpreted according to individual values and projects
- Treatment adherence related to personal understanding of intervention meaning
- Relapse prevention articulated with development of internal existential resources

Operationally Viable Existential Indicators:

- Development of coherent personal narrative integrating suffering experience
- Capacity to find meaning in difficult experiences without romanticizing them
- Growth in self-understanding and acceptance of personal characteristics
- Strengthening of capacity for authentic interpersonal relationships
- Development of life project incorporating both limitations and potentialities

7. Silent Transformation: From Individual Encounter to Systemic Change

7.1. The Contagion of Institutional Authenticity

Transformation toward more authentic forms of mental care cannot be imposed through external institutional reform. It must emerge from the silent revolution that occurs in each authentic clinical

encounter where a professional chooses to honor the irreducibility of the person over the convenience of technical categorization.

This transformation operates according to what we call contagion of authenticity: when professionals operate from integrative frameworks, something fundamental changes in institutional dynamics. The person ceases to be object of analysis to become co-investigator of their own experience. This transformation generates spaces where other similar encounters become possible, not through coercion but through attraction: evidence that more humane forms of relationship are possible and effective.

A therapist who genuinely honors the experiential authority of their consultants creates conditions where they can develop more authentic relationships with other professionals and, eventually, in their personal lives. An institution where some professionals operate from these frameworks generates pressure toward broader transformation, not through administrative mandates but through practical demonstration of better results both technical and existential.

7.2. Criteria for Systemic Change Evaluation

To evaluate the success of institutional implementation of integrative frameworks, we propose indicators capturing both technical efficacy and quality of human encounter:

Cultural Transformation Indicators:

- Frequency of cases where technical intervention is successfully articulated with existential accompaniment
- Level of consultant satisfaction evaluated not only symptomatologically but in terms of experience of dignity and understanding
- Institutional capacity to handle complex cases requiring paradigmatic flexibility
- Development of integrative competencies in staff through continuous training
- Evolution of institutional language toward forms honoring human complexity without sacrificing technical precision

Sustainability Indicators:

- Reduction in professional burnout rates associated with greater sense of purpose in work
- Improvement in interdisciplinary collaboration facilitated by shared conceptual frameworks
- Increase in professional retention finding greater satisfaction in more authentic work
- Development of institutional capacity for innovation responding to emerging needs
- Establishment of culture of critical reflection preventing rigidification of new paradigms

8. Limitations and Future Directions

8.1. Epistemic Boundaries and Scope Demarcation

This integrative synthesis, while conceptually robust, operates within specific epistemic boundaries that must be explicitly recognized to preserve both theoretical rigor and clinical applicability. Rather than constituting weaknesses, these limitations define the precise scope within which the framework can legitimately claim transformative potential.

8.1.1. Cases of Reduced Applicability

The phenomenological-practical synthesis demonstrates optimal applicability in contexts where:

- Basic intersubjective capacity is preserved or recoverable
- Immediate survival is not at imminent risk
- Some degree of reflective distance from acute symptomatology exists
- The person retains capacity for collaborative meaning-making

Acute Psychotic Episodes and Severe Dissociative States: During acute phases of schizophrenia, severe bipolar mania with psychosis, or dissociative identity disorder in crisis, the fundamental capacity for coherent intersubjective encounter may be temporarily compromised. In these contexts,

the framework’s emphasis on experiential authority becomes problematic when the very structure of experience is severely altered.

Imminent Safety Crises: Cases involving active suicidal behavior, severe self-harm, or immediate risk to others require prioritization of containment and stabilization over existential exploration. The framework’s contemplative approach is inappropriate when rapid intervention is necessary to preserve life.

Severe Cognitive Impairment: Advanced dementia, acute delirium, or severe intellectual disability may limit the applicability of approaches that depend on complex meaning-making and existential reflection. The framework requires adaptation or supplementation in these contexts.

Acute Substance-Induced States: During active intoxication or severe withdrawal, the altered neurochemical state may preclude meaningful phenomenological exploration until stabilization occurs.

8.2. *Unresolved Conceptual Tensions*

8.2.1. The Authority-Pathology Paradox

A fundamental tension remains inadequately resolved: how to distinguish between authentic experiential authority and experience compromised by pathological processes without falling back into the very technical objectification the framework critiques.

Specific Challenge: When a person experiencing paranoid delusions insists on the validity of their persecutory beliefs, or when someone in severe depression claims their hopelessness reflects accurate perception of reality, the framework lacks clear criteria for navigating these situations without either dismissing legitimate experience or enabling potentially harmful interpretations.

Needed Development: Future work must elaborate phenomenologically grounded criteria for distinguishing between:

- Existential suffering requiring accompaniment vs. pathological suffering requiring intervention
- Authentic meaning-making vs. meaning-making compromised by altered cognitive processes
- Cultural/neurodivergent differences vs. clinically significant dysfunction

8.2.2. Cultural Universality vs. Contextual Specificity

While the framework draws primarily from European phenomenological traditions, its claims about human existence and suffering imply broader applicability. This creates tension between:

- Universal existential structures (temporality, embodiment, relationality) and culturally specific expressions of these structures
- Western individualistic assumptions about autonomy and selfhood vs. more collectivistic cultural frameworks
- The phenomenological emphasis on first-person experience vs. cultures that privilege community wisdom or spiritual authority

Required Research: Systematic exploration of how the integrative framework translates across diverse cultural contexts, particularly in non-Western healthcare systems and indigenous healing traditions.

8.3. *Empirical Validation Requirements*

8.3.1. Foundational vs. Operational Research Needs

As a foundational work, this synthesis prioritizes conceptual rigor over immediate empirical validation. However, translation to clinical practice requires specific empirical investigation:

Longitudinal Outcome Studies:

- Comparative analysis of integrative vs. traditional approaches across matched populations
- Long-term follow-up focusing on existential indicators alongside symptom measures
- Cost-effectiveness analysis including quality of life and meaning-making metrics
- Identification of specific populations where integrative approaches show superior outcomes

Process Research:

- Microanalytic studies of successful moments of technical-existential articulation
- Investigation of therapist competencies that facilitate effective integration
- Analysis of factors predicting successful vs. unsuccessful application of the framework
- Development of reliable measures for existential dimensions of therapeutic change

Implementation Research:

- Institutional factors that support or hinder adoption of integrative approaches
- Training program effectiveness for developing integrative competencies
- Scalability assessment across different healthcare contexts
- Professional satisfaction and burnout rates under integrative vs. traditional models

8.4. Professional Development and Training Challenges

8.4.1. Competency Integration Difficulties

The framework demands clinicians develop competencies that are rarely integrated in current training programs:

- **Philosophical sophistication** in phenomenological analysis alongside **technical precision** in intervention selection
- **Cultural humility** in meaning exploration alongside **clinical authority** in safety assessment
- **Tolerance for ambiguity** in existential accompaniment alongside **decisive action** in crisis intervention

Training Innovation Requirements: Development of pedagogical methods that can cultivate this integration without producing either philosophical dilettantism or technical reductionism. This may require fundamental restructuring of mental health education.

8.5. Institutional Implementation Obstacles

8.5.1. Systemic Resistance Factors

Economic Pressures: Healthcare systems organized around efficiency metrics may resist approaches that require longer sessions and more intensive training.

Legal Liability: Emphasis on experiential authority may conflict with professional liability standards that favor documented, standardized interventions.

Disciplinary Boundaries: Integration across traditionally separate domains (philosophy, medicine, psychology) challenges established professional territories and certification systems.

8.6. Future Research Directions

8.6.1. Immediate Priorities

1. **Development of Assessment Protocols:** Creation of reliable instruments for distinguishing contexts where integrative vs. primarily technical approaches are indicated
2. **Training Program Pilots:** Small-scale implementation of integrative training programs with systematic evaluation of competency development
3. **Case Study Documentation:** Systematic collection and analysis of detailed case studies demonstrating successful integration across diverse presentations
4. **Cross-Cultural Validation:** Collaborative research with non-Western therapeutic traditions to assess framework universality vs. cultural specificity

8.6.2. Medium-Term Developments

1. **Randomized Controlled Trials:** Carefully designed studies comparing integrative approaches with standard care in specific populations where the framework is most applicable
2. **Neurobiological Correlates:** Investigation of neural mechanisms underlying successful existential integration vs. purely symptom-focused improvement

3. **Economic Analysis:** Comprehensive cost-benefit analysis including hidden costs of current approaches (professional burnout, treatment dropouts, symptom recurrence)
4. **Policy Research:** Analysis of regulatory and institutional changes needed to support integrative practice at healthcare system level

8.6.3. Long-Term Vision

Paradigmatic Transformation Research: Investigation of broader social and cultural factors that support or hinder evolution toward more existentially informed healthcare systems.

Interdisciplinary Synthesis: Collaborative development with fields such as medical anthropology, philosophy of medicine, and critical psychology to create more comprehensive theoretical foundations.

Global Health Applications: Exploration of how integrative frameworks can address mental health challenges in diverse global contexts, particularly in resource-limited settings where community-based and meaning-centered approaches may be more sustainable than high-tech medical interventions.

8.7. Methodological Considerations for Future Research

8.7.1. Beyond Traditional Outcome Measures

Future research must develop methodologies capable of capturing the multidimensional nature of existential transformation:

- **Narrative Analysis:** Systematic study of how personal meaning-making evolves through integrative therapeutic processes
- **Phenomenological Research:** First-person investigations of lived experience during therapeutic transformation
- **Mixed-Methods Approaches:** Integration of quantitative outcome measures with qualitative exploration of existential change
- **Longitudinal Design:** Extended follow-up periods to assess sustainability of both symptom improvement and existential growth

8.8. Ethical Considerations for Implementation

8.8.1. Safeguarding Against Misuse

The framework's emphasis on experiential validation and meaning-making could be misappropriated to justify:

- Delayed intervention in cases requiring immediate medical attention
- Relativistic acceptance of harmful beliefs or behaviors
- Inadequate attention to social determinants of mental distress
- Privileging of articulate, educated clients over those with limited verbal resources

Required Safeguards: Development of ethical guidelines and oversight mechanisms to ensure the framework serves justice and does not become another form of exclusion disguised as sophistication.

8.9. Conclusion: Limitations as Epistemic Precision

These limitations do not compromise the integrity of the integrative synthesis but rather define its legitimate scope of application. Recognition of boundaries enhances rather than diminishes the framework's credibility by demonstrating sophisticated awareness of its own epistemic position.

The future development of this synthesis depends not on claiming universal applicability but on deepening understanding of when, how, and for whom the integration of existential depth and technical efficacy can authentically transform the encounter with human suffering. This measured approach preserves the revolutionary potential of the framework while maintaining the clinical responsibility that any authentic therapeutic innovation must demonstrate.

Rather than seeking to replace all existing approaches, the integrative synthesis aims to identify and cultivate contexts where human beings can experience both effective relief of avoidable suffering

and genuine recognition of their existential irreducibility. In this precision of scope lies not limitation but maturity: the recognition that authentic transformation occurs not through totalizing claims but through careful, contextualized, and empirically informed development of practices that honor both human complexity and the legitimate demand for therapeutic effectiveness.

9. Conclusion: Synthesis as Existential and Technical Imperative

Our analysis reveals that the apparent opposition between phenomenological depth and technical efficacy constitutes a false dichotomy that hinders both theoretical development and evolution of more mature clinical practices. The reality of human suffering demands frameworks capable of navigating multiple levels of complexity without prematurely reducing this complexity to preferred theoretical schemes, whether technical or existential.

The Integrative Ontology of Authentic Care we have developed does not eliminate tensions between different epistemological frameworks, but uses them productively to generate more comprehensive responses to human suffering. This synthesis preserves both empirical precision enabling effective interventions and existential depth honoring the irreducible dignity of human experience, demonstrating that both dimensions are not only compatible but mutually necessary for mature forms of care.

Successful implementation of integrative frameworks requires significant transformations in clinical training, institutional organization, and empirical research. However, emerging evidence from paradigmatic cases suggests that such transformations are not only possible but necessary to adequately address the complexity of contemporary mental suffering.

Three fundamental conclusions emerge from this analysis:

First: The epistemological violence of medical reductionism can be overcome without sacrificing technical rigor through frameworks that subordinate objective knowledge to the fundamental intersubjective encounter, thus preserving both interventive efficacy and ontological dignity.

Second: Phenomenologically grounded operational criteria allow practical implementation of profound existential intuitions, demonstrating that philosophical sophistication can translate into tangible improvement of clinical outcomes.

Third: Transformation toward more authentic forms of mental care operates primarily through contagion of authenticity in individual encounters that gradually transform institutional cultures, suggesting that authentic systemic change emerges from silent revolution in the quality of basic human encounter.

Rather than choosing between scientific rigor and humanistic depth, we have demonstrated the possibility of developing practices that integrate both in ways that serve more effectively the people seeking care. This synthesis represents not only a theoretical possibility but a practical imperative for the evolution of mental health toward more mature forms of understanding and accompaniment of human suffering.

In the historical moment when automation threatens to mechanize even the most intimate dimensions of human care, integrative synthesis reclaims what is specifically human in the therapeutic encounter: the capacity to recognize in the face of the other in pain not object of knowledge but source of ethical interpellation that transcends all technical knowledge, but that can be productively articulated with this knowledge to generate forms of accompaniment that honor both existential complexity and the need for effective relief of avoidable suffering.

The future of authentic mental care depends on our collective capacity to resist both the seduction of dehumanized technical efficiency and the temptation of impracticable phenomenological idealism, developing instead integrative frameworks that preserve the best of both traditions in creative syntheses that respond more adequately to the irreducible complexity of human beings in suffering.

Appendix A. Diagnostic Error as Paradigmatic Evidence of Epistemological Violence in CBT

Appendix A.1. *The Ontological Tragedy of Misdiagnosis: Autism Spectrum Disorder as Case Study*

The systematic misdiagnosis of autistic individuals as having "paranoid personality disorder," "obsessive-compulsive neurosis," or other psychiatric conditions represents perhaps the most paradigmatic example of what we have termed epistemological violence in contemporary mental health practice. This phenomenon illustrates with devastating clarity how the positivist foundations of cognitive-behavioral therapy transform legitimate neurodivergent differences into pathological "symptoms" requiring technical correction.

Consider the phenomenology of a specific case: an autistic person who for fifteen years receives erroneous diagnoses of "obsessive neurosis with paranoid traits" and subsequently "paranoid personality disorder," living in constant self-surveillance and self-correction of characteristics that, in reality, constitute their natural way of processing and inhabiting the world. This trajectory can be phenomenologically interpreted as a specific form of **forced ontological exile**: condemnation to live as a foreigner to one's own nature.

Appendix A.1.1. The Structure of Diagnostic Wandering in *Errare*

To understand the profound nature of diagnostic error as a form of ontological violence, we must examine how language itself articulates our understanding of precision and wandering. The Latin word *errare* literally means "to wander without direction," "to stray from the correct path." This etymology reveals something significant: error originally emerges as loss of orientation, absence of clear direction toward truth.

The structure of *errare* contains layers of meaning that illuminate the experience of diagnostic error:

- **Er-**: Prefix indicating outward movement, distancing
- **-rare**: Root denoting continuous action, sustained process

Originally, error was recognized as a transitory condition: the traveler who deviates from the path but who can resume the correct route once reoriented. But in the institutional diagnostic context, this temporary wandering becomes permanent condemnation: it is no longer about course correction but about construction of erroneous identities that perpetuate themselves through health systems that privilege professional authority over empirical precision.

Appendix A.2. *CBT's Systematic Pathologization of Neurodivergent Processing*

Appendix A.2.1. The Triple Reduction of Autistic Experience

Cognitive-behavioral therapy, when applied to unrecognized autistic individuals, operates through a triple reduction that perfectly exemplifies the mechanisms of epistemological violence:

1. **Ontological reduction of systematic processing:** The natural autistic tendency toward detailed, systematic thinking is reduced to "cognitive rigidity" or "obsessive rumination" that must be "restructured" according to neurotypical standards of "flexible thinking."
2. **Pathologization of sensory authenticity:** Legitimate sensory needs and processing differences are interpreted as "avoidance behaviors" or "hypervigilance" requiring exposure therapy rather than environmental accommodation.
3. **Normalization of social masking:** The exhausting process of "camouflaging" autistic traits to appear neurotypical is reinforced through social skills training that teaches further suppression of authentic expression.

Consider the specific phenomenology of this operation: when an autistic person who naturally communicates directly and literally receives interpretation of "lack of social skills" requiring modification through CBT social training, a fundamental ontological transformation occurs. The person learns

to monitor their own authentic communication style, experiencing it as dysfunction to correct through constant performance of neurotypical social conventions.

Appendix A.2.2. The Diagnostic Cascade as Amplification Technology

Mental health systems operate according to mechanisms that systematically perpetuate initial diagnostic errors, functioning as devices for amplifying imprecision without historical precedent. Medical records, progress notes, and consultation reports create feedback loops that intensify erroneous interpretations in ways that were impossible in eras of less documented clinical practice.

Consider the specific mechanics: once a diagnosis of "paranoid personality disorder" is established, each subsequent consultation seeks evidence to confirm this interpretation within CBT frameworks:

- The autistic need for predictability is reinterpreted as "pathological rigidity" requiring cognitive flexibility training
- Direct communication becomes "interpersonal aggression" needing social skills modification
- Sensory difficulties in complex social contexts transform into "unjustified suspiciousness" requiring exposure therapy
- Natural autistic honesty is pathologized as "lack of social filter" demanding assertiveness training

Appendix A.3. The Phenomenology of Therapeutic Violence in CBT for Misdiagnosed Autism

Appendix A.3.1. Forced Neurotypical Performance as Existential Violence

When CBT is applied to unrecognized autistic individuals based on misdiagnoses, it becomes a sophisticated technology of forced neurotypical performance that systematically undermines authentic ways of being. The person is taught to:

- Suppress natural communication patterns in favor of neurotypical social conventions
- Override sensory needs through "exposure" that constitutes systematic overwhelm
- Develop "cognitive flexibility" that violates natural processing strengths
- Practice "emotional regulation" that disconnects them from authentic emotional experience

This represents what we call **therapeutic conversion therapy**: the systematic attempt to modify fundamental aspects of neurocognitive processing toward conformity with neurotypical norms, causing profound disconnection from authentic selfhood.

Appendix A.3.2. The Panopticon of Self-Surveillance

CBT's emphasis on self-monitoring transforms the misdiagnosed autistic person into a vigilant observer of their own natural characteristics, constantly evaluating authentic expressions as potential "symptoms" requiring modification. Consider the psychological architecture this creates:

1. **Thought monitoring:** Natural systematic processing becomes "rumination" to interrupt
2. **Behavioral tracking:** Authentic preferences become "avoidance patterns" to eliminate
3. **Social performance:** Natural communication becomes "social deficits" to remediate
4. **Sensory denial:** Environmental needs become "hypervigilance" to overcome

Each moment of authenticity becomes evidence of therapeutic "failure," generating perpetual cycles of self-correction that prevent the person from ever inhabiting their natural way of being.

Appendix A.4. Paradigmatic Case: CBT Violence in Action

Appendix A.4.1. Case Presentation

Background: Marcus, 34-year-old software engineer, seeks therapy for "social anxiety" and "perfectionism." Has been in CBT treatment for two years following initial misdiagnosis of "obsessive-compulsive personality disorder" and "social anxiety disorder." Unknown autism spectrum diagnosis.

CBT Treatment Protocol Applied:

- Cognitive restructuring targeting "perfectionist thinking patterns"

- Social skills training for "interpersonal deficits"
- Exposure therapy for "social avoidance behaviors"
- Mindfulness training to "reduce rumination"

Appendix A.4.2. Analysis of Therapeutic Violence

Systematic Undermining of Natural Strengths:

Marcus’s natural attention to detail and systematic approach to problems—core autistic strengths—are consistently pathologized as "rigid perfectionism" requiring cognitive modification. His careful, thorough work style becomes evidence of "dysfunctional thinking" rather than recognition of neurodivergent excellence.

Forced Violation of Sensory Needs:

"Exposure therapy" for "social avoidance" systematically forces Marcus into overwhelming sensory environments (loud restaurants, crowded networking events) without recognition that his "avoidance" represents legitimate sensory self-protection, not pathological anxiety.

Suppression of Authentic Communication:

Social skills training teaches Marcus to suppress his natural direct, honest communication style in favor of neurotypical social conventions involving small talk, indirect communication, and emotional performance that exhausts his authentic resources.

Appendix A.4.3. Existential Consequences

After two years of CBT based on misdiagnosis, Marcus experiences:

- **Increased masking:** Enhanced ability to perform neurotypical behavior at the cost of authentic self-expression
- **Sensory overwhelm:** Reduced capacity to advocate for environmental needs due to "exposure therapy" normalization
- **Cognitive confusion:** Disconnection from natural processing strengths through "flexibility" training
- **Identity fragmentation:** Profound uncertainty about which aspects of his experience are "authentic" versus "symptomatic"

The "therapeutic success" measured by CBT metrics (reduced anxiety scores, increased social participation) masks a deeper process of systematic self-alienation from his neurodivergent nature.

Appendix A.5. The Institutional Amplification of Diagnostic Violence

Appendix A.5.1. Training Programs as Vectors of Epistemological Violence

CBT training programs systematically prepare clinicians to pathologize neurodivergent processing through frameworks that present neurotypical functioning as universal mental health standards. Consider the specific mechanisms:

- **Diagnostic oversimplification:** Complex neurodivergent presentations reduced to symptom clusters requiring technical intervention
- **Cultural bias normalization:** Neurotypical social and cognitive patterns presented as objectively "healthy" functioning
- **Intervention standardization:** Manualized protocols that cannot accommodate fundamental differences in neurological processing
- **Outcome measurement bias:** Success metrics based on neurotypical behavioral conformity rather than authentic flourishing

Appendix A.5.2. The Economics of Misdiagnosis

Healthcare systems incentivize rapid diagnostic categorization and standardized treatment protocols that systematically favor superficial symptom matching over careful phenomenological understanding. This creates economic pressures that reinforce epistemological violence:

1. **Time constraints:** Insurance reimbursement models that prevent thorough assessment necessary for accurate autism recognition
2. **Training limitations:** Limited education about autism presentation in adults, particularly in women and individuals with higher support needs
3. **Protocol adherence:** Institutional pressure to apply standardized CBT interventions regardless of underlying neurodivergent characteristics
4. **Outcome measurement:** Success metrics based on symptom reduction rather than authentic identity integration

Appendix A.6. Toward Diagnostic Precision and Ontological Dignity

Appendix A.6.1. Principles for Phenomenologically Informed Assessment

The development of assessment frameworks that honor neurodivergent dignity requires principles that privilege authentic understanding over convenient categorization:

1. **Empirical humility:** Recognition of limitations in current clinical knowledge and openness to correction based on emerging evidence about neurodiversity
2. **Experiential validation:** Systematic inclusion of structured self-report as legitimate source of diagnostic information, particularly regarding internal processing patterns
3. **Cultural contextualization:** Consideration of neurodiversity frameworks that interpret differences as natural variation rather than inherent pathology
4. **Reversibility protocols:** Systems that allow review and correction of previous diagnoses without professional or institutional penalty

Appendix A.6.2. Integrative Assessment Protocol for Suspected Autism

Phase 1: Phenomenological Understanding of Processing Patterns

Before applying diagnostic categories, exploration of lived experience is required:

- **Sensory processing:** "How do you experience different sensory environments? What helps you feel comfortable and focused?"
- **Social communication:** "What are your natural preferences for communication style and social interaction?"
- **Cognitive processing:** "How do you naturally approach learning, problem-solving, and organizing information?"
- **Special interests:** "What topics or activities naturally capture your sustained attention and passion?"
- **Routine and predictability:** "How do you naturally structure your time and environment for optimal functioning?"

Phase 2: Differential Contextualization

Table A1. Common Misdiagnoses and Underlying Autistic Realities.

Potential Misdiagnosis	Autistic Reality
Obsessive-Compulsive Personality Disorder	Systematic processing strengths and need for predictability
Paranoid Personality Disorder	Sensory sensitivity and honest communication in hostile environments
Social Anxiety Disorder	Sensory overwhelm in social environments designed for neurotypical processing
Generalized Anxiety Disorder	Natural awareness of unpredictability in environments not designed for autistic needs
Depression	Exhaustion from chronic masking and environmental mismatch

Appendix A.6.3. Reparative Protocols for Previously Misdiagnosed Individuals

For people who have experienced years of diagnostic error, specific protocols of **ontological repair** are required:

- **Comprehensive re-evaluation:** Structured processes to identify and correct historical diagnostic errors
- **Experiential validation:** Explicit recognition of harm caused by prolonged clinical imprecision
- **Transition support:** Specialized services to assist in reconstruction of authentic identity after years of self-alienation
- **Family education:** Programs to update family understanding according to correct diagnosis
- **Therapeutic repair:** Specialized interventions to address internalized pathologization and restore connection to authentic neurodivergent strengths

Appendix A.7. Implications for CBT Practice and Training

Appendix A.7.1. Toward Neurodiversity-Affirming CBT

The recognition of systematic misdiagnosis and therapeutic violence requires fundamental transformation of CBT theory and practice:

1. **Diagnostic precision prerequisite:** No CBT intervention should proceed without careful assessment for underlying neurodivergent characteristics
2. **Strength-based reframing:** Systematic processing, sensory awareness, and direct communication recognized as strengths requiring accommodation rather than modification
3. **Environmental focus:** Intervention emphasis on environmental modification and accommodation rather than individual behavioral change
4. **Identity integration:** Therapeutic goals oriented toward authentic identity development rather than neurotypical performance

Appendix A.7.2. Training Reform Requirements

CBT training programs require systematic reform to prevent perpetuation of epistemological violence:

- **Neurodiversity education:** Mandatory training on autism spectrum characteristics across the lifespan, with particular attention to presentations in women and individuals with higher support needs
- **Diagnostic humility:** Training in recognition of assessment limitations and protocols for diagnostic revision
- **Phenomenological competencies:** Development of skills in experiential exploration that honors first-person authority over internal experience
- **Cultural competency:** Understanding of neurodiversity frameworks as legitimate alternatives to pathology models

Appendix A.8. Conclusion: From Therapeutic Violence to Ontological Dignity

The systematic misdiagnosis of autistic individuals and subsequent application of CBT based on erroneous conceptualizations represents one of the most clear examples of epistemological violence in contemporary mental health practice. Each diagnostic error followed by years of therapy aimed at suppressing authentic neurodivergent characteristics constitutes a form of institutional harm that destroys rather than heals.

The path toward authentic therapeutic practice requires recognition that diagnostic precision is not a technical luxury but an ethical imperative. Every prolonged diagnostic error represents a life condemned to live in exile from its own nature, forced to perform neurotypical conventions while suppressing the very characteristics that constitute authentic selfhood.

The future of ethical mental health practice depends on our collective capacity to develop assessment and intervention frameworks that honor neurodivergent dignity, that recognize the authority of lived experience over institutional convenience, that privilege authentic flourishing over conformity to neurotypical behavioral standards.

This transformation requires more than technical correction: it demands what we have called a **revolution of precision**: a paradigmatic transformation that privileges authentic understanding over convenient categorization, neurodivergent dignity over institutional normalization, experiential *veritas* over professional *errare*.

The invitation remains open: to choose precision over convenience, dignity over categorization, authentic understanding over therapeutic violence. In that choice lies not only the integrity of clinical practice but the very possibility of health systems that authentically serve the diversity of human neurological experience.

Behind every diagnosis lies a human life whose existential trajectory can be fundamentally altered by the quality of our clinical understanding. The ethical responsibility is clear: to ensure that this understanding is grounded in the best available evidence, informed by neurodivergent perspectives, and dedicated to honoring both scientific objectivity and the irreducible dignity of each unique human experience.

Appendix B. Toward an Integrative Synthesis of Cognitive-Behavioral Therapy

Appendix B.1. CBT as Paradigm of Technically Effective Epistemological Violence

Cognitive-behavioral therapy constitutes the most paradigmatic example of what we have called epistemological violence in the context of contemporary mental health. However, its empirically documented technical efficacy obliges us to a more nuanced analysis that transcends both absolute phenomenological condemnation and uncritical acceptance of its ontological presuppositions.

Appendix B.1.1. Anatomy of Technical Colonization in CBT

CBT operates through a triple reduction that perfectly exemplifies the mechanisms of epistemological violence identified in our main analysis:

1. **Ontological reduction of existential thought:** The complexity of human thought—including legitimate existential intuitions, symbolic elaborations of suffering, and culturally specific forms of processing—is reduced to "cognitive distortions" measurable according to criteria of rationality that are apparently universal but culturally specific.
2. **Disciplinary normalization of emotional experience:** Emotions are transformed into "symptoms" that must be "regulated" according to predefined functioning patterns, thus losing access to their existential function as forms of being-open-to-the-world and revelation of meaning.
3. **Technical totalization of therapeutic encounter:** The interpersonal relationship is subordinated to manualized protocols that promise control through elimination of all non-protocolizable dimensions of human encounter.

Consider the specific phenomenology of this operation: when a person experiencing existential anxiety in the face of confrontation with their finitude receives interpretation of "catastrophic thinking" that must be "restructured," a fundamental ontological transformation occurs. The person learns to monitor their own existential intuitions, experiencing them as dysfunctions to correct. Disciplinary power now operates through them: they have become guardians of their own existential normalization.

Appendix B.2. Recognition of Technical Efficacy Without Uncritical Acceptance

However, diagnosing this epistemological violence should not lead us to total rejection of CBT's technical contributions. Such rejection would constitute another form of reductionism—anti-technical reductionism—equally inadequate for responding to the complexity of human suffering.

Empirical evidence consistently documents the efficacy of cognitive-behavioral interventions for:

- Symptom reduction in anxiety, depression, and trauma disorders
- Development of concrete tools for emotional self-regulation
- Improvement in social and work functioning
- Prevention of relapses in recurrent conditions

This efficacy suggests that CBT has identified real mechanisms of psychological change, although it interprets them from inadequate ontological frameworks. Integrative synthesis requires preservation of these technical mechanisms through their phenomenological re-grounding.

Appendix B.3. Elements Toward Phenomenologically Informed CBT

We propose specific criteria for an integrative synthesis that preserves CBT's technical efficacy while overcoming its structural epistemological violence:

Appendix B.3.1. Fundamental Principles for Synthesis

1. **Subordination of technical knowledge to existential encounter:** Cognitive-behavioral techniques must be articulated as tools facilitating existential exploration, not as ends in themselves.
2. **Cultural contextualization of "rationality":** Criteria of "functional" thinking must be contextually negotiated with each person, recognizing legitimacy of culturally specific forms of processing.
3. **Integration of existential dimensions:** Exploration of "meaning" of symptoms and patterns must precede their technical modification.
4. **Hermeneutic collaboration:** The person as co-investigator of their own experience, not object of technical correction.

Appendix B.3.2. Operational Criteria for Integrative CBT

Phenomenologically Informed Initial Evaluation:

- Do "dysfunctional thoughts" reflect cognitive dysfunction or legitimate existential elaboration of difficult experiences?
- Do "emotional symptoms" require technical regulation or existential accompaniment of natural processes?
- Do problematic behavioral patterns serve existential functions that must be understood before modification?
- Does the person experience their characteristics as ego-dystonic (requiring change) or as ego-syntonic but socially misunderstood?

Integrative Articulation of Interventions:

For generalized anxiety in adolescence:

- **Existential exploration:** Does "excessive worry" reflect legitimate existential sensitivity to vital uncertainty?
- **Specific techniques:** Emotional regulation tools preserving capacity for "worry" as form of existential care

- **Synthesis:** Development of discernment between functional anxiety (which orients) and dysfunctional anxiety (which paralyzes)
For post-loss depression:
- **Existential exploration:** Understanding grief as natural process of existential reorganization after significant loss
- **Specific techniques:** Behavioral activation respecting natural rhythms of grief without premature "acceleration"
- **Synthesis:** Integration of loss into coherent personal narrative preserving both legitimate pain and capacity for vital renewal

Appendix B.4. Paradigmatic Case: Integrative CBT in Action

Presentation: 32-year-old woman, visual artist, consults for "obsessive thoughts" about work quality and "procrastination" interfering with productivity. Traditional cognitive-behavioral evaluation would identify "dysfunctional perfectionism" and "behavioral avoidance" to modify through cognitive restructuring and gradual exposure.

Application of Integrative Synthesis:

Existential Understanding Phase:

- Exploration of existential meaning of "perfection" in her artistic practice
- Understanding "procrastination" as possible protection of creative integrity against external pressures
- Analysis of tension between authentic expression and productivity demands

Technical-Existential Synthesis Phase:

- Development of personal criteria for "excellence" honoring both technical quality and expressive authenticity
- Anxiety management techniques preserving artistic sensitivity necessary
- Temporal organization strategies respecting natural creative rhythms

Result: Greater artistic productivity + preservation of personal quality standards + reduction of unnecessary suffering + authentic integration of technical aspirations and expressive goals.

Appendix B.5. Limitations and Future Directions

This integrative synthesis of CBT presents limitations orienting future research:

1. **Empirical validation:** Proposed criteria require validation in controlled studies comparing outcomes between traditional CBT versus phenomenologically informed CBT.
2. **Professional training:** Development of integrative competencies in cognitive-behavioral therapists presents specific pedagogical challenges requiring innovative training programs.
3. **Cultural adaptation:** Criteria of "rationality" and "functionality" require contextual adaptation for culturally diverse populations.
4. **Institutional sustainability:** Implementation of integrative frameworks in institutional contexts structured according to technical paradigms presents resistances requiring specific organizational change strategies.

Appendix B.6. Conclusion: CBT as Bridge Toward Broader Syntheses

Cognitive-behavioral therapy, precisely because of its documented technical efficacy and dominant institutional influence, constitutes privileged terrain for implementation of broader integrative syntheses. Its phenomenological transformation does not require abandonment of its technical tools but their re-grounding in frameworks honoring both interventive efficacy and existential dignity.

This specific synthesis illustrates the practical viability of overcoming false dichotomies between technical rigor and existential depth, demonstrating that evolution toward more authentic forms of

mental care can occur through gradual transformation of dominant paradigms from within, preserving their valid contributions while overcoming their fundamental ontological limitations.

The future of authentically integrative CBT depends on our capacity to form professionals capable of fluidly navigating between technical frameworks and existential understanding, thus developing forms of accompaniment serving both the human need for effective relief of suffering and the ethical imperative of preserving the ontological irreducibility of each therapeutic encounter.

Appendix C. Operational Protocols for the Implementation of Phenomenologically Informed CBT

Appendix C.1. Conceptual Framework for Clinical Application

The practical implementation of the ontological-practical synthesis developed in this essay requires specific protocols that preserve both technical rigor and existential depth. This section develops concrete operational criteria for the transformation of traditional CBT toward phenomenologically informed forms.

Appendix C.1.1. Guiding Principles for Implementation

- 1. **Phenomenological subordination of technical knowledge:** Cognitive-behavioral interventions must be articulated as tools that facilitate existential exploration, not as ends in themselves.
- 2. **Preservation of experiential authority:** The consulting person maintains interpretative authority over the meaning of their experience, being co-investigator of their own process.
- 3. **Cultural contextualization of “rationality”:** Criteria of “functional” thinking must be contextually negotiated, recognizing the legitimacy of culturally specific forms of processing.
- 4. **Integration of existential dimensions:** Exploration of the “meaning” of symptoms and patterns must precede their technical modification.

Appendix C.2. Integrative Clinical Decision Matrix

The following matrix operationalizes the criteria developed in Section 3.2.1 for decision-making in specific clinical contexts:

Table A2. Decision Matrix for Intervention Prioritization.

Evaluative Criterion	Technical Priority Indicator	Phenomenological Priority Indicator
Ego-syntonicity	Experiences lived as alien to the authentic self	Characteristics integrated into personal identity
Contextual functionality	Severe impediment in basic activities	Functioning preserved in appropriate contexts
Temporality of distress	Acute crisis with sudden deterioration	Stable patterns of characteristic processing
Avoidable suffering	Distress that the person wishes to eliminate	Experiences requiring meaning elaboration
Reversibility	Conditions with treatable neurobiological correlates	Constitutive characteristics of temperament

Appendix C.3. Differential Initial Assessment Protocol

Appendix C.3.1. Phase 1: Phenomenological Understanding of the “Symptom”

Before applying diagnostic categories, exploration of lived experience is required:

- **Existential function:** “What function does this experience serve in your life?”
- **Personal meaning:** “What does this way of experiencing tell you about yourself?”
- **Lived temporality:** “How do you experience time when this occurs?”
- **Embodiment:** “How does this manifest in your body and movement?”
- **Relationality:** “How does this affect your relationships with others?”

Appendix C.3.2. Phase 2: Application of Articulation Criteria

Based on phenomenological understanding, the type of synthesis required is determined:

1. If there is immediate safety risk:
- Biomedical priority with preparation for subsequent existential work
2. Else, if ego-dystonic symptoms AND severe distress:
- Biomedical evaluation articulated with meaning exploration
3. Else, if ego-syntonic differences AND contextual functioning:
- Phenomenological approach with technical support as needed
4. Else, if evidence of treatable neurobiological condition:
- Integrative synthesis: technical intervention + existential elaboration
5. Else, if suffering reflects existential growth process:
- Phenomenological accompaniment with technical monitoring

Appendix C.4. Phenomenological Reformulation of Standard CBT Techniques

Appendix C.4.1. Cognitive Restructuring → Existential Discernment

Traditional CBT:

“Let’s identify your distorted thoughts and develop more rational alternatives.”

Phenomenologically Informed CBT:

“Let’s explore what your way of thinking tells us about what is important to you. When is that concern wisdom and when does it become sterile rumination?”

Table A3. Phenomenological Reformulation of CBT Concepts

Traditional CBT Concept	Phenomenological Reformulation
Catastrophic thinking	Existential sensitivity to vulnerability
Dysfunctional perfectionism	Excessive care for authentic excellence
Behavioral avoidance	Protection of personal integrity
Pathological rumination	Stuck search for understanding
Hypervigilance	Increased attention to relational environment

Appendix C.4.2. Exposure Techniques → Gradual Exploration of Vulnerability

Behavioral exposure is reframed as an opportunity to:

1. Explore the existential meaning of “fear”
2. Develop confidence in one’s own capacity for encounter with uncertainty
3. Cultivate authentic presence in challenging situations
4. Integrate vulnerability as a constitutive aspect of the human condition

Appendix C.5. Paradigmatic Case: Complete Implementation

Appendix C.5.1. Case Presentation

Client: Elena, 28 years old, software engineer

Presenting concern: “Social anxiety” interfering with work presentations

Symptoms: Anxious anticipation, meeting avoidance, severe post-interaction self-criticism

Appendix C.5.2. Application of Integrative Protocol

Sessions 1-2: Phenomenological Understanding

THERAPIST: Elena, before talking about “social anxiety,” I would like to understand what that experience in meetings means to you.

ELENA: It's like... like there's a part of me that wants to protect me from being judged. But it also prevents me from showing what I really know.

THERAPIST: So there's wisdom in that protection, although also a cost. What does that protective part see that leads it to activate?

ELENA: I think it sees that I'm different. I process things more slowly than others, but more deeply. In fast-paced meetings, I feel like I can't show my best version.

Evaluation According to Decision Matrix:

- *Ego-syntonicity*: Partial - recognizes value in her deep processing
- *Functionality*: Preserved in appropriate contexts, limited in meetings
- *Temporality*: Stable pattern, not acute crisis
- *Suffering*: Wants to modify avoidance, preserve sensitivity

Decision: Integrative synthesis - specific techniques + identity integration

Sessions 3-8: Technical-Existential Synthesis

1. **Existential reframing:** Her "anxiety" as legitimate sensitivity to pace and quality of exchange
2. **Reformulated specific techniques:**
 - *Conscious breathing* → Embodied presence techniques
 - *Cognitive restructuring* → Discernment between appropriate/inappropriate contexts
 - *Gradual exposure* → Exploration of authentic vulnerability
3. **Development of contextually appropriate strategies:**
 - Request advance agenda for deep preparation
 - Develop written interventions to complement oral ones
 - Identify allies who value her processing style

Appendix C.5.3. Synthesis Results

Technical Metrics:

- Reduction in social anxiety scale (SIAS): 45 → 23 points
- Increase in meeting participation: 2/10 → 7/10
- Improvement in professional performance self-assessment

Existential Indicators:

- Authentic integration of temperamental characteristics
- Development of contextually appropriate strategies
- Greater self-understanding and self-acceptance
- Capacity to advocate for her processing needs

Appendix C.6. Limitations and Implementation Considerations

Appendix C.6.1. Institutional Challenges

1. **Professional training:** Requires additional training in phenomenological competencies
2. **Session time:** Existential exploration may require more extensive sessions
3. **Outcome measurement:** Need for metrics that capture existential dimensions
4. **Paradigmatic resistance:** Possible resistance from institutions structured according to single technical models

Appendix C.6.2. Applicability Criteria

This integrative protocol is especially appropriate for:

- Conditions where traditional CBT shows technical efficacy but existential limitations
- Persons with temperamental or neurological characteristics requiring non-pathologizing understanding

- Contexts where cultural diversity demands adaptation of “rationality” criteria
- Cases where identity integration is as important as symptom reduction

Appendix C.7. Future Directions for Research

1. **Comparative efficacy studies:** Traditional CBT vs. phenomenologically informed CBT in specific populations
2. **Development of measurement instruments:** Scales that capture existential dimensions in operationally viable ways
3. **Analysis of change mechanisms:** Identification of specific processes through which integrative synthesis produces transformation
4. **Implementation studies:** Analysis of factors that facilitate or hinder institutional adoption of integrative approaches

This section demonstrates that the phenomenological transformation of CBT does not require abandonment of its technical tools, but rather their re-grounding in frameworks that honor both interventive efficacy and existential dignity, illustrating the practical viability of overcoming false dichotomies between technical rigor and existential depth.

Appendix D. Restoring the Subject: Biomedical Intervention as a Precondition for Existential Accompaniment

A key operational insight of this integrative framework concerns the management of cases in which the subject’s capacity for self-report, reflective awareness, or intersubjective contact is profoundly compromised. Psychotic episodes, severe manic states, and disorganized thought processes may radically alter the intentional structure of consciousness to the point where existential accompaniment becomes temporarily unviable.

Appendix D.1. Phenomenological Collapse and the Descent in Ontological Level

When the subject loses the capacity to articulate coherent meaning or sustain basic intersubjective contact, the phenomenological horizon—the shared space of world-disclosure—collapses. In such cases, any attempt to validate experience as “existential authority” may result in ontological confusion or even therapeutic harm. Existentialism presupposes a minimal structure of selfhood capable of meaning-making. When that structure is disorganized, a shift in the level of intervention becomes ethically necessary.

We call this operational move a **descent in ontological level**: the temporary suspension of phenomenological dialogue in favor of neurobiological stabilization. However, unlike reductive psychiatry, this descent is not understood as a denial of subjectivity but as a *protective strategy* aimed at restoring the very conditions of authentic selfhood.

Appendix D.2. Clinical Stratification by Level of Subjective Integrity

The framework thus proposes a stratified model of care:

Subjective Integrity	Appropriate Clinical Level
Preserved intersubjectivity	Phenomenological-existential priority
Partial disorganization	Integrative synthesis with technical support
Severe disorganization (psychosis, mania)	Neurobiological priority for restoration

This model avoids both epistemological violence (treating all difference as pathology) and existential idealism (treating all pathology as misunderstood authenticity). It grounds intervention in *clinical pragmatics informed by ontological depth*.

Appendix D.3. From Stabilization to Rehumanization

The ultimate goal of biomedical intervention, in this integrative view, is not symptom suppression for its own sake, but the **rehumanization of the clinical encounter**. Once safety and minimal coherence are restored, the framework calls for a transition back toward existential dialogue, meaning reconstruction, and identity reintegration.

This dialectic between levels ensures that even in moments of maximal desubjectivation, the clinical act remains teleologically ordered toward the recovery of the subject as a center of meaning—not merely as a system of symptoms. It affirms that *to treat the brain is, ultimately, to rescue the person who suffers through it*.

Appendix E. Critical Dialogue: Is CBT Violent in Reducing Patients to Distorted Thoughts?

Appendix E.1. Formulation of the Fundamental Critique

The central question that motivates this dialogue is: *Is CBT not violent in treating the patient as a bundle of distorted thoughts, without integrating them into their existentiality?*

This interrogation points to a fundamental critique that is addressed in the theoretical development of the Integrative Ontology of Authentic Care itself. Indeed, the present analysis recognizes that traditional Cognitive-Behavioral Therapy (CBT) can incur a form of epistemological violence by reducing the patient to a set of distorted thoughts that must be corrected, without integrating or validating the profound existential dimension of suffering.

Appendix E.2. Proposed Integrative Synthesis

The response does not consist in total rejection of CBT's technical efficacy, but in implementing an integrative and phenomenologically informed synthesis that demands:

1. **Subordination of cognitive techniques** to prior and contextualized existential exploration
2. **Recognition of patient authority** as co-investigator of their experience, not merely object of correction
3. **Validation of suffering and meaning** of thoughts before mechanically restructuring them
4. **Contextual discernment** between genuine cognitive distortions and legitimate expressions of existential concerns

Appendix E.3. Concretization of Existential Integration in CBT

Appendix E.3.1. Phenomenological Initial Assessment

Before applying cognitive or behavioral techniques, the therapist conducts an evaluation that:

- **Explores the subjective meaning** of problematic thoughts and emotions through questions such as:
 - What function does this thought serve in your life?
 - What is this emotion telling you?
- **Distinguishes between:**
 - Thoughts that represent cognitive distortions susceptible to restructuring
 - Thoughts that express legitimate existential tensions or dilemmas
- **Evaluates ego-syntonicity** to avoid pathologizing authentic identity characteristics

Appendix E.3.2. Phenomenological Reformulation of CBT Techniques

Standard techniques are reinterpreted to preserve respect for existential experience:

- **Cognitive restructuring → Existential discernment:** Development of practical wisdom to differentiate genuine concerns from destructive thoughts

- **Behavioral exposure** → **Gradual exploration of vulnerability:** Accompanying the patient to inhabit their vulnerability with authentic presence
- **Emotional regulation** → **Accompaniment of existential emotional processes:** Integration of emotions with existential meaning rather than suppression

Appendix F. Comparative Evaluation: Traditional CBT vs CBT with Existential Framework

Appendix F.1. General Assessment (0-100 Scale)

Table A4. General Comparative Assessment of CBT

Therapeutic Approach	Score	Justification
Traditional CBT	70	• High technical efficacy in symptom reduction • Ontological and epistemological limitations • Risk of epistemological violence • High institutional accessibility
CBT with Existential Integration	90-95	• Preserves proven technical efficacy • Integrates phenomenological validation • Reduces epistemological violence • Promotes existential growth • Requires specialized training

Appendix F.2. Detailed Multidimensional Analysis

Table A5. Multidimensional Comparative Analysis of CBT.

Dimension	Traditional CBT	Integrated CBT	Traditional CBT Justification	Integrated CBT Justification
Technical Efficacy	85	85	Extensive empirical evidence in symptom reduction and behavioral management	Preserves all proven technical efficacy
Existential Validation	40	90	Reduces human existence to cognitive distortions	Integrates and validates subjective experience and meaning
Professional Ethics	70	95	Respects norms but may operate with epistemological violence	Promotes respect, patient authority, and authentic accompaniment
Clinical Flexibility	60	90	Rigid protocols limit adaptation to singularities	Contextual flexibility that articulates different needs
Institutional Accessibility	90	65	Wide dissemination, standardized training	Requires advanced training and institutional changes
Impact on Identity & Growth	40	90	May fragment and pathologize identity	Fosters identity integration and personal growth

Appendix F.3. Paradigmatic Case Example

Appendix F.3.1. Case Presentation

Client: Marcus, 34-year-old software engineer
Presenting concern: "Social anxiety" interfering with work presentations
Traditional CBT approach: Cognitive restructuring for "catastrophic thinking," exposure therapy for "social avoidance"

Appendix F.3.2. Integrative CBT Application

Phenomenological Understanding Phase:

THERAPIST: Marcus, before talking about "social anxiety," I would like to understand what that experience in meetings means to you.

MARCUS: It's like... there's a part of me that wants to protect me from being judged. But it also prevents me from showing what I really know.

THERAPIST: So there's wisdom in that protection, although also a cost. What does that protective part see that leads it to activate?

MARCUS: I think it sees that I'm different. I process things more slowly than others, but more deeply. In fast-paced meetings, I feel like I can't show my best version.

Technical-Existential Synthesis:

- **Existential reframing:** "Anxiety" as legitimate sensitivity to pace and quality of exchange
 - **Specific techniques:** Breathing exercises for embodied presence, not just symptom reduction
 - **Contextual strategies:** Environmental accommodations honoring processing style
- Outcomes:**
- **Technical metrics:** Reduced social anxiety scores, increased meeting participation
 - **Existential indicators:** Authentic integration of temperamental characteristics, self-advocacy for processing needs

Appendix F.4. Conclusions of Comparative Analysis

The multidimensional evaluation reveals that traditional CBT maintains significant strengths in **technical efficacy** and **institutional accessibility**, but presents critical limitations in:

- Attention to the existential dimension of suffering
- Flexibility to address patient singularity
- Prevention of epistemological violence
- Promotion of authentic identity growth

Conversely, CBT with existential integration achieves an expanded synthesis that:

- **Preserves empirically demonstrated technical efficacy**
- **Respects and articulates the consultant's existential experience**
- **Generates significant ethical and personal growth benefits**
- **Requires institutional adaptation** and additional specialized training

This synthesis represents not a superficial "improvement" of traditional CBT, but a **paradigmatic transformation** that overcomes the false dichotomy between technical rigor and existential depth, demonstrating that both dimensions are not only compatible but mutually necessary for mature forms of accompanying human suffering.

Appendix F.5. Implementation Implications

The successful integration of existential frameworks into CBT practice requires:

1. **Professional training reform:** Development of curricula that cultivate both technical competence and phenomenological sensitivity

2. **Institutional culture change:** Creation of clinical environments that support longer sessions and deeper exploration
3. **Measurement innovation:** Development of outcome metrics that capture both symptomatic improvement and existential growth
4. **Supervision transformation:** Training of supervisors capable of evaluating integrative competencies

This transformation represents not merely a technical adjustment but a fundamental evolution toward more authentic and effective forms of therapeutic accompaniment that honor both human complexity and the legitimate demand for empirically validated intervention.

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