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PSICOLOGÍA POSITIVA
OPTIMISMO, CREATIVIDAD, HUMOR, ADAPTABILIDAD AL ESTRÉS

LA INVESTIGACIÓN SOBRE LOS EFECTOS DE LAS EMOCIONES POSITIVAS

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Special section

POSITIVE PSYCHOLOGY IN PERSPECTIVE

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The subject matter of this issue of *Papeles del Psicólogo* is indicative of the interest being taken among academics and professionals in Positive Psychology. In recent years, prestigious journals (American Psychologist, Journal of Social and Clinical Psychology, Psychological Inquiry, American Behavioral Scientist, School Psychology Quarterly, *Ricerche di Psicología*, Review of General Psychology, among others) have also devoted special issues to the subject. Without going into debates about the aptness of the term or the need for a more original label, the proponents of this approach highlight something as apparently simple as taking into account the positive and negative aspects of human functioning. We must acknowledge, with no little pride, that psychology has developed effective and efficient methods of intervention for many psychological problems. However, we have not made so much progress in conceiving methods for (re)establishing happiness in the unfortunate or, in a more general way, for providing a solidly knowledge-based formula for improving well-being. This situation is due in part to the fact that –for reasons too complex to go into in this brief presentation– the study of the negative has, by and large, occupied more of our attention than its opposite. An analysis of psychology publications since 1872, carried out by PsycINFO, shows that the ratio of negative to positive aspects dealt with is 2 to 1 (Rand & Snyder, 2003).

But pondering the question of human well-being is no mere passing fashion. In a sense, it has always been a core concern of Western philosophy, either from the direct analysis of the fundamental conditions of well-being (Aristotle's *eudemonia*) or, in more modern times, from the analysis of the existential conditions that limit the scope of this ideal. Thus, Aristotle, but also Spinoza, Schopenhauer, Bertrand Russell, Heidegger and Cioran have rendered reflection on happiness one of the central shafts of thinking about "the human condition". However, science has found itself obliged to respond to other, more pressing demands, related to the struggle against illness, suffering or poverty, and only recently has it been in a condition to use its tools for exploring these terrains more traditionally falling within the province of philosophy.

Indeed, it is no historical accident that the Welfare State was a central European and Scandinavian invention of the 1960s, a concept that could only emerge when the principal epidemic illnesses had ceased to be the prime causes of mortality, and when economic prosperity in the West was greater than it had ever been before. Nor is it coincidental that it was in the 1970s that there appeared the first large-scale sociological studies on the state of the happiness of nations, which have continued uninterrupted to the present day, or that it was the mid-1980s that witnessed the explosion of research on quality of life in the field of medicine, an aspect which continues to be studied with enviable vigour in that field.

Psychology has also begun quite recently to accept subjective well-being as a relevant object of study and to take on directly, as a systematic academic duty, the exploration of human strengths and of the factors that contribute to the happiness of human beings. The inception of this commitment is so close, indeed, that the formal foundation of so-called Positive Psychology is accepted as being marked by Martin Seligman's inaugural lecture of his term as President of the American Psychological Association (Seligman, 1999), even though the seed of Positive Psychology can be traced to a much earlier period, in psychological approaches now consigned to history that showed the utmost good intentions but a severe lack of empirical support.

This new sensitivity toward the scientific study of well-being is, in a general sense, not exclusive to psychology. The analysis of well-being and the search for objective indicators is the concern of the social sciences as a whole. Among those involved in this undertaking are, for example, groups of sociologists and economists (including, in an active role, the psychologist and Nobel laureate for Economics Daniel Kahneman), addressing their efforts to the analysis of the factors which, beyond the official rhetoric, are related to citizens' well-being (Kahneman & Krueger, in press). How can we speak of the Welfare State if public policy does not concern itself with

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the well-being of the population? We know that while the wealth of many industrialized nations has grown almost exponentially in recent decades, the happiness of their inhabitants has not substantially increased, which constitutes an alarming political paradox in relation to the meaning and scope of the Welfare State (Diener & Seligman, 2004).

