

The Actualization Diagnostic Framework¹

—A Structured Psychological Assessment System Grounded in Aristotelian Propositional Logic

Anna E. Becker

Kenosha, WI, USA

Email: anna.becker.mail@gmail.com

How to cite this paper: Becker, A. E. (2026). The Actualization Diagnostic Framework. *Psychology*, 17, 723-741. <https://doi.org/10.4236/psych.2026.176036>

Received: May 7, 2026

Accepted: June 27, 2026

Published: June 30, 2026

Copyright © 2026 by author(s) and Scientific Research Publishing Inc. This work is licensed under the Creative Commons Attribution International License (CC BY 4.0). <http://creativecommons.org/licenses/by/4.0/>



Open Access

Abstract

This paper introduces the Actualization Diagnostic Framework (ADF), a structured psychological assessment and intervention system derived from the propositional logic embedded in Aristotle's *Metaphysics* and *Physics*. The ADF organizes clinical practice across three logical tiers—Primary (foundational assessment), Intermediate (process diagnosis), and Secondary (intervention)—each grounded in formally derived propositions concerning being, generation, agency, and actuality. The system maps nine Aristotelian passages onto nine clinical instruments, producing a coherent framework in which diagnostic and therapeutic decisions follow from logical necessity rather than clinical heuristics alone. The paper describes the system's theoretical foundations, clinical architecture, assessment instruments, and generated outputs, and concludes by examining the framework's potential to develop into a broader meta-theoretical approach to psychological practice—one capable of integrating extant therapeutic modalities under a unified ontological structure.

Keywords

Actualization Diagnostic Framework, Aristotelian Propositional Logic, Philosophical Psychology, Theory of Being, Clinical Assessment, Potentiality and Actuality, Telos, Schema Therapy, Process-Based Therapy, Psychotherapy Integration, Meta-Theoretical Framework, Ontology, Clinical Practice

1. Introduction

Psychology as a discipline has long grappled with the problem of theoretical frag-

¹ *A Contribution to Philosophical Psychology: Deriving Clinical Method from Aristotle's Metaphysics and Physics.*

mentation. Cognitive-behavioral, psychodynamic, humanistic, existential, dialectical, and systemic approaches each offer partial accounts of human suffering and change, yet no overarching framework has successfully integrated them under a common theoretical structure. The present paper proposes that such integration may be achieved not by deriving a new theoretical synthesis within psychology, but by returning to a prior layer of inquiry—the philosophical logic of being itself.

The Actualization Diagnostic Framework (ADF) begins not with a theory of mind, but with a theory of being. Specifically, it derives its clinical architecture from nine propositions found in Aristotle's *Metaphysics* and *Physics*, formalized in propositional logic and organized into a three-tier hierarchical argument. The resulting system produces a clinical instrument in which assessment, diagnosis, and intervention are not merely correlated activities but logically ordered stages—each tier following necessarily from the one before it.

This approach is not presented as a replacement for existing therapeutic modalities. Rather, the ADF functions as a meta-framework: a logical scaffolding onto which existing approaches can be mapped, unified, and extended. Cognitive-behavioral therapy finds its place within the ADF's intermediate tier; schema therapy within its primary tier; behavioral activation within its secondary tier. What the ADF adds is not new technique, but logical necessity—a formal account of why these techniques work and in what order they must be applied.

The paper proceeds as follows. Section 2 presents the theoretical foundations, including the Aristotelian propositions, their formalization in propositional logic, and their validity assessment. Section 3 describes the clinical architecture of the ADF across its three tiers. Section 4 presents the nine structured assessment instruments derived from the framework. Section 5 discusses the ADF's relationship to existing therapeutic traditions. Section 6 examines the framework's potential for development as a larger system of practice. Section 7 offers concluding reflections.

The Philosophical Significance of a Theory of Being Prior to a Theory of Mind

The decision to begin with a theory of being rather than a theory of mind is not merely a methodological preference; it carries deep philosophical significance that determines the logical structure of everything that follows. Most psychological frameworks commence with assumptions about mental states—beliefs, affects, representations, or behaviours—and derive their clinical architecture from those assumptions. The ADF inverts this order: it begins with ontological claims about what it means for anything to exist, to have come to be, and to stand in a relationship between actuality and potentiality, and only then asks what follows for the specific case of a minded being. This inversion, far from being a mere philosophical affectation, resolves a set of foundational problems that a theory-of-mind-first approach cannot address without circularity.

Aristotle's ontological priority claim is stated with precision in the *Metaphysics*:

“Though all things ‘are’ they are not in the same way—some are primarily and the rest dependently” (Metaphysics VII.1, 1028a10-20; Aristotle, 1966). This is not a claim about cognition; it is a claim about being itself. It establishes that the structure of reality is stratified—that some entities or properties have being in their own right, while others depend for their being on something prior. Only once this ontological principle is in place can the question “which of a person’s beliefs is primary, and which are derived from it?” be given a non-arbitrary answer. Without the prior ontological principle, the distinction between core and conditional beliefs in schema therapy (Young et al., 2003) rests on nothing more than clinical intuition. With it, the distinction becomes a formal consequence of how being is structured.

The same logic applies to generation. Aristotle’s claim in the Physics that “whatever comes to be is generated by the agency of something out of something and comes to be something” (Physics II.3, 194b29-195a3; Aristotle, 1969) is, again, an ontological claim before it is a psychological one. It establishes that the structure of causation—that coming-to-be always involves a generating agency, a matter from which, and a form toward which—applies universally to anything that exists within the natural order. The mind is not exempt from this structure; it is an instance of it. A psychological state that came to be has come to be through some agency (nature, art, or spontaneity), from some prior condition, and as some determinate kind of state. To begin with a theory of mind and then import causal language is to presuppose what ontology makes explicit; beginning with ontology ensures that the causal structure of psychological reality is derived from principles that hold for all being, not merely stipulated for mental being alone.

Perhaps the most philosophically consequential advantage of a theory of being over a theory of mind concerns the concepts of actuality and potentiality. Aristotle’s demonstration that actuality is prior to potentiality—“actuality is prior to power in being” (Metaphysics IX.8, 1049b4-12; Aristotle, 1966)—establishes an asymmetry that no purely mentalist framework can generate from its own resources. A theory of mind begins with mental states as they currently are; it has no internal resources for saying that the client’s unrealized capacities are ontologically prior to, and more fully real than, the diminished state in which they currently exist. This is precisely the claim that makes sense of why therapeutic change is not merely desirable but ontologically appropriate: the actualized state is the more fully real state, and the unactualized state is a kind of privation—a being-toward-what-is-not-yet rather than a fully achieved being. Without this ontological grounding, the therapeutic claim that a client “is capable of more than they are currently expressing” is a motivational hypothesis; with it, the claim has ontological weight.

The concept of telos—which the ADF identifies as the organizing principle of the secondary tier—similarly requires an ontological rather than a merely psychological foundation. Aristotle argues that “everything that is produced proceeds according to its principle, for its wherefor is its principle, and its coming into being

is directed by the end” (Metaphysics IX.8, 1049b4-12; Aristotle, 1966). The telos is not a goal chosen by the subject; it is the actualized endpoint toward which a thing’s nature directs it. A theory of mind can speak of goals, desires, and values, but it cannot speak of telos in this sense, because telos presupposes that there is something the person most fully is when realized—a determinate form of actualized being that is not chosen but disclosed. This is a claim about being, not about preference, and it can only be made on the basis of a prior theory of being that establishes what actuality, form, and natural directedness mean.

Finally, the priority of a theory of being over a theory of mind resolves what might otherwise appear as a category error in the ADF’s application of metaphysical concepts to clinical phenomena. Aristotle’s proposition that “one discovers what is potential by performing an operation” (Metaphysics IX.8, 1049b35-1050a3; Aristotle, 1966) is, in the first instance, a claim about how potentiality is known in general: for any kind of being with potentialities, those potentialities are only disclosed through actual exercise. The mind is not a special case to which this principle has been extended by analogy; it is a natural instance to which the principle applies directly. The ADF’s S3 instrument—which frames behavioural activation as epistemological necessity rather than motivational technique—is not a creative reapplication of physics to psychology; it is the straightforward consequence of an ontological principle that was never restricted to non-mental being in the first place. This is the deepest reason why a theory of being must precede a theory of mind: the principles governing being apply to mind not as imported metaphors but as primary instances.

2. Theoretical Foundations

2.1. The Aristotelian Source Propositions

The ADF is grounded in nine passages drawn from Aristotle’s *Metaphysics* and *Physics*. These passages were selected because they constitute, when read as a unified argument, a coherent account of how things come to be, what it means for something to have being, and what the relationship is between actuality and potentiality. Each passage was subjected to propositional formalization, yielding a logical structure that maps directly onto clinical concerns.

The nine source propositions address: the nature of generation and its generating agencies (1.1); the priority of being and its modes (1.2); the mental constitution of true being and the priority of mind over chance (1.3); the traceable origins of all processes to determinate agencies (1.4); the non-contradictory co-existence of being and non-being (1.5); the multiplication and copying of patterns across instances (1.6); the logical priority of actuality over potentiality in being (1.7); the superior value of the actuality of good over the power for good (1.8); and the epistemological necessity of action for the discovery of potential (1.9). Specific passage references are as follows: (1.1) *Physics* II.3, 194b29-195a3; *Metaphysics* I.3, 983a24-983b1; (1.2) *Metaphysics* VII.1, 1028a10-20; (1.3) *Metaphysics* I.3, 984b8-18; (1.4) *Physics* II.3, 195b12-21; (1.5) *Metaphysics* IV.3, 1005b19-25; (1.6) *Metaphysics*

VII.8, 1034a2-8; (1.7) Metaphysics IX.8, 1049b4-12; (1.8) Metaphysics IX.9, 1051a4-15; (1.9) Metaphysics IX.8, 1049b35-1050a3. All passage references follow the Aristotle (1966, 1969) translations used throughout this paper; see Ross (1924) for alternative scholarly commentary.

The formalized propositional logic for the three primary tier propositions is presented in Figures 1-3 below.

When arranged in logical sequence, these propositions form a valid argument—subject to two enthymematic premises that Aristotle assumes but does not state explicitly in these passages. The argument concludes that actuality is prior to potentiality in being, in value, and in knowledge, and that powers exist for the sake of their actualities rather than the reverse.

2.2. Glossary of Key Terms and Abbreviations

The following terms and abbreviations are used throughout this paper. Readers are encouraged to consult this glossary on the first encounter with any term before proceeding to the formalized propositions and clinical instruments.

Actualization: The process by which a latent capacity or potentiality is brought into actual exercise or concrete expression. Within the ADF, actualization is both an ontological concept (the transition from potentiality to actuality) and a clinical target (the movement from what a client is capable of to what they demonstrably enact).

Telos (pl. teloi): The end or final cause toward which a thing is directed by its nature. In Aristotle's framework, the telos of a thing is not arbitrarily assigned but is given by what that thing most fully is when realized. Clinically, the client's telos is the actualized endpoint that orientates the entire intervention sequence; it is established through S1 (Telos Mapping) before any behavioral operations are assigned.

Primary Belief: A belief that has being in its own right and does not derive its content or force from another belief. Corresponds to the logical status $P(x)$ in proposition P2. Clinically, primary beliefs are the foundational schema-level convictions that generate and sustain dependent beliefs; they are assessed by the Core and Derived Belief Inventory (P2).

Dependent Belief: A belief that derives its content and persistence from a primary belief. Corresponds to $D(x)$ in proposition P2. Therapeutically significant because addressing a dependent belief without treating the primary belief from which it is derived typically yields unstable gains.

Same Respect (SR): A condition in which two contradictory predicates (e.g., "I am capable" and "I am incapable") are held to apply simultaneously to the same subject, in the same respect, at the same time. Following Aristotle's principle of non-contradiction (Metaphysics IV.3, 1005b19-20), SR indicates a pathological collapse of distinction. Its absence ($\neg$ SR) indicates a productive paradox in which contradictory predicates apply in different respects and is clinically normative.

AG (Actualized Good): The good that a client has concretely enacted or ex-

pressed; the exercise of a capacity rather than its mere possession. Evaluated by the Actualization Value Audit (S2).

PG (Potential Good): The good that a client is capable of but has not yet enacted; the possession of a capacity without its exercise. The gap between AG and PG ($V(AG) > V(PG)$) is the central diagnostic quantity of the secondary tier.

CH (Chance): The governing principle of events that arise without a determinate mental agency; circumstance rather than intention as the locus of causation. In the ADF, a high CH score on I1 indicates that the client experiences their situation as governed by forces external to their intentional agency.

PR (Prior Rational Agency): The condition in which mind (nous) has been established as the governing principle of a client's life-world, as against chance (CH). PR is the target state of the Locus of Control Assessment (I1). ADF: Actualization Diagnostic Framework. P1 - P3: Primary tier propositions/instruments. I1 - I3: Intermediate tier instruments. S1 - S3: Secondary tier instruments.

2.3. Propositional Formalization

Each source proposition was rendered in standard propositional notation. The primary tier propositions establish the foundational premises (**Figures 1-3**):

$$P1: C \rightarrow (N \vee A \vee S) \quad \text{and} \quad C \rightarrow G$$

Figure 1. ADF primary tier propositions (P1): The generation principle—whatever comes to be done so through nature, art, or spontaneity, and always through some generating agency (Aristotle, Physics II.3, 194b29-195a3).

$$P2: B(x) \rightarrow (P(x) \vee D(x)) \quad \text{and} \quad \neg(P(x) \wedge D(x))$$

Figure 2. ADF primary tier propositions (P2): The priority of being—everything that has being has it either primarily or dependently, but not both simultaneously (Aristotle, Metaphysics VII.1, 1028a10-20).

$$P3: (B \wedge NB) \wedge \neg SR$$

Figure 3. ADF primary tier propositions (P3): The non-contradiction principle—a thing can be being and non-being simultaneously provided these are not predicated in the same respect (Aristotle, Metaphysics IV.3, 1005b19-25).

The intermediate tier propositions derive sub-conclusions from these primary premises, establishing claims about agency, mental origin, and pattern replication. The secondary tier propositions derive the framework's clinical conclusions: the priority of actuality (S1: $E \rightarrow AC \rightarrow PW$), the superior value of actualized good (S2: $V(AG) > V(PG)$), and the epistemological necessity of action for knowledge of potentiality (S3: $O \rightarrow PD$ and $MC \rightarrow KP$).

2.4. Validity Assessment

The complete argument was assessed for formal validity using conditional proof. The assessment found that S1 and S3 are fully valid given the stated premises, while

S2 is enthymematic—its conclusion that ontological priority entails value priority requires a hidden premise (HP2: if X is prior to Y in being, then X is more valuable than Y) that Aristotle asserts but does not derive in these passages.

For clinical purposes, this enthymematic structure is significant rather than problematic. It means that S2—the claim that the actuality of good is more valuable than the power for good—functions in the ADF not as a derived conclusion but as an axiological commitment that the clinician and client must share. The ADF makes this commitment explicit, transforming a logical gap into a therapeutic premise: the client is invited to recognize that actualized good exceeds capacity for good in value, and this recognition becomes the motivational foundation for intervention at the secondary tier.

Two hidden premises are required for full formal validity:

HP1: Actuality = primary being; Potentiality = dependent being HP2: If X is prior to Y in being, then X is more valuable than Y

Figure 4. Hidden premises (HP1 - HP2): The two enthymematic premises required for full formal validity of the ADF argument.

With these premises made explicit, the argument is formally valid and the ADF's logical chain is complete.

The two hidden premises required for formal validity are presented in **Figure 4**.

3. Clinical Architecture

The ADF organizes clinical activity across three tiers, each corresponding to a logical stage in the underlying argument. The tiers are not merely sequential phases of treatment but logically ordered domains: conclusions drawn in the primary tier constrain and inform the intermediate tier, which in turn constrains and informs the secondary tier. Clinical decisions at any given tier follow from the logical structure established in the tier below.

The Primary, Intermediate, and Secondary tier summaries are presented in **Figures 5-7** respectively.

1) Bridging Assumptions: From Metaphysical Claims to Clinical Practice.

The ADF rests on three bridging assumptions that mediate between Aristotle's metaphysical propositions and their clinical application. These assumptions do not follow from the propositions by logical necessity alone; they represent principled interpretive commitments without which no clinical inference from the philosophical text would be possible. The first bridging assumption (BA1) is that psychological states are proper instances of Aristotelian being and therefore subject to the same ontological analysis as natural substances: a client's belief system, emotional life, and behavioral repertoire can meaningfully be analysed as having primary or dependent being (P2), as exhibiting the transition from potentiality to actuality (S1 - S3), and as standing in a teleological relationship to an end (telos).

Without BA1, propositions about substance and being would have no purchase on clinical phenomena. The second bridging assumption (BA2) is that the logical ordering of Aristotle's propositions maps onto a therapeutically appropriate ordering of clinical steps: what is logically prior in the argument is also temporally prior in the treatment sequence. This assumption licenses the ADF's central methodological claim—that primary-tier assessment must precede intermediate-tier diagnosis, which must precede secondary-tier intervention—but is itself a clinical-theoretical commitment rather than a purely formal entailment. The third bridging assumption (BA3) is that a client's telos is, in principle, identifiable through structured clinical inquiry (S1) and is not merely a projection of the clinician's values. BA3 is contested territory discussed further in the Limitations section (6.7). Together, BA1 - BA3 make explicit the inferential steps that permit a conclusion about being, actuality, or telos to warrant a specific clinical action, and they should be treated as the framework's transparent axiological and methodological commitments rather than as hidden premises.

2) Clinical Boundary Conditions and Override Criteria. The ADF's claim that clinical decisions follow in a logically ordered sequence holds under standard conditions of engagement. Clinicians must recognise that specific clinical circumstances appropriately override this default tier order. Three boundary conditions warrant explicit acknowledgement. First, where acute risk is present—including active suicidal ideation with intent or plan, current self-harm, or risk of harm to others—safety assessment and crisis intervention take unconditional precedence over any tier of the ADF. The framework's logical sequence presupposes a degree of psychological stability sufficient for collaborative structured inquiry; that presupposition fails in acute-risk presentations, and clinicians must follow established risk-management protocols (e.g., [National Institute for Health and Care Excellence \(NICE\), 2022](#)) before resuming ADF-guided work. Second, where severe cognitive or perceptual disorganisation is present—including acute psychosis, dissociative states that preclude reflective engagement, or significant intellectual disability affecting the self-report demands of the instruments—standard ADF administration may be clinically inappropriate. Adapted protocols should be developed for such presentations in future iterations of the framework. Third, where safeguarding obligations arise—including disclosure of abuse, neglect, or risk to a child or vulnerable adult—the clinician's legal and professional duties take precedence over the therapeutic frame established by the ADF. These boundary conditions do not undermine the framework's logical structure; they delimit the conditions under which that structure appropriately applies.

3.1. Primary Tier—Foundational Assessment (Figure 5)

The three instruments of the primary tier are the Origin Mapping Inventory (P1), the Core and Derived Belief Inventory (P2), and the Dialectical Self-Mapping tool (P3). Together, they answer three questions that the logic of P1 - P3 makes mandatory: Where did this come from? What is primary versus derived in how this per-

son understands themselves? And where are the contradictions, and what is their logical character?

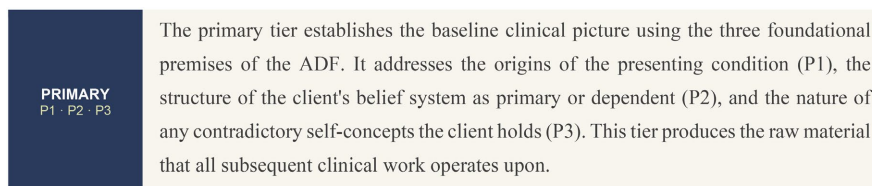


Figure 5. Primary tier clinical summary (P1 - P3): Foundational assessment instruments addressing origin, belief structure, and contradiction type.

The primary tier's most clinically distinctive contribution is P3—the Dialectical Self-Mapping tool. Rather than treating internal contradiction as a symptom of pathology, the ADF following Aristotle treats it as logically expected: the same thing can be being and non-being, provided these are not predicated in the same respect. This reframes the clinical task from eliminating contradiction to determining its logical character. A client who is strong at work and helpless in relationships is exhibiting productive paradox ($\neg$ SR); a client who experiences these as simultaneously true in the same domain is experiencing collapse into pathological contradiction (SR). The distinction carries direct implications for intervention.

3.2. Intermediate Tier—Process Diagnosis (Figure 6)

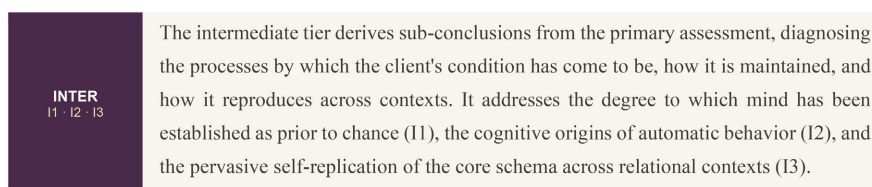


Figure 6. Intermediate tier clinical summary (I1 - I3): Process diagnosis instruments addressing locus of control, cognitive origins, and schema replication.

The intermediate tier instruments follow necessarily from the primary tier findings. If P1 established that the presenting condition has a generating agency, I2 is obligated to trace that agency to its cognitive origin. If P2 established a primary schema, I3 is obligated to map how that schema replicates itself as copies across the client's relational world. If P3 established the character of the client's contradictions, I1 is obligated to assess whether mind or chance is the governing principle—since P3's finding that contradictions are collapsing into the same respect implies that the client's intentional agency (PR) has not been established as prior to circumstance (CH).

This logical obligation is one of the ADF's most significant clinical contributions. It means that the clinician cannot skip the intermediate tier or treat its instruments as optional refinements. They are logically required by the primary tier findings.

3.3. Secondary Tier—Intervention (Figure 7)

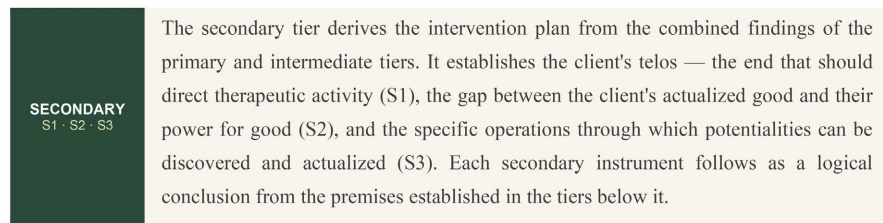


Figure 7. Secondary tier clinical summary (S1 - S3): Intervention instruments addressing telos mapping, actualization value, and constructive knowledge.

The secondary tier's most theoretically significant instrument is S1—Telos Mapping. Following Aristotle's demonstration that the end (E) directs coming-into-being, S1 requires the clinician to establish the client's actualized telos before assigning any intervention. This reverses what is often the implicit logic of therapy—where technique is applied before the end is clearly specified—and replaces it with a teleological structure: the end is established first, and all interventions are directed toward it.

S3—the Constructive Knowledge Protocol—formalizes the epistemological necessity of action. Following Aristotle's demonstration that potentiality is only discoverable through actual operation (S3: $O \rightarrow PD$), the instrument frames behavioral activation not as a motivational technique but as a logical requirement: if the client does not act, their potentiality remains literally unknown. This transforms the therapeutic rationale for action from encouragement to logical necessity, offering clients a philosophical rather than merely motivational reason to engage.

4. The Nine Assessment Instruments

The ADF's nine structured assessment instruments correspond directly to the nine source propositions. Each instrument combines qualitative clinical inquiry with quantitative rating scales, ensuring that the clinician captures both the phenomenological particulars of the client's experience and a standardized measure of the relevant clinical dimension.

Table 1 presents all nine instruments with their codes, names, tier assignments, logical forms, and clinical domains.

Each instrument produces both qualitative clinical data (open-text fields for phenomenological description) and quantitative scores on 1 - 5 Likert scales measuring the relevant clinical dimension—agency identifiability, schema entrenchment, contradiction distress, locus of control, process traceability, schema pervasiveness, actualization gap, gap awareness, and action readiness.

The instrument's automated report aggregates these scores and generates a diagnostic summary that identifies the highest-priority intervention targets by reading across the score profile. For example, a profile showing high schema entrenchment (P2), high schema pervasiveness (I3), and low action readiness (S3) generates a summary that prioritizes schema-level work before behavioral activation—

a logical prescription that follows from the ADF's tier structure rather than from clinical judgment alone.

Table 1. The nine ADF assessment instruments: Code, instrument name, tier, logical form, and clinical domain for each of the nine structured assessment tools derived from the Aristotelian source propositions.

Code	Instrument	Tier	Logical Form	Clinical Domain
P1	Origin Mapping Inventory	Primary	$C \rightarrow (N \vee A \vee S) \cdot C \rightarrow G$	Generation & agency identification
P2	Core & Derived Belief Inventory	Primary	$B(x) \rightarrow (P(x) \vee D(x))$	Schema structure & entrenchment
P3	Dialectical Self-Mapping	Primary	$(B \wedge NB) \wedge \neg SR$	Contradiction type & distress
I1	Locus of Control Assessment	Intermediate	$T \rightarrow M \cdot CH \rightarrow PR$	Mind vs. chance as governing principle
I2	Process Tracing Interview	Intermediate	$(HA \rightarrow FT) \wedge (HS \rightarrow WA)$	Cognitive origin of behavior
I3	Relational Pattern Mapping	Intermediate	$(IP \wedge II) \rightarrow MP \cdot GS \rightarrow PC$	Schema replication across contexts
S1	Telos Mapping	Secondary	$E \rightarrow AC \rightarrow PW$	Actualization gap & telos definition
S2	Actualization Value Audit	Secondary	$V(AG) > V(PG)$	Capacity-actuality gap & awareness
S3	Constructive Knowledge Protocol	Secondary	$(O \rightarrow PD) \wedge (MC \rightarrow KP)$	Behavioral activation & readiness

Illustrative Clinical Vignette: From P1 - P3 to I1 - I3 to S1 - S3

The following composite vignette illustrates how the ADF's three tiers generate linked assessments, diagnoses, and interventions in a single case. All identifying details are fictional. *Maria is a 34-year-old secondary-school teacher referred for persistent low mood, chronic under-performance at work despite acknowledged competence, and an inability to sustain close relationships. She describes herself as "someone who could do more but somehow never does".*

Primary Tier (P1 - P3). Administering P1 (Origin Mapping Inventory), the clinician establishes that Maria's presenting condition has two identifiable generating agencies: a critical parental environment (art/dispositional agency) that modelled conditional worth contingent on performance, and a series of key failures in adolescence (spontaneous events) that consolidated the schema. Agency is traceable: P1 finding = AG clearly identifiable. Administering P2 (Core and Derived Belief Inventory), the clinician identifies the primary belief as "I am fundamentally defective unless I prove otherwise" (rated 4.5/5 for entrenchment) and three dependent beliefs derived from it: "effort signals inadequacy", "intimacy reveals deficiency", and "success would be fraudulent". Administering P3 (Dialectical Self-Mapping), the clinician notes that Maria holds "I am competent" and "I am defec-

tive” simultaneously—but analysis reveals these apply in different domains (classroom vs. relational self), indicating $\neg$ SR (productive paradox) rather than SR (pathological collapse). Contradiction distress score = 3.8/5.

Intermediate Tier (I1 - I3). P1’s finding that agencies are traceable obliges I2 (Process Tracing Interview) to identify the cognitive origins of automatic behaviour: Maria’s habitual under-preparation for observed lessons is traced to the automatic thought “if I try fully and fail, the defect is confirmed”, which is itself generated by the primary belief identified at P2. P3’s finding of $\neg$ SR contradiction (high distress) obliges I1 (Locus of Control Assessment) to assess whether mind or chance governs her experience: I1 yields a score of CH 4.1/PR 1.9, indicating that Maria experiences her situation as predominantly governed by external circumstance and chance rather than intentional agency—despite objective evidence of significant competence. P2’s identification of the primary schema obliges I3 (Relational Pattern Mapping) to map replication: the “defective unless proven otherwise” schema is found to replicate as a copy-pattern across three relational domains—professional relationships with senior colleagues, romantic partnerships, and friendship maintenance—in each case producing the same withdrawal-under-intimacy sequence.

Secondary Tier (S1 - S3). S1 (Telos Mapping) is administered before any behavioral assignment. Maria identifies her telos as “to teach in a way that reflects what I know I can do, and to maintain one close friendship without withdrawing”. The actualization gap score is 3.9/5: her actualized good (AG) is significantly below her potential good (PG) as jointly assessed. S2 (Actualization Value Audit) surfaces Maria’s implicit commitment to the axiom $V(AG) > V(PG)$: she agrees that having actually taught well matters more than merely having the capacity to do so, and that capacity without exercise is a form of loss. This shared axiological commitment becomes the motivational foundation for the subsequent intervention. S3 (Constructive Knowledge Protocol) establishes that Maria’s potentialities are not yet known even to herself—action readiness score = 2.1/5—and frames behavioral activation not as motivational encouragement but as epistemological necessity: she cannot know what she is capable of without acting. The prescribed sequence—primary schema work (P2-derived), then locus-of-control restructuring (I1-derived), then graded behavioral experiments directed toward the identified telos (S1/S3-derived)—follows from the logical structure of the tiers rather than from clinical heuristic alone. This vignette illustrates how each P1 - P3 finding generates a logically obligated I1 - I3 diagnosis, and how the combined tier-one and tier-two findings jointly determine the S1 - S3 intervention sequence.

5. Relationship to Existing Therapeutic Traditions

The ADF does not introduce new therapeutic techniques. Its distinctive contribution is structural and logical: it provides a formal order in which existing techniques must be applied and a logical account of why they work. This section maps the ADF’s instruments onto the therapeutic traditions they most closely engage.

Table 2 provides a systematic mapping of each ADF instrument to its corre-

sponding therapeutic tradition and the logical contribution the ADF makes to that tradition.

Table 2. ADF instruments and corresponding therapeutic traditions: Mapping of ADF instruments onto existing therapeutic modalities, with specification of the logical contribution of each ADF instrument.

ADF Instrument	Primary Therapeutic Tradition	What ADF Adds
P1—Origin Mapping	Biopsychosocial Model	Logical requirement: every condition must have a traceable generating agency
P2—Belief Inventory	Schema Therapy (Young) (Young et al., 2003)	Formal distinction between primary and dependent beliefs; logical ordering of treatment targets
P3—Dialectical Mapping	Dialectical Behavior Therapy (Linehan) (Linehan, 1993)	Logical classification of contradictions: $\neg$ SR (healthy) vs. SR (pathological)
I1—Locus of Control	CBT/Rotter (Rotter, 1966; Beck, 1979)	Formal derivation from P2: mind must be prior to chance ($CH \rightarrow PR$)
I2—Process Tracing	Psychodynamic Formulation (Eells, 2007; McWilliams, 1994)	Logical obligation to trace every automatic behavior to its cognitive origin
I3—Pattern Mapping	Transference Analysis	Formal schema-copy structure: same thing is both pattern and copy across relationships
S1—Telos Mapping	Humanistic/Existential Therapy	Teleological necessity: end must be established before intervention is assigned
S2—Value Audit	Acceptance & Commitment Therapy (Hayes et al., 2012)	Logical rather than motivational rationale: $V(AG) > V(PG)$ as axiomatic commitment
S3—Behavioral Activation	Behavioral Activation/CBT (Martell et al., 2010; Dimidjian et al., 2006)	Epistemological necessity: action is required for knowledge of potentiality ($O \rightarrow PD$)

What distinguishes the ADF from a simple eclectic integration of these traditions is the logical order it imposes. Schema therapy and DBT, for example, are typically applied according to clinical judgment about which is appropriate for a given client. The ADF specifies that P2 (schema) and P3 (dialectical) work must precede I1 - I3 (process diagnosis), which must precede S1 - S3 (intervention). This is not a clinical recommendation but a logical requirement: the intermediate tier's conclusions are derived from the primary tier's premises, and cannot be reached without them.

Similarly, the ADF specifies that S1 (Telos Mapping) must precede S3 (Behavioral Activation). This follows from Aristotle's demonstration that the end (E) directs coming-into-being: assigning operations (S3) without first establishing the telos (S1) produces action without direction—a logical error, not merely a clinical suboptimality.

6. Potential for Development as a Larger Framework

The ADF as presented here constitutes a proof of concept—a demonstration that philosophical logic can generate a clinically viable assessment structure. Its potential for development as a larger framework of practice is considerable, and operates along several dimensions.

6.1. Extension across Aristotelian Categories

The nine source propositions used in the ADF represent a selective but not exhaustive engagement with Aristotle's metaphysical framework. The four causes—material, formal, efficient, and final—provide a richer taxonomy of generating agencies than P1's tripartite nature/art/spontaneity distinction. A fully developed Aristotelian clinical framework would incorporate all four causes as diagnostic categories, allowing the clinician to identify not only how a condition came to be (efficient cause) but what it is made of (material cause), what pattern it instantiates (formal cause), and what end it is directed toward (final cause).

Aristotle's categories of substance, quality, quantity, relation, place, time, position, state, action, and passion offer an additional dimension: a systematic taxonomy of the kinds of claims a client can make about themselves, and therefore a formal classification of the kinds of distortions, deficits, and pathologies that can arise. A developed ADF would map psychopathological presentations onto this categorical structure, producing a diagnostic nosology grounded in ontological rather than symptom-based classification.

6.2. Integration with Developmental Psychology

Aristotle's account of actuality and potentiality has direct implications for developmental psychology. The ADF's secondary tier instruments implicitly address development—Telos Mapping asks where the client is going, Behavioral Activation asks what they need to do to get there—but the framework does not yet incorporate a systematic account of how potentialities unfold across the lifespan.

A developed ADF would integrate Aristotle's concept of natural development (the acorn becoming an oak according to its form) with empirical developmental psychology, producing a normative account of actualization across life stages. This would allow the clinician to assess not only whether a client is actualizing their potentialities, but whether they are doing so in accordance with developmentally appropriate sequence—identifying, for instance, whether a failure of actualization in adulthood is traceable to an interrupted developmental process in an earlier stage.

6.3. A Logic-Driven Diagnostic Nosology

Perhaps the most significant potential development of the ADF is as a meta-theoretical alternative to symptom-based diagnostic systems such as the DSM and ICD. These systems classify psychopathology by symptom cluster, without theoretical account of the mechanisms by which symptoms arise or the ontological

status of the conditions they describe. The ADF offers the foundation for a radically different approach: a diagnostic nosology grounded in logical analysis of what it means for a psychological state to have being, to have come to be in a particular way, and to stand in a particular relation to the client's potentialities and telos.

Within such a nosology, depression might be understood not primarily as a symptom cluster (low mood, anhedonia, fatigue) but as a particular configuration of the ADF's logical variables: a condition in which the gap between AG and PG (S2) is wide and the locus of control (I1) is external, such that the client's potentialities remain undiscovered because the logical prerequisites for their discovery—operation and construction (S3)—are absent. This account is not in conflict with symptom-based description but provides a deeper theoretical layer beneath it, explaining why the symptoms arise and what must logically change for them to resolve.

6.4. Group and Systemic Applications

The ADF's current formulation addresses the individual client. Its logical structure, however, is in principle applicable to any entity that can be said to have being, to have come to be through generating agencies, and to stand in a relationship between actuality and potentiality. This includes groups, families, organizations, and communities.

A systemic ADF would ask: What are the generating agencies (P1) of this group's presenting pattern? What beliefs are primary versus derived in the group's shared meaning-making system (P2)? What contradictions does the group hold, and are they operating in different respects (P3) or have they collapsed into the same respect? What is the group's collective telos (S1), and what operations must the group perform to discover its collective potentialities (S3)?

Applied to organizational psychology, this framework would constitute a logic-driven approach to institutional assessment and development. Applied to family therapy, it would provide a formal account of how family schemas (I3) replicate themselves across generations as pattern-copy structures—and what telos-directed intervention would be required to interrupt that replication.

6.5. Empirical Validation

The ADF's development as a larger framework requires empirical validation. Several testable hypotheses follow directly from the framework's logical structure. First, the ADF predicts that interventions addressing dependent beliefs (P2) without first identifying and addressing the primary schema will produce unstable gains—because the dependent belief will reconstitute itself from the primary schema that was left unaddressed. Second, the ADF predicts that behavioral activation (S3) without prior telos mapping (S1) will produce action without sustained motivation—because the operations are not directed toward an established end. Third, the ADF predicts that classifying contradictions as $\neg$ SR versus SR (P3)

will improve therapeutic outcomes compared to treating all contradictions as pathological—because the former distinguishes healthy complexity from genuine dissonance.

These predictions are specific enough to be tested in randomized controlled trials. The ADF's digital assessment instrument—which records responses across all nine instruments and generates structured reports—provides the infrastructure for systematic data collection. Aggregated across clients, this data would allow empirical assessment of the framework's predictive validity and the logical ordering of its intervention sequence.

6.6. Training and Supervision

The ADF offers a distinctive contribution to clinical training and supervision. Because its clinical decisions are logically ordered rather than heuristically guided, the framework provides a formal check on clinical reasoning: the supervisor can ask not merely whether a particular intervention seems clinically appropriate, but whether it is logically warranted given the findings of the tier below. This transforms supervision from an art of clinical judgment into a practice that can be partially formalized—without eliminating the clinical judgment that remains irreducibly necessary at each stage.

Training in the ADF would develop in clinicians a capacity for what might be called logical clinical reasoning: the ability to trace the logical implications of a clinical finding across tiers, to identify when an intermediate-tier conclusion does not follow from the primary-tier premises, and to recognize when a secondary-tier intervention is being assigned without the logical prerequisites established at the tiers below. This capacity is not currently a standard element of clinical training, which tends to focus on technique, formulation, and relational skill rather than formal reasoning.

6.7. Limitations: Formal Derivation, Therapeutic Axiom, and Interpretive Commitment

The ADF's claims occupy three epistemologically distinct registers, and intellectual honesty requires that these be clearly separated. Conflating them risks overstating the framework's logical authority or, conversely, dismissing its genuine formal achievements.

What the framework treats as formal derivation. S1 (the priority of actuality: $E \rightarrow AC \rightarrow PW$) and S3 (the epistemological necessity of action: $O \rightarrow PD$; $MC \rightarrow KP$) are formally valid conclusions of the argument assessed by conditional proof, given the stated premises P1 - P3 and the two hidden premises HP1 - HP2. The logical ordering of the tiers—primary before intermediate before secondary—is also formally grounded insofar as the intermediate tier's conclusions are derived from the primary tier's premises and cannot be reached independently. These claims carry genuine logical authority within the framework's axiomatic system, though they remain subject to the bridging assumptions BA1 - BA3 described

above.

What the framework treats as therapeutic axiom. S2—the claim that $V(AG) > V(PG)$, that the actuality of good is more valuable than the power for good—is explicitly acknowledged in Section 2.3 as enthymematic. Its conclusion requires the hidden premise HP2 (if X is prior to Y in being, then X is more valuable than Y), which Aristotle asserts but does not derive. In clinical application, S2 therefore functions not as a derived conclusion but as an axiological commitment shared by clinician and client as a precondition of productive intervention. This is not a weakness of the framework but a site of transparency: the ADF makes explicit a value assumption that is implicit in many therapeutic approaches—including Acceptance and Commitment Therapy’s commitment to valued action over mere cognitive capacity (Hayes et al., 2012)—without deriving it from premises. The clinical consequence is that S2 cannot be applied to clients who do not share, or cannot be brought to share, the axiological commitment $V(AG) > V(PG)$; for such clients, the secondary tier intervention must be restructured accordingly.

What remains interpretive. Several of the framework’s most significant clinical operations involve interpretive judgments that resist full formalization. The identification of a client’s telos (S1) requires the clinician to distinguish between a client’s stated desires, their reflectively endorsed values, and the actualization-endpoint that the framework’s logic designates as telos—a distinction that cannot be resolved by the instruments alone and requires clinical judgment informed by the relational knowledge built over the course of therapy (see Bordin, 1979, on the working alliance). The classification of contradictions as $\neg SR$ versus SR (P3) similarly requires interpretive judgment about what constitutes “the same respect”, a question that Aristotle’s own text leaves substantially open (see Metaphysics IV.3–4; see Priest, 2006, for contemporary discussion of dialetheism). The mapping of generating agencies at P1 involves historical reconstruction that is irreducibly interpretive and subject to revision. Future empirical work—including inter-rater reliability studies on P3 classification and on telos identification at S1—will be essential to determine how far these interpretive elements can be standardised without loss of clinical validity. The framework’s claim to logical rigour depends on continued transparency about where formal necessity ends and interpretive judgment begins.

7. Conclusion

The Actualization Diagnostic Framework represents a novel approach to the integration of philosophy and psychological practice. By grounding clinical assessment and intervention in the propositional logic of Aristotle’s *Metaphysics* and *Physics*, the ADF produces a system in which clinical decisions are not merely heuristically guided but logically ordered—each tier following from the one before it as sub-conclusions follow from premises in a valid argument.

The framework makes several distinctive contributions. It provides a logical account of why contradictions need not be pathological (P3), why schema-level work

must precede process-level diagnosis ($P2 \rightarrow I2, I3$), why telos must be established before operations are assigned ($S1 \rightarrow S3$), and why action is epistemologically necessary for the discovery of potentiality ($S3$). These are not new therapeutic insights, but they are new logical derivations—and their derivation from formal premises transforms them from clinical wisdom into logical requirements.

The ADF's potential for development is substantial. Extension across the full range of Aristotelian categories, integration with developmental psychology, application to groups and systems, development of a logic-driven diagnostic nosology, empirical validation of its predictive hypotheses, and incorporation into clinical training—each of these represents a significant research and development programme. The present paper has provided only the foundation: a proof of concept demonstrating that philosophical logic can generate a clinically coherent and practically usable assessment framework.

Aristotle's central thesis—that actuality is prior to potentiality in being, in value, and in knowledge—is not merely a metaphysical claim. It is a clinical prescription: begin with what the client already is, establish where they are going, and assign the operations that will reveal what they are capable of becoming. The ADF translates this prescription into a structured instrument. The larger project—of building a psychology adequate to the ontological depth of human being—remains open.

“Actuality is the end, and it is thanks to it that a power is possessed; for animals do not see in order that they may have the power of sight, but they have the power of sight in order that they may see.”—Aristotle, Metaphysics

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

References

- Aristotle (1966). *Metaphysics* (R. Hope, Trans.). University of Michigan Press.
- Aristotle (1969). *Physics* (H. G. Apostle, Trans.). Indiana University Press.
- Beck, A. T. (1979). *Cognitive Therapy of Depression*. Guilford Press.
- Bordin, E. S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research & Practice*, 16, 252-260.
<https://doi.org/10.1037/h0085885>
- Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E. et al. (2006). Randomized Trial of Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Acute Treatment of Adults with Major Depression. *Journal of Consulting and Clinical Psychology*, 74, 658-670.
<https://doi.org/10.1037/0022-006x.74.4.658>
- Eells, T. D. (Ed.) (2007). *Handbook of Psychotherapy Case Formulation* (2nd ed.). Guilford Press.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change* (2nd ed.). Guilford Press.
- Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*.

- der. Guilford Press.
- Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral Activation for Depression: A Clinician's Guide*. Guilford Press.
- McWilliams, N. (1994). *Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process*. Guilford Press.
- National Institute for Health and Care Excellence (2022). *Self-Harm: Assessment, Management and Preventing Recurrence (NICE Guideline No. 225)*.
<https://www.nice.org.uk/guidance/ng225>
- Priest, G. (2006). *In Contradiction: A Study of the Transconsistent* (2nd ed.). Oxford University Press.
- Ross, W. D. (1924). *Aristotle's Metaphysics: A Revised Text with Introduction and Commentary* (2 Vols.). Clarendon Press.
- Rotter, J. B. (1966). Generalized Expectancies for Internal versus External Control of Reinforcement. *Psychological Monographs: General and Applied*, 80, 1-28.
<https://doi.org/10.1037/h0092976>
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. Guilford Press.