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Article

The Contemporary Cognitive Model, an Integrative and Dimensional Approach

Javier Prado-Abril[1], Rosa Domínguez-Grimbergen[1], Félix Inchausti[2], Sergio Sánchez-Reales[3] & Jesús López-Gómez[4]

[1] Hospital Universitario Miguel Servet, Zaragoza, Spain
[2] Hospital Universitario San Pedro, Logroño, Spain
[3] Hospital Universitario de Jerez de la Frontera, Spain
[4] Badalona Serveis Assistencials (BSA), Spain

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ABSTRACT

The cognitive model has evolved from its origins into an open, integrative paradigm that is sensitive to the complexity of human suffering. This paper aims to systematize part of this evolution and to propose a multidimensional formulation of psychopathology that is useful for clinical practice. Classical and contemporary contributions to the cognitive model are synthesized, incorporating elements from the constructivist, narrative, experiential, and relational traditions. A clinical case is presented to illustrate the applicability of the model. The case of Hugo shows how an integrative and dimensional conceptualization provides a useful framework for understanding and addressing human suffering. Finally, we discuss how the flexibility and openness of the cognitive model foster dialogue across approaches, while also presenting challenges for systematization and empirical validation.

El Modelo Cognitivo Contemporáneo, una Aproximación Integradora y Dimensional

Palabras clave
Modelo cognitivo
Psicoterapia
Formulación dimensional
Integración
Self

RESUMEN

El modelo cognitivo ha evolucionado desde su origen hacia un paradigma abierto, integrador y sensible con la complejidad del sufrimiento humano. Este trabajo tiene como objetivo sistematizar parte de dicha evolución y proponer una formulación multidimensional de la psicopatología útil para la práctica clínica. Se sintetizan aportaciones clásicas y contemporáneas del modelo cognitivo que incluyen elementos de las tradiciones constructivistas, narrativas, experienciales y relacionales. Asimismo, se presenta un caso clínico para ilustrar la aplicabilidad del modelo. El caso de Hugo muestra cómo una conceptualización integradora y dimensional ofrece un marco útil para comprender y tratar el sufrimiento humano. Por último, se discute cómo la flexibilidad y la apertura del modelo cognitivo favorece el diálogo entre modelos, aunque también presenta desafíos de sistematización y validación empírica.

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Correspondence: Javier Prado-Abril jprado@salud.aragon.es

Introduction

Since its origins as an alternative to behaviorism in the 1950s and 1960s, the cognitive model has established itself as one of the major paradigms in the contemporary history of psychology. The *cognitive revolution* marked a decisive shift in the scientific study of human behavior by placing mental processes—such as perception, memory, language, and reasoning—at the very center of topics worthy of interest and empirical research (Gardner, 1985; Miller, 2003). In addition to representing a powerful transformation in the intellectual landscape of the time and in academic circles, it quickly exerted its influence in the clinical sphere, which had been characterized by the dominance of psychoanalysis. This dominance was beginning to decline with the emergence of other ways of understanding human suffering together with advances in psychopharmacology (Alford & Beck, 1998; Mahoney, 1991; Paris, 2017).

Among the pioneers of the cognitive model are authors such as George Kelly, Albert Ellis, and Aaron Beck, who, in the early part of the second half of the 20th century, laid the foundations of the paradigm in the fields of psychopathology and psychotherapy (Alford & Beck, 1998; Beck, 2011). From this perspective, mental disorders are thought to originate in the cognitive processes that people employ in processing and analyzing life experiences. Subsequently, the essence of the model's evolution was characterized by the breadth, richness, and diversity of its theoretical and technical proposals (Fernández-Álvarez & Fernández-Álvarez, 2017; Norcross et al., 2019). Currently, it is understood that human suffering arises from the way people perceive, interpret, and assign meaning to their personal experiences by constructing more or less functional life narratives that allow them to maintain autobiographical coherence, a sense of self, or the integrity of the self (Dimaggio et al., 2015; Fernández-Álvarez & Fernández-Álvarez, 2017; Gonçalves & Machado, 1999; Greenberg & Safran, 1987; Guidano, 1987, 1991; Inchausti, 2025; Liotti, 2004, 2017; Mahoney, 1991; Prado-Abril et al., 2013; Safran & Segal, 1990).

The epistemological evolution of the cognitive model has been a progressive process punctuated by theoretical tensions. Various reformulations have enriched, deepened, and added complexity to the original notions regarding human cognitive functioning. This process has crystallized into a broad, relatively coherent explanatory theoretical framework with a high degree of systematicity, the result of the capacity for synthesis and the drive toward integration characteristic of recent decades (see Table 1).

Some authors argue that the cognitive model and its cognitive-behavioral variant represent the most appropriate theoretical framework for attempting to achieve that seemingly elusive goal of integrating the theory and practice of psychotherapy (Alford & Beck, 1998; Castonguay et al., 2019; Fernández-Álvarez & Fernández-Álvarez, 2017; Norcross et al., 2019). However, a comprehensive theoretical integration must still address a range of aspects with less heterogeneity than currently defines the state of the field. Any paradigm worthy of the name must be capable of articulating and sequencing a unified theoretical framework that allows for the integration of normal and abnormal experience with the cognitive, affective, motivational, interpersonal, developmental, and behavioral processes involved in the context in which identity is constructed. For an overview, see Figure 1.

Table 1
Historical Phases in the Evolution of the Cognitive Model Toward Complexity and the Progressive Shift Toward Integration

Years	Phase	Key Elements
50-70	Founding rupture.	The emergence of cognitive therapy as an alternative to behaviorism and psychoanalysis. Emphasis on automatic thoughts, perceptual distortions, and cognitive structures.
80s-90s	Epistemological tension.	Debate between rationalist and constructivist epistemology. Emergence of models centered on the self as the organizing axis of personal meanings.
1990s-2000s	Integrative approach.	Emergence of the first decidedly integrative cognitive models (e.g., schema therapy). Need to address more complex clinical issues by synthesizing contributions from different approaches.
2000 →	Maturity, theoretical and technical plurality.	Explicit recognition of integration as a current process. Diversification of models under the conceptual umbrella of the cognitive model.

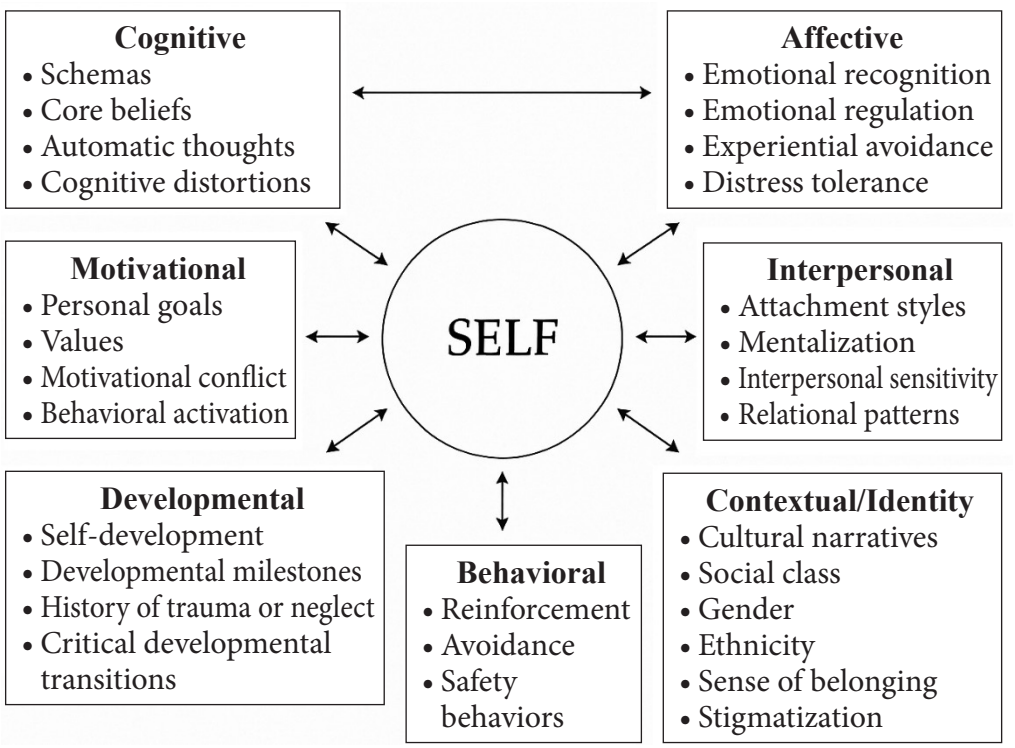
Note. Adapted from Fernández-Álvarez & Fernández-Álvarez (2017).

The aforementioned elements of psychopathological analysis should guide the assessment, formulation, and psychological treatment of mental disorders in such a way that they are amenable to explicit operationalization and systematic empirical evaluation. Valuable efforts have been made in this direction, but the project is far from being the norm in the current landscape of cognitive psychotherapies. However, this is not a flaw exclusive to the cognitive ecosystem; rather, it defines the field of contemporary psychotherapies as a whole, which is characterized by the specificity of a myriad of models offering partial answers to different types of clinical problems (Paris, 2013; Norcross & Goldfried, 2019; Wampold, 2019; Wampold & Imel, 2015; Zilcha-Mano, 2025).

Although the cognitive model acknowledges that integration is a very real phenomenon, its inherent diversity still prevents us from speaking of a single framework or sufficient consensus that would allow us to conceptualize, formulate, and integrate people's suffering and distressing experiences (i.e., psychopathology) with the best means of healing, restoring, articulating, or overcoming them (i.e., the treatment modality). At best, we must speak of a family of theoretical-technical approaches that all share the same worldview, while placing greater emphasis on some of the dimensions presented in Figure 1 over others. Likewise, the integrative aspiration must bridge another gap in order to have substantial scope. This gap consists of the disconnect between the information and knowledge derived from basic research and that stemming from the realm of direct, intuitive experience more characteristic of clinical settings (Fernández-Álvarez et al., 2020). Perhaps the development of practice-oriented research networks may serve this objective in the future (Areas et al., 2022; Barkham, 2014).

This work strives for the utmost intellectual honesty. However, it is not free from bias and necessarily occupies a specific position within the evolution of the cognitive model and the current state of the schools of thought that shape it. In this case, we have chosen to follow the trajectory that has led the cognitive model toward complexity and the broad integration of elements from different sources of knowledge. An alternative could have been to take the

Figure 1
Proposed Integrative Cognitive Model for Understanding Psychopathology as an Emergent Phenomenon



more orthodox and institutional path that led to the current hegemony of the biomedical model and cognitive-behavioral therapy (CBT; Beck, 2011; David et al., 2018). The reasons stem primarily from the authors' interest in complex models. These approaches typically offer a wider range of solutions in the clinical setting, although, in return, they require tolerating higher levels of uncertainty associated with the heuristic nature of the formulation itself and its psychotherapeutic application (Prado-Abril et al., 2017, 2019; Sperry & Sperry, 2020).

From this perspective, the cognitive model has, since its inception, delved deeper into progressive levels of introspection in tandem with constructivist epistemology. For example, Mahoney (1991) shifted the focus from cognitive content to experiential and self-regulated processes that form dynamic patterns of interaction centered on personal meaning. For his part, Guidano (1987, 1991) defined the self as a narrative organization, in constant change and construction, where dysfunction stems from the inability to achieve integration into a coherent narrative. Liotti (2004, 2017) enriches this aspect by articulating in greater detail the relationship between attachment history and dissociative mechanisms to understand the processes of self-disintegration. Safran and Segal (1990) and Greenberg and Safran (1987) play an essential role in incorporating emotional and interpersonal aspects into the framework of the configuration of cognitions, personal belief systems, and processes of human change. Thus, citing only a few of the most prominent authors, the model's evolution toward narrative, experiential, and relational complexity found a systematized expression for clinical work in Young et al.'s (2003) schema therapy. This form of structured treatment can be conceptualized as an operational integration of many of the aforementioned elements. On the one hand, it maintains the structure and empirical approach of early traditional CBT. At the same time, it incorporates elements of constructivism and attachment theory, emphasizing the importance of emotional and interpersonal aspects when formulating maladaptive early schemas as narrative-affective nuclei that organize the experience of the self. Consequently, identity would be the primary vector upon which to organize assessment, formulation, and psychological treatment. Not so much to disconfirm the underlying schemas (Alford & Beck, 1998; Beck, 2011), but rather to understand the nature of people's dysfunctional experiences with the aim of making them more flexible, enriching them, and adding nuance, thereby promoting a more complex and multifaceted view of the self (Dimaggio et al., 2015; Prado-Abril et al., 2013; Safran & Segal, 1990; Young et al., 2003).

Finally, it should be noted that the process of expansion and internal enrichment that the cognitive paradigm has undergone in the clinical setting has taken place in dialogue with the transformations within cognitive science itself. As Osbeck (2009) points out, the traditional computational paradigm of the mind, as an abstract symbolic processing system, has gradually given way to more integrative perspectives such as embodied cognition, situated cognition, and the extended mind. These new approaches challenge the strict separation established by the classical model between mind, body, and environment, situating the process of human knowledge as a phenomenon deeply shaped by affective, relational, and contextual aspects. Therefore, cognition cannot be understood as a mere manipulation of internal representations, just as human suffering cannot be reduced to logical errors, misinterpretations, or isolated distortions, nor psychotherapy to a sort of technology for correcting dysfunctional thoughts. Rather,

these are emergent phenomena that involve the organism as a whole and require theoretical frameworks and clinical interventions capable of addressing complexity without fragmenting it under the illusion of sequential thinking. Consequently, the cognitive model presents itself as an open, integrative, and pluralistic paradigm that aspires to understand and explain human nature, as well as that condition inherent to living which is suffering, and how to cope with it in order to build lives worth living.

Some Basic Aspects of Psychopathology

As noted, the cognitive model has gone through different stages that have influenced the understanding and formulation of mental disorders. Initially, mental disorders were understood to be the product of cognitive distortions and negative automatic thoughts stemming from dysfunctional schemas developed in early life (Alford & Beck, 1998; Beck, 2011; David et al., 2018). Subsequently, it has been observed that a perspective based on the person as an active agent who gives meaning to their life experiences by articulating contextual narratives is an approach that broadens and enriches this position (Gonçalves & Machado, 1999; Guidano, 1987, 1991; Mahoney, 1991; Young et al., 2003).

From the constructivist metatheory that informs the cognitive model, mental disorders cannot be conceived of as fixed, natural entities—much less as diseases, as is often implied by the biomedical model (Deacon, 2013). Symptoms and syndromes are understood as a complex, emergent phenomenon, rooted in the person's life history and with a decisive contextual component. They are experienced by a person who is an active agent in the construction of realities endowed with personal meaning. This subjective experience arises from a complex interaction with the relational and socio-cultural influences that frame the development of the self as a psychological entity subject to a discursive logic (Guidano, 1987, 1991; Mahoney, 1991; Safran & Segal, 1990). This approach aligns well with the tenets of the biopsychosocial model and invites us to consider that mental disorders are related to the history of personal meanings and the cultural norms of the era that define the channels through which suffering is expressed. Our era represents a paradigmatic example, where the thresholds required to receive a psychopathological diagnosis have been lowered; there is a notable subjective perception among people that they are ill, likely as a consequence of social phenomena such as disease mongering, resulting in prevalence rates of mental health problems that appear to represent an unprecedented international alarm (Moynihan et al., 2008; Whitaker, 2015). Such phenomena call into question official psychopathology as a natural science capable of objectively defining the onset of experiences or behaviors that might be considered abnormal. In fact, they define psychopathology as a profoundly malleable discipline, imprecise and open to interpretation, characterized by a high degree of subjectivity and determined by the normative frameworks and not always explicit needs imposed by the social reality of the time (Berrios, 1996).

In what follows, we present a multidimensional proposal regarding how people may express their suffering, with a clear focus on understanding and explaining it. The aim is for this to serve as a useful guide for conceptualizing and formulating problems, thereby enabling the development of psychotherapeutic treatment systems tailored to the specific needs each individual may require to thrive in life. Table 2 expands on the content of the proposal outlined in Figure 1 and shows the blocks that may be involved in the emergence of psychopathology as a subjective phenomenon. It highlights the dimensions involved, their main components, and some clinical examples intended to illustrate the symptomatic expression that can be observed in clinical practice.

Psychological suffering and its psychopathological manifestation are understood as an emergent subjective experience that will vary in its form of presentation, intensity, persistence, and extent depending on the dimensions and components involved and the

Table 2
Dimensions and Main Components of an Integrative Cognitive Psychopathology

Dimension	Components	Definition	Clinical example
Cognitive	Schemas, core beliefs, automatic thoughts, cognitive distortions.	Mental structures that organize experience and guide the interpretation of reality.	A person with core beliefs of worthlessness interprets their mistakes as proof of their structural personal incompetence.
Affective	Emotional recognition, emotional regulation, experiential avoidance, distress tolerance.	Emotional processes that influence the perception, evaluation, and response to internal and external events.	A person with generalized anxiety avoids confronting their emotions, increasing their emotional distress in the long term.
Motivational	Personal goals, values, motivational conflict, behavioral activation.	Systems that direct behavior toward meaningful goals, influencing decision-making and therapeutic change.	A person with sexual obsessions comes into conflict with their personal goal of starting a family, generating ambivalence, guilt, and behavioral blockage.
Interpersonal	Attachment styles, mentalization, interpersonal sensitivity, relational patterns.	Patterns internalized in childhood that influence how one relates to others.	A patient with disorganized attachment may alternate between a strong need for emotional contact and behaviors of rejection or distrust toward their therapist.
Developmental	Self-development, developmental milestones, history of trauma, critical developmental transitions.	Personal trajectory throughout the life cycle, including significant early experiences.	An adult who experienced childhood neglect may have persistent difficulties in building a stable, integrated identity.
Behavioral	Reinforcement, avoidance, safety behaviors, coping skills.	Behavioral patterns maintained by their consequences.	A person with a phobia systematically avoids feared situations, reinforcing their fear in the long term.
Contextual	Cultural narratives, social class, gender, ethnicity, sense of belonging, stigmatization.	Sociocultural factors that influence identity formation and the expression of psychological distress.	A migrant woman interprets her emotional distress as weakness, influenced by an environment that minimizes and does not validate her subjective experience.

interrelationship among them. In other words, psychopathology is conceived as a multidimensional, multifactorial, and multicausal phenomenon that follows a logic that is not always easy to fully conceptualize in clinical practice. Being aware of this distinctive quality of the nature of human suffering, taking into account all the dimensions involved in a person within a given sociocultural context, is key to establishing a psychotherapy plan that is more individualized and sensitive to people's idiosyncratic life trajectories. Ultimately, these trajectories lie at the very heart of the formation of their identities and the stories they tell (Guidano, 1987, 1991). As we will see below, a model of these characteristics facilitates comprehensive and complex formulations that are highly useful for idiographic clinical work.

Implications for Clinical Practice

To ground the conceptual framework we have developed and, from there, guide the construction of the psychotherapeutic process, we will begin with a clinical case based on the authors' professional experience with individuals suffering from severe mental disorders. Hugo is a 32-year-old man who has been officially diagnosed with borderline personality disorder and is currently undergoing outpatient psychological treatment at his local mental health center. During the initial assessment interview, he reports that his work performance remains stable and that his consultation stems from an emotional crisis resulting from a breakup with his partner, which he describes as conflict-ridden. Since the breakup, he reports episodes of social isolation, intense distress, and constant unproductive rumination. His narrative is characterized by self-demand, an intense need for emotional control, fear and suspicion in the face of criticism, as well as a focus on grievance and the externalization of responsibility. On an interpersonal level, it is evident that he alternates between an intense search for support, empathetic containment, and emotional validation, and behaviors of avoidance and rejection, generating a countertransference in the clinician of discomfort and heightened alertness as he feels evaluated and emotionally pressured. Likewise, among other autobiographical episodes of interest, he reports that during his childhood and adolescence, his relationship with his parents was contentious, describing them as neglectful and authoritarian.

Cognitive Dimension

From the outset of the psychotherapeutic process, the possibility is assessed that Hugo may exhibit maladaptive schemas related to abandonment, instability, emotional deprivation, grandiosity, and punishment. According to Young et al. (2003), schemas cover broad areas of thematic content that are significant to individuals. Their themes represent persistent elements regarding one's view of oneself and one's relationships with others. It is suggested that they originate in childhood but develop, modulate, and consolidate throughout subsequent life development. With habit, they become comfortable and automatic ways of maintaining coherence in personal meanings. For this reason, they are often found at the core of people's most particular subjective perceptions. By way of summary, Table 3 presents the five domains of experience that encompass the eighteen proposed schemas (Bernstein & Clercx, 2018; Young, 2006; Young et al., 2003).

Adapted to the Spanish language and cultural context by Calvete et al. (2013), Young's Schema Questionnaire (2006) is a useful tool for systematizing psychological assessment in this area. However, schemas can also be identified by paying close attention to the content of speech during therapeutic conversations, especially when these take on an emotionally charged tone (Greenberg, 2016; Greenberg & Safran, 1987; Safran & Segal, 1990; Young et al., 2003). For example, schemas of abandonment and instability are evident in expressions such as *"I'm a person of brief but intense love stories, followed by long periods of grief, with relapses, until everything ends tragically or they disappear without a word"*; the schema of emotional deprivation in *"I give myself completely, but I feel I never get everything I deserve"*; the grandiosity schema in *"maybe it's because I'm a conformist and I always choose men who aren't my equal and they get scared"*; and, finally, the punishment schema in *"he deserves everything bad that happens to him for not meeting my standards; he wasn't worthy of my commitment*." These brief excerpts from the sessions of the psychotherapeutic process outline how these schemas operate in everyday life, filtering Hugo's subjective, emotional, and relational experience. For its part, repeated and unproductive rumination serves as a coping strategy that, while reinforcing his sense of control and the coherence of the self in the short term, in the long term it perpetuates his way of seeing the world, preventing the inclusion of alternative perspectives that would enable increased self-awareness, the enrichment of his subjective experience, a change in his life narrative, and the development of more flexible behavioral and interpersonal patterns.

Affective Dimension

During the first sessions, Hugo displays very high emotional reactivity, episodes of disconnection, and emotional numbing: "*Sometimes, I don't even know what I'm feeling; it's as if I'm shutting down inside*." He speaks openly about dissociation: "*I'm dissociated; I want to believe we'll fix this, and I want him to suffer for what he's done to me*." This discourse, coupled with the high emotional intensity that accompanies it in psychotherapy sessions, forms part of a narrative that is unable to integrate contradictory positions, where episodes of disconnection—by blocking the continuity of the necessary affective processing of subjective experience—maintain the cycle of distress and psychological suffering (Guidano, 1987, 1991; Liotti, 2004, 2017).

Motivational Dimension

As the psychotherapeutic process progressed and a certain degree of symptomatic stabilization was achieved, Hugo began to express his desire to one day start a family in the traditional sense. This life goal, when explored in detail, seemed to clearly reflect a deep desire to achieve personal stability and identity coherence. However, his fear of abandonment and his need for constant validation revealed a relational history in which his habitual patterns—excessive dependence and controlling behaviors toward others—had blocked the possibility of creating a climate of authentic intimacy and the development of relational mechanisms that would facilitate the achievement of this life goal. The

Table 3
Domains and Schemas Proposed by Young et al. (2003)

Domains	Schemas	Description
Disconnection and rejection: Difficulty forming and maintaining satisfying and stable interpersonal relationships.	1. Abandonment and instability.	Perception of others in interpersonal relationships as unpredictable, anticipating the end of the relationship.
	2. Mistrust and abuse.	A tendency to anticipate mistreatment, humiliation, deception, or manipulation by others.
	3. Emotional deprivation.	Expectation that one's emotional needs (care, empathy, or protection) will not be met by the other person.
	4. Defectiveness and shame.	A sense of being imperfect, inferior, or unworthy of affection.
	5. Social isolation and alienation.	Perception of oneself as different, with difficulty developing a sense of belonging.
Impaired autonomy and functioning: Expectations of limited ability to distinguish oneself, survive independently, or function satisfactorily.	6. Dependence and incompetence.	Viewing oneself as incapable of handling daily responsibilities without help from others.
	7. Vulnerability to harm or illness.	Exaggerated fear of medical, emotional, or external catastrophes.
	8. Enmeshment, undeveloped self.	Excessive involvement and emotional closeness with significant others. Lack of a sense of self.
	9. Failure.	Belief that one has failed or expectation of future failure.
Deficient boundaries: Deficit in self-control, responsibility, or long-term orientation.	10. Grandiosity and entitlement.	Perception of oneself as entitled to special privileges over others, not bound by the norms of reciprocity.
	11. Insufficient self-control and discipline.	Tendency toward impulsivity, intolerance of frustration, avoidance of discomfort and responsibilities, affecting goal achievement.
Driven by the needs of others: Excessive focus on the desires and needs of others, to the detriment of oneself.	12. Subjugation.	Suppression of one's own desires, preferences, or emotions when perceiving coercion or external control.
	13. Self-sacrifice.	Sacrificing one's own gratification with the intention of satisfying the needs of others or preventing potential harm.
	14. Approval-seeking/recognition-seeking.	Excessive emphasis on seeking approval, recognition, or attention from others.
Hypervigilance and inhibition: A tendency to suppress one's own emotions or impulses, leading to a lack of spontaneity and satisfaction.	15. Negativity and pessimism.	A tendency to focus attention generally on the negative aspects of an experience, downplaying the positive ones.
	16. Emotional inhibition.	Excessive suppression of emotional expression to avoid embarrassment, disapproval, or loss of control.
	17. Unrelenting standards and hypercriticalness.	A tendency toward rigid, perfectionist effort to meet certain behavioral standards, generally to avoid criticism.
	18. Punitiveness.	Belief that mistakes must be severely punished.

contradiction between his discourse and his behavior is evident throughout his autobiographical account. The consequences are the emergence of symptoms such as existential disorientation, reactive depression following romantic breakups, or frustration at the perceived happiness of others whom he does not consider more deserving of good fortune in life than he is.

Interpersonal Dimension

Hugo describes superficial and unstable friendships based on cycles of idealization and disappointment, as well as ambivalent relationships with his younger sister and parents, whom he describes as very close to one another, with him occupying a sort of peripheral position within that family unit. In therapy, he is occasionally cooperative and even submissive, but when faced with core questions about his behavior—even subtle ones—he becomes distrustful, defiant, and dismissive of the psychotherapeutic process. These fluctuations are common in this patient profile and are often linked to complex upbringings and attachment styles on the disorganized spectrum (Crittenden, 2016). The fact that the sessions generate fatigue in the clinician and, at times, a sense of heightened alertness also supports this point. People who demand high emotional intensity from others, while simultaneously exhibiting moments of coldness or rejection, often reflect relational patterns internalized in childhood.

Developmental Dimension

The autobiographical milestones that emerge in therapeutic conversations throughout the course of treatment trace a developmental trajectory marked by parental neglect and experiences of emotional detachment: "*It was common, when I was still very young, for me to be left at home alone without knowing where my parents were*." Moreover, the reactions of his attachment figures were authoritarian: "*My father always scolded me when I cried, and my mother looked the other way*." During his adolescence, he frequented social groups he describes as transgressors of social boundaries, through which he began using alcohol, drugs, and engaging in sexual activity. His account of the past always maintains a certain distance from the current self-image he wishes to convey, in which he presents himself as a socially integrated person with a high-performing career who has successfully moved forward despite having come from a difficult background, as a "*survivor of the neighborhood and its dynamics*." However, his discourse also notes, with a hint of nostalgia, that "*cohesion and loyalty*" were core elements of "*the old days*." The discomfort and shame generated by his past self (which he seems to want to renounce, yet at the same time recalls with affection) and his current self (which remains unstable), underpin some of the different instances of identity that have not yet found a balanced coexistence on the level of subjective experience.

Behavioral Dimension

At the start of treatment, before the most obvious and distressing symptoms had been initially stabilized, Hugo resorted to dysfunctional coping mechanisms for emotional regulation and managing distress that achieved his short-term goals, yet simultaneously served to perpetuate and exacerbate his anxiety and depressive symptoms. Among these, the most notable were self-harming ideation that did not progress to action as it had in his adolescence, social and familial isolation, and the abuse of benzodiazepines when he needed to disconnect from his disturbing thoughts and painful emotions. At the same time, these behaviors reinforced his narrative of victimization and the externalization of responsibility. The persistence of dysphoria, anger, and sadness due to loss seemed to play a role in legitimizing his experience as a victim of an unjust life. However, at the same time, he presented a positive valence that allowed him to project an image of apparent balance and normality as a strong man capable of weathering adversity, defending himself firmly, maintaining work performance, and keeping a well-groomed physical appearance.

Contextual Dimension

Hugo grew up in a humble neighborhood with a strong sense of community and a deep feeling of belonging. However, the atmosphere of neglect and lack of emotional support he experienced at home may have interfered with his ability to safely internalize these community values. On the other hand, the neighborhood's codes offered the security of loyalty, but they also shaped relationships through confrontation, black-and-white thinking, hypervigilance, and suspicion. Consequently, he may have internalized the idea that belonging means giving up parts of oneself and that pain can be compensated for with toughness. Over time, as he became a grown man with a prestigious career that would underscore his own worth and capabilities, he still did not feel entirely at home in his world. This dissonance creates a sort of dual register: privately proud, resentful, insecure, unstable, and ashamed of his past; publicly competent, balanced, ambitious, methodical, and polished. The rift between these two worlds highlights one of the most complex issues the psychotherapeutic process will need to address. That is, this structural lack of a sense of belonging acts as a cross-cutting element that colors his entire subjective experience, perpetuating chronic suffering through the diffusion of identity.

A Brief Formulation for Clinical Practice

Hugo's case, beyond diagnostic entities or other conceptualization alternatives derived from other psychopathological and psychotherapeutic models, can be considered an exemplary case of what the cognitive model refers to as identity diffusion. That is, an inability or difficulty in establishing a clear, coherent, and balanced identity. This is often a central issue in individuals who receive psychopathological diagnoses, particularly in the realm of personality. Hugo's identity diffusion arises as a result of a developmental trajectory marked by attachment within the disorganized spectrum, crystallized dysfunctional schemas, and a life narrative split between pride in having achieved social advancement and the unacknowledged and unintegrated shame of his background. This unspoken internal experience lies at the root of his pattern of emotional, interpersonal, and behavioral dysregulation, which, in turn, perpetuates his internal conflict, hindering the construction of a coherent and multifaceted identity where the different parts of the self can coexist. Very often, a reduction in fragmentation and identity diffusion, following an effective psychotherapeutic process, is associated with improvements in symptoms, functioning, and subjective quality of life.

The Development of the Psychotherapy

The implications of this assessment and dimensional formulation of the case for the psychotherapeutic process are presented succinctly in Figure 2 in sequential order.

Figure 2
Areas of the Psychotherapeutic Process

The sequence should be interpreted in a cyclical way and situated within a psychotherapeutic process that typically unfolds through repeated revisiting and progressive deepening of the individual's subjective experience. In other words, the linearity serves merely for didactic and expository purposes. The aim is to briefly summarize six areas that effective psychotherapy would need to successfully address in Hugo's case. A description of the phases, techniques, and duration of treatment exceeds the scope of this paper, but various psychotherapeutic approaches consistent with what has been presented here can be found in Dimaggio et al. (2015), Guidano (1987, 1991), Mahoney (1991), Inchausti (2025), Prado-Abril et al. (2013), Safran and Segal (1990), and Young et al. (2003), among other proposals available in the field of psychotherapy.

Finally, it is worth paying attention to the first-person accounts of patients in our psychotherapeutic processes:

> *"For a long time, I thought what was happening to me was that I was simply broken. Without a compass. No one told me that outright, of course, but that was what was implied behind the looks, the reports, and the diagnosis of borderline personality disorder. When I read those words for the first*

time, it was as if a stamp had been pressed onto my forehead. 'This is who you are,' as if everything else… My story, my efforts, my contradictions, my suffering, were reduced to three letters: BPD. I felt shame. Fear. Anger, too. Because part of me wanted to believe that someone could help me, but another part assumed I was already marked, that all paths would narrow from there on out. That my efforts to get ahead would be futile. Sometimes I think the diagnosis hurt me more than the symptoms. That the problem wasn't so much how I felt, but how the professionals began to treat me—with distance, always recommending pills. I remember that during the first few sessions with you, I was a little defensive. As if I had to prove that I wasn't that diagnosis, but at the same time knowing that I needed your help. It was hard for me to trust. It was hard for me to speak without fear of being misunderstood or judged as unstable, seductive, and manipulative. But little by little, something began to change. It was like a different way of being heard. It seemed to matter how I experienced what was happening to me. We started talking about my way of seeing the world, my ways of relating to others, and how certain experiences in my life had influenced certain ways I behaved, understood myself, and protected myself. I think that's when something different began to happen in the way I understood what was happening to me. I remember when we first talked about the different aspects of my case and how they were connected to explain my suffering. I felt seen. It was a story that made sense. There are still days when I doubt myself. Sometimes the impulses and fears come back, but now I know how to recognize those parts of me. I no longer cover them up with pills, alcohol, or sex. I observe them. Not always, of course, but more often than before. I feel like I'm starting to build a story of my own that I can control, instead of constantly reacting to what's happening around me. I know this is a process, but I trust the process. I suppose that's what change is all about. At my own pace. No rushing. I don't know if that's healing. But I do know it's another way of living."

An Epistemological Bridge Between Models?

One of the defining features of most of the current models in the field of understanding human suffering and its psychological treatment is the presence of integrative approaches within their frameworks (Norcross & Goldfried, 2019). This often makes comparing models an impossible task to delineate with precision, beyond resorting to generalizations or simplifications. Table 4 itself should be viewed with this issue in mind and as a map of trends that does not literally define the clinical territory in which the described models are subsequently deployed. Likewise, as noted for the cognitive model, as a particular model delves deeper into its own complexity regarding human understanding, it eventually converges with other perspectives. At times, the differences are simply a matter of jargon or allegiance (Norcross & Goldfried, 2019; Paris, 2013). It is worth recalling that a finding consistently observed in psychotherapy research in naturalistic settings is that clinicians who achieve better therapeutic outcomes resemble one another more closely—in terms of observable behavioral aspects—than their own theoretical models of reference would have predicted (Castonguay & Hill, 2017; Prado-Abril et al., 2017, 2019; Wampold & Imel, 2015).

No matter how strictly one seeks to define these concepts, it is easy to see that mentalization, reflexivity, metacognition, and theory of mind all fall within the realm of describing psychological aspects that are closely intertwined. The same is true when one chooses to speak of schemas that shape subjective affective-narrative realities, rather than of operational patterns of intrapsychic conflict. Therefore, without intending to oversimplify the theoretical and technical richness of other models, this section will attempt to identify some similarities and differences from a perspective we might label as standard. Not surprisingly, Young himself faced significant challenges and resistance within the cognitive-behavioral community when he began developing schema therapy after having been a star pupil of Beck's. The incorporation of elements from attachment theory, emotion theory, and the psychodynamic field was viewed as an eclectic deviation lacking empirical grounding rather than as a legitimate evolution of the model as it is currently understood (Bernstein & Clercx, 2018;). It could also be argued that its formal and official presentation in institutional and international settings, particularly in the form of its inclusion in clinical practice guidelines as the gold standard for psychological treatment, makes CBT the most visible hallmark of the cognitive model. Similarly, a parallel could be drawn with the contemporary relational psychodynamic approach regarding the more paradigmatic psychoanalysis (Shedler, 2010). In sum, building bridges between models to articulate their commonalities stems from the strong component of internal heterodoxy shared by most models.

The integrative cognitive model presented here shares many tenets with the standard cognitive-behavioral model, in that it evolved from the same starting point, even though it subsequently followed different epistemological and theoretical paths. For example, it assumes that cognitive and behavioral aspects are essential to understanding individuals and that increasing the flexibility of patterns is one of the primary goals of treatment. However, its emphasis on understanding people's subjective experience, recognition of tacit internal structures seeking personal meaning, and links to attachment history bring it closer to the psychodynamic model, especially in its more relational and contemporary form (Shedler, 2010). The incorporation of experiential elements and the weight of emotion as a driver of change in psychotherapy clearly aligns with the humanistic view that psychological change requires not only understanding but also experiences of personal transformation. For its part, the central importance given to relational factors in life trajectories and to the influence of socio-cultural narratives on the shaping of identity opens the possibility of a fruitful dialogue with systemic models. At this point, since the cognitive model is an open and pluralistic approach, it can serve as an epistemological, theoretical, and technical bridge to structure models—primarily for those whose interest centers on theoretical-technical integration with a strong focus on understanding people's subjective experience.

Finally, for the sake of clarity, Table 4 presents some of the elements that must be considered when establishing a constructive dialogue between the cognitive model, CBT, the psychodynamic model, and the systemic-relational model. In line with the synthesis by Wachtel and Gagnon (2019), mutual recognition and interest among models, the exchange of ideas, and even theoretical-

Table 4
Elements for Dialogue Between Models

	Integrative Cognitive Model	Cognitive-Behavioral Approach	Contemporary Psychodynamic Model	Relational Systems Model
Unit of analysis	Organization of subjective experience.	Automatic thoughts, observable behaviors.	Unconscious conflicts, object relations.	Family-relational system structure.
Source of suffering	Self-diffusion.	Cognitive distortions.	Internalized early experiences.	Family dysfunction.
Assessment method	Idiographic and contextual clinical formulation.	Structured assessment, standardized protocols.	Free association, transference analysis.	Relationship mapping, genogram.
Role of the therapist	Explorer, active.	Instructor, active.	Explorer, passive.	Participant observer.
Theory of change	Self-integration, re-signification of experience.	Correction of distortions, acquisition of skills.	Processing of conflicts and reframing of past relationships.	Change in communication patterns and modification of hierarchies.
Therapeutic relationship	Space for reflection and collaborative work on personal narrative.	A collaborative relationship based on treatment goals.	Transference and countertransference as drivers of change.	The relationship as part of the observed system.
Epistemology	Constructivist.	Positivist.	Hermeneutic.	Complexity theory.

Note. Adapted from Wampold (2019).

technical hybridization—all approached with an open and sensitive attitude toward broad theoretical integration—likely constitute one of the most stimulating and fruitful paths a mental health professional can follow throughout their entire career.

Summary

This text has sought to provide a balanced overview of the evolution of the cognitive model from its origins, linked to the *cognitive revolution*, to the present day. This process has been carried out with an emphasis on the inherent complexity that defines the model's internal structure. An effort has been made to avoid oversimplifications and generalizations that might have hindered the demonstration of its potential from an applied perspective. Likewise, an attempt has been made to integrate different epistemological currents to convey a pluralistic perspective on psychopathology that emphasizes its clinical, experiential, narrative, relational, and contextually situated aspects. This approach is not simply a matter of taking up a particular position within the currents that make up the cognitive paradigm; rather, as exemplified in Hugo's case, it has practical implications for how we conceptualize suffering, formulate the steps to be taken, and conduct psychotherapy from a scientifically informed and ethically guided perspective.

The cognitive model, particularly in its contemporary form, approaches human suffering through the individual's introspective capacity to delve into the subjective nature of their experience with confidence in their ability to articulate their autobiographical story in a coherent, multifaceted manner, capable of give meaning to their life story. From this perspective, the practice of psychotherapy cannot be reduced to the sequential application of intervention techniques or protocols derived from a categorical diagnosis as the axis around which treatment organization pivots. Nor is psychopathology conceptualized as a taxonomy of supposedly discrete, exhaustive, and mutually exclusive categories, but rather it is understood as the reflection of a complex expressive web that emerges from people's biographies, bonds, traumas, interpersonal relationships, and life trajectories at a given socio-cultural moment.

This article proposes a multidimensional model for the cognitive conceptualization of psychopathology that stands out for its idiographic sensitivity, its openness, and its flexibility to integrate the elements that scientific research identifies as necessary. The aim has been to ensure that it can capture complexity in detail while maintaining adequate operational capacity. The seven proposed dimensions help organize the individual's subjective experience, which may ultimately manifest as various psychopathological symptoms. For example, in Hugo's case, this manifests as a personality disorder. However, what is important is that the model can serve to connect the story the person brings to therapy with their belief system, symptoms, life course, and so on. The main objective is to facilitate the identity development toward progressively greater levels of stability, organization, and complexity, naturally integrating the different self-states involved. In the section on the development of psychotherapy, a first-person account illustrates how, through the psychotherapeutic process, a person's voice can be restored by encouraging the development of more elaborate, reflective, and useful personal narratives to navigate suffering.

Dialogue with other models has made it possible to identify certain common pathways, as well as some differences in how clinical practice is approached. Committing to a reflective integration that respects these differences may be the most appropriate path toward improving our understanding of the state of the field and the effectiveness of treatments received by people with mental disorders. In any case, it is important to be aware that no single model on its own exhausts all possibilities for understanding people's subjective experience. It is probably not even appropriate to attempt to do so. Anyway, the cognitive model presented here is offered as an open paradigm—a platform from which to weave networks of theoretical and technical collaboration that can serve to articulate different sources of knowledge.

However, despite its advances in depth, complexity, and clinical sensitivity, the contemporary cognitive model is not without its challenges. Its integrative aspiration risks becoming diluted into a theoretical amalgam that is difficult to systematize unless clear demarcation criteria are established to define its main components. Furthermore, its openness to multiple dimensions may strain its ability to be operational in clinical practice if it is not accompanied by sufficiently developed technical procedures to support such complexity. Additionally, in its evolution, the model appears to rely on conceptual elements drawn from other perspectives. This may raise questions about its internal consistency as an independent paradigm. Finally, its limited institutional adoption, compared to the cognitive-behavioral approach, poses an obstacle to its educational dissemination and systematic empirical validation. These limitations, which in turn are pending challenges, reinforce

the need to continue exploring the model's capacity to offer more sophisticated formulations and solutions regarding the nature of suffering and its relationship to processes of human change.

Thus, what remains is an invitation to view the cognitive model not as a finished theory, but as an open-source theoretical-technical system that is evolving and seeking the best possible solutions for clinical practice. In the 1990s, it was thought that the beginning of this century would bring about the definitive integration of theory and practice in the field of psychotherapy (Mahoney, 1991; Norcross & Goldfried, 2019; Wampold, 2019; Wampold & Imel, 2015). However, thirty years later, perhaps the most important development was planting the seed that would allow subsequent generations to continue the endeavor with sensitivity and openness. Perhaps, from the very beginning, it was simply a matter of stimulating curiosity and the desire to understand, in all its depth, the mystery that the human mind still is.

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Conflicts of Interest

The authors declare that they have no conflicts of interest.

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