It is somewhat venturesome to speculate on the future of what we currently refer to as Positive Psychology. Quite probably, what is for the time being a "movement" or, as some might say, a fashion, will dissolve without further ado into the everyday business of psychology. Indeed, in our view, and to paraphrase André Malraux, it might be said that the Positive Psychology of the future will be psychology or simply will not be. That is, the most likely scenario is that what we now call Positive Psychology will be perfectly integrated into the everyday work of future generations of psychologists, and the analysis and measurement of well-being, of positive emotions or of the effective improvement in the lives of people we treat will be the unquestioned manner of doing things. It is noticeable, in this regard, that the excellent contributions in this issue of *Papeles del Psicólogo* come from young professionals and researchers who do not appear unduly troubled by any such false conceptual or epistemological dilemma. From a theoretical or meta-theoretical point of view, then (as Linley et al., 2006, point out), it is of no great interest to discuss whether or not Positive Psychology pretends to constitute a new perspective within the discipline. In our view, it is all much more simple, but equally challenging: it is not a question of creating a new, isolated variant of psychology, but rather of taking into account, promoting and studying those aspects related to human well-being and happiness, even with a view to throwing light on the nature of psychological suffering (Vázquez et al., 2005). When all is said and done, such objectives are in accordance with that which concerns people, and which we should aspire to study and promote with enthusiasm. From this pragmatic point of view, there is little doubt that Positive Psychology has a brilliant future, and the proliferation of articles, new journals and rigorous research serves only to support such a prediction.

An interesting initiative in this regard is the ongoing project involving psychologists from several countries, myself among them, at the University of Pennsylvania. The year 2006 saw the launch of a website, initially based on the www.authentichappiness. model, in English, Spanish and Chinese. All the Scandinavian languages are also scheduled to be included, with the aim that it will serve as a centre for national and cross-cultural psychological resources and research on human well-being.

Psychology's concern with human happiness (or subjective well-being, to use a more scientifically well-defined term) is certainly no turn-of-the-century whim or fancy, and still less an opportunist attempt to seek advantageous positions, especially if we consider that some of its most prominent proponents (Ed Diener, Martin Seligman, Daniel Kahneman, Chris Peterson, Csikszentmihalyi, to name but a few) have for many years figured among the most widely-cited authors in the psychological scientific literature for their achievements in their respective fields. It will be a formidable undertaking for psychology to contribute to the systematic theoretical consolidation of the most relevant concepts and the relationships between them (positive emotions, well-being, biases, positive health, etc.), the development of valid instruments for assessing such concepts (how do we measure, for example, an individual's level of well-being?) and, finally, the exploration and analysis of means of intervention (Seligman et al., 2005) that promote or help to maintain citizens' level of well-being. There is probably no greater challenge for social scientists and healthcare professionals than to promote people's true health and well-being, and our efforts would certainly not be wasted in the pursuit of such a noble goal.

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POSITIVE PSYCHOLOGY: A NEW WAY OF UNDERSTANDING PSYCHOLOGY

Beatriz Vera Poseck

Mention of the concept of positive psychology often leads to its interpretation as some new trend of spiritual philosophy, or the latest miraculous self-help method to add to the many that have already flooded the market. However, it only requires the slightest interest in the concept to understand how far removed these assumptions are from reality. Positive psychology is nothing less than a branch of psychology which, with the same scientific rigour as the rest of the discipline, focuses on fields of research and interest quite different from those traditionally studied: positive human qualities and characteristics.
Key words: *Positive emotions, optimism, humour, resilience.*

A menudo, cuando se hace referencia al término de psicología positiva se tiende a interpretar como alguna nueva corriente de filosofía espiritual o un nuevo método milagroso de autoayuda de los tantos que saturan el mercado. Sin embargo, poco hace falta interesarse en el concepto para comprender cuán lejanas se encuentran estas suposiciones de la realidad. La psicología positiva, no es sino una rama de la psicología, que, con la misma rigurosidad científica que ésta, focaliza su atención en un campo de investigación e interés distinto al adoptado tradicionalmente: las cualidades y características positivas humanas.
Palabras clave: *Emociones positivos, optimismo, humor, adaptabilidad.*

If we ask a range of different people of all types and from all walks of life about the objective of psychology and the work of those involved in it, we will surely find a predominant response: to treat and cure mental disorders.

Undoubtedly, psychology has for many years focused exclusively on the pathology and weakness of human beings, indeed becoming identified and even almost confused with psychopathology and psychotherapy. This phenomenon has given rise to a theoretical framework of a pathogenic nature, which has seriously biased the study of the human mind. The exclusive focus on the negative that has dominated psychology for so long has led to the assumption of a model of human existence that overlooks or even denies the positive characteristics of the human being (Seligman & Csikszentmihalyi, 2000), and which has contributed to the adoption of a pessimistic view of human nature (Gilham & Seligman, 1999). Thus, characteristics such as joy, optimism, creativity, humour, excited anticipation, and so on have been ignored or only superficially dealt with.

The limitations of this focus on the negative have begun to attract attention in recent years and in relation to different disorders. Thus, for example, depressive disorders appear to be insufficiently explained from a model based exclusively on negative emotions. Depression is not only the presence of negative emotions, but also the absence of positive emotions, and it is essential to take this into account, for example, in the development of treatments. In this context, techniques and therapies conceived for fighting depression have traditionally focused on the elimination of negative emotions such as apathy, sadness or helplessness. However, recent research has begun to develop intervention strategies based on the stimulation in the depressed person of positive emotions such as joy, excited anticipation, hope, and so on.

A large part of research and theoretical work in psychology in recent years has focused on seeking how to prevent the development of disorders in risk subjects. However, it cannot be denied that, still today, psychology has shown itself unable to provide a solution to this question. The pathogenic model adopted over many years has proved incapable of even approaching the prevention of mental disorders. The key to this failure might perhaps be found in the fact that prevention has always been understood in terms of negative aspects, and that the focus has been placed on avoiding or eliminating negative emotions.

Indeed, the greatest advances in prevention have derived from perspectives based on the systematic construction of competencies (Seligman & Csikszentmihalyi, 2000). In this regard, research has shown the existence of human strengths that act as cushions against mental disorders, and there seems to be sufficient empirical evidence to state that certain positive characteristics and hu-

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man strengths, such as optimism, hope, perseverance or courage, among others, act as barriers against such disorders.

The reductionist perspective has converted psychology into a "science of victimology" (Seligman & Csikszentmihalyi, 2000). Historically, psychology has conceived the human being as a passive subject, who reacts to environmental stimuli. The focus of applied psychology has been the cure of suffering, and there has been an explosion in research on mental disorders and the negative effects of stressors. Professionals have the task of treating patients' mental disorders within a pathogenic framework in which the repair of damage is crucial. However, psychology is not only a branch of medicine dealing with mental illness-health; it is much more than that. In recent years, voices have been raised which, taking up once more the ideas of humanist psychology about the need to study the "positive side" of human existence, have offered solid empirical and scientific support to this neglected part of psychology.

The term "positive psychology" was developed by Martin Seligman, a researcher who, having devoted a large part of his career to mental disorders and the development of concepts such as learned helplessness, made a U-turn in his work, developing and promoting a more positive conception of the human species.

The object of positive psychology is to improve quality of life and prevent the appearance of mental disorders and pathologies. The current conception of psychology, centred around the pathological, focuses on correcting defects and repairing what was broken. In contrast, positive psychology insists on the construction of competencies and on prevention.

For Seligman, the concept of positive psychology is not new to the discipline, for prior to the Second World War the main objectives of psychology were three: curing mental disorders, making people's lives more productive and fuller, and identifying and developing talent and intelligence. However, after the war, different events and circumstances led psychology to forget two of these objectives and focus exclusively on mental disorders and human suffering (Seligman & Csikszentmihalyi, 2000).

Likewise, we can find clear positive tendencies in the humanist current of psychology, which flourished in the 1960s and was represented by such recognized authors as Carl Rogers, Abraham Maslow or Erich Fromm. Unfortunately, humanist psychology has not enjoyed a solid empirical basis, and has indeed given rise to an immense quantity of doubtful and quite unreliable self-help movements (Seligman & Csikszentmihalyi, 2000).

In this quest for the best in the human being, for the good things that allow our potential to flourish, positive psychology does not trust in pipedreams, utopias, delusions, faith or self-deception, bur rather adopts the method of scientific psychology, broadening the traditional field of activity and distancing itself from the questionable methods of self-help and spiritual philosophies so widespread today.

According to Martin Seligman, positive psychology emerged as an attempt to overcome the resistant barrier of a 65% success rate that none of the psychotherapies have been capable of surpassing to date. The techniques developed in research in positive psychology support and complement those already in existence. Thanks to theoretical research in this area, the spectrum of intervention is considerably broadened and enriched. In this context, the involvement of variables such as optimism, humour or positive emotions in physical states of health emerges as one of the key points of research in positive psychology. The hope for the coming years is a large quantity of empirical results that will allow a new theory of psychology to take shape.

Positive psychology is not... a philosophical or spiritual movement, nor does it set out to promote spiritual or human growth through methods of questionable foundation. It is not a form of self-help, nor a magic method for achieving happiness. Nor does it pretend to be a cloak for wrapping beliefs and dogmas of faith, or indeed a path for anyone to follow. Positive psychology should in no case be confused with dogmatic movements whose aim is to attract devotees or followers, nor must it ever be considered outside of a rigorous professional context.

Positive psychology is... a branch of psychology that seeks to understand, through scientific research, the processes underlying the positive qualities and emotions of the human being, for so long ignored by psychology.

The object of this interest is none other than to contribute new knowledge about the human psyche, not only to help solve the mental health problems that affect individuals, but also with a view to improving quality of life and well-being, always in accordance with the rigorous scientific methodology that must characterize all health sciences.

Positive psychology represents a new perspective from which to understand psychology and mental health that serves as a complement and support for that which al-

ready exists.

CHALLENGES FOR THE FUTURE

Psychology must overcome concepts focused on pathology and create a positive terminology to complement the negative expressions so abundant today in traditional psychology.

It must also create new assessment instruments, aimed at identifying the strengths of the individual, so as to guide prevention and treatment and promote personal development.

Furthermore, it must design intervention programmes and techniques aimed at developing the precious resources that people, groups and communities undoubtedly possess. The positive effects of these developments will be evident not only at the individual level, but also at a social level in a complex world that is constantly erecting new challenges for its inhabitants.

The intention throughout this special issue is to offer an overview of some of the areas of interest of positive psychology, and to outline a first approach to the development of valid and reliable instruments with which to work.

POSITIVE EMOTIONS

The majority of research on emotions has focused exclusively on the negative emotions, and this is to some extent logical if we consider that emotions such as fear, sadness or anger are alarm signals which, if systematically ignored, may generate considerable problems. The natural tendency to study that which threatens the well-being of humans has led to a concentration on those emotions that help them to deal with imminent danger or problems.

Moreover, there are other reasons that explain why positive emotions have had a lower scientific profile. For example, they are more difficult to study, given that they are relatively fewer in number and more difficult to distinguish. Thus, if we consider the scientific taxonomies of the basic emotions we can identify 3 or 4 negative emotions for each positive one. This negative ratio is indeed faithfully reflected in everyday language, so that people in general have more difficulty naming positive emotions.

There are also differences with regard to the expression of each type of emotion. Thus, negative emotions have been assigned specific facial configurations that make possible their universal recognition (Ekman, 1989). In contrast, positive emotions have not been assigned such unique and characteristic facial expressions. Moreover, at a neurological level, negative emotions trigger different responses in the autonomic nervous system, while positive emotions do not provoke such differentiated responses.

Another explanation for the imbalance in scientific interest between negative and positive emotions resides in the way their study is approached. Thus, on considering positive emotions, researchers have always done so from the theoretical framework used for the study of negative emotions. From this perspective, the emotions are, by definition, associated with action impulses. Negative emotions have obvious adaptive value, representing efficient solutions to the problems mankind has faced since its origins. However, the adaptive value of positive emotions is more difficult to explain, and has been ignored for many years. But if it were truly the case that they lacked value, we would have to ask ourselves why they have remained with us throughout thousands of years of evolution.

What, then, is the adaptive value of positive emotions? We can answer this question if we abandon the theoretical framework from which we understand negative emotions. Positive emotions resolve problems related to personal growth and development. Experiencing positive emotions leads to mental states and forms of behaviour that indirectly prepare the individual to cope successfully with future adversity (Fredrickson, 2001).

Fortunately, in recent years, many experts have begun to carry out research and theorize in this field, opening up new ways of understanding human psychology. One of the theories most solidly representative of this trend is that developed by Barbara Fredrickson. She highlights the importance of positive emotions as a means of resolving many of the problems generated by negative emotions, stressing how, through them, human beings can succeed in getting through difficult times and come out stronger. According to this model, positive emotions can be channelled towards prevention, treatment and coping to become authentic arms for dealing with problems (Fredrickson, 2000).

OPTIMISM

Optimism is a dispositional psychological characteristic that refers to positive expectations and future objectives, and whose relationship with variables such as perseverance, achievement, physical health and well-being (Peterson & Bossio, 1991; Scheier & Carver, 1993) have turned it into one of the central aspects in positive psy-

chology.

The modern interest in optimism emerges from findings on the role of pessimism in depression (Beck, 1967). Since then, many studies have shown optimism to have predictive value in relation to health and well-being, as well as acting as a modulator of stressful events, palliating the problems of those who are suffering or stressed, or have serious illnesses (Peterson, Seligman & Vaillant, 1988). Optimism can also act as a strengthener of well-being and health in those who, though free from disorders, wish to improve their quality of life (Seligman, 2002). From an evolutionary point of view, moreover, optimism is considered as a characteristic of the human species selected through evolution for its survival-related advantages (Taylor, 1989).

Common sense tells us that it is positive to look to the future with optimism, and numerous empirical works support this idea. Thus, for example, studies with the general population show a clear tendency to overestimate one's degree of control over situations (Langer, 1975), while depressed people would estimate highly accurately their true degree of control (Alloy & Abramson, 1979). This illusion of control, together with other mechanisms, contributes to explaining why some people do not become depressed and others do.

What distinguishes an optimistic person from a pessimistic one? Is it good to see life as a little better than it really is? Are pessimists realists while optimists live on illusions? It is these and other questions that scientific study in this field aims to resolve. Thus, optimism promises to be one of the most important topics in research on positive psychology.

HUMOUR

The book "Anatomy of an Illness", published in 1979 by the late magazine editor Norman Cousins, was the first work that dealt openly with the correlation between humour and health. Cousins describes how he recovered from a disease (ankylosing spondylitis) that is usually irreversible through a treatment that included, among other therapies, watching comedy films by the Marx brothers.

Humour and its commonest external manifestation, laughter, constitute an important pillar of research in positive psychology. Although the idea that laughter and humour are good for the health is not a new one, it is only the last few decades that have seen the gradual proliferation of therapies and clinical interventions based on this conception. Scientific research has shown that laughter is capable of reducing stress and anxiety and thus improving the individual's quality of life and health.

Humour "serves as an internal safety valve that permits us to release tensions, dispel worries, relax and forget everything", asserts Dr. Lee Berk, Associate Professor of Pathology at Loma Linda University in California, and one of the principal researchers in the world of health and good humour. In a series of studies he examined participants' blood samples before and after they watched comedy videos and compared them with those of a group who did not watch the videos. Berk discovered considerable reductions in the concentrations of tension-related hormones and an increase in the immune response of those who watched the videos.

RESILIENCE AND POST-TRAUMATIC GROWTH

Experiencing a traumatic event is perhaps one of the situations most likely to transform a person's life. Without in any way belittling the seriousness and horror of such experiences, it should be underlined that it is in extreme situations that human beings have the opportunity to reconstruct their way of understanding the world and their system of values, to reconsider their conception of the world and to modify their beliefs, so that in this reconstruction there can (and often does) occur a process of learning and personal growth (Janoff-Bulman, 1992; Calhoun & Tedeschi, 1999). However, traditional psychology has tended to assume that all traumatic events leave people with psychological wounds, and to ignore the study of phenomena such as resilience and post-traumatic growth, based on the capacity of human beings to resist and recover from life's onslaughts and build on their effects.

Resilience and post-traumatic growth emerge as research concepts in positive psychology, through which it is aimed to determine why some people succeed in learning from their experiences and even extract benefits from them. Resilience is situated within a positive and dynamic current of psychology that promotes mental health, and would seem to be a reality confirmed by the testimonies of many people who, despite having gone through a traumatic situation, have managed to get over it and get on with life –even on an improved level, as though having experienced the trauma and come to terms with it had enabled them to develop latent and unexpected resources. Although for a long time responses of resilience have been considered as unusual (and even

pathological) by experts, the current scientific literature shows clearly that resilience is a common response, and that its appearance, far from indicating pathology, suggests a healthy adjustment to adversity.

Events such as the recent terrorist attacks in New York and in Madrid can provide a good scientific basis for the analysis of these phenomena, and although there is an enormous preponderance of studies devoted to post-traumatic stress disorder, there is also a small body of work on positive emotions, coping and resilience.

CREATIVITY

Creativity is the capacity to create, to produce new things. It is the ability of the human brain to reach conclusions, to conceive ideas and to solve problems in an original way. The form it adopts can be artistic, literary, scientific, and so on, and it can also be employed in everyday life, improving its quality. This last-mentioned expression of creativity probably does not leave its mark on the history of mankind, but it is in essence what makes life worth living (Csikszentmihalyi, 1996).

Creativity is considered, therefore, as a key process in personal development and social progress, and hence falls squarely within the field of interest of positive psychology. Nevertheless, the potential this suggests is weakened by the widespread assumption that creativity is a dichotomic differential characteristic possessed by some and not by others. Research on creativity has contributed to the promotion of this belief, focusing as it has done for many years on traits, that is, on the identification of the personality characteristics (stable and scarcely modifiable) of "creative people". As a result, some other important research areas have been neglected, such as the physical and social contexts in which creative people have developed their creations, or the specific skills they have learned. Furthermore, it has been assumed that creativity cannot be altered, and that creative persons can produce creative work at any time and in any field.

In the light of current research, neither of these assumptions appears to be completely true. Today we understand that creativity does not depend exclusively on stable personality traits, but is rather the result of a specific constellation of personal characteristics, cognitive abilities, technical knowledge, social and cultural circumstances, material resources, and even luck (Amabile, 1983; Csikszentmihalyi, 1996; Sternberg & Lubart, 1995). Creativity can be developed and encouraged in all areas of life, and can also be considered as another resource available for coping with adverse circumstances. Anybody, moreover, can develop their creative potential and improve the quality of their everyday life, even if the final result is not earth-shattering discoveries for humanity or universally valued creations.

MEASUREMENT INSTRUMENTS

One of the challenges for positive psychology is the development of valid and reliable measurement instruments capable of measuring and delimiting the variables involved in the field.

Traditional assessment and the models deriving from it have clarified aspects of human illness and weakness. What is necessary now is the creation of instruments that permit the assessment of positive resources and emotions, with a view to developing more functional, more dynamic and healthier models.

Pioneering in this regard are the efforts of Martin Seligman and Christopher Peterson, who have designed a measurement instrument based on a classification of the individual's positive resources.

The VIA Inventory of Strengths (VIA-IS) is a 240-item questionnaire that uses 5-point Likert-style items to measure the degree to which respondents possess each of the 24 strengths and virtues in the classification developed at the Values in Action Institute under the direction of Martin Seligman and Christopher Peterson.

The 24 strengths measured by the VIA-IS, and which form the basis of the Character Strengths and Virtues Handbook classification, are grouped in 6 sections: wisdom and knowledge, courage, humanity, justice, temperance and transcendence.

The VIA study with more than 4000 participants reveals that, of the 24 qualities or strengths assessed through the VIA-IS, five are consistently related to life satisfaction to a far greater extent than the remaining 19. These are: gratitude, optimism, enthusiasm, curiosity and the capacity to love and be loved.

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POSITIVE EMOTIONS

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Within the emerging field of positive psychology, the study of positive emotions, such as joy, satisfaction, pride or hope, has increased significantly in recent years. Furthermore, numerous empirical studies have shown the relationship between positive emotions and health, subjective well-being, creativity, resiliency, and so on. The present article discusses some of these studies and places them within the framework of the broaden and build theory of positive emotions, proposed by Barbara Fredrickson for explaining the adaptive benefits of positive emotions. Finally, we describe two positive emotions, elevation and flow, which are often overlooked, but are nevertheless important vehicles for individual growth and social connection.
Key words: *positive emotions, elevation, flow.*

Dentro del campo emergente de la Psicología positiva el estudio de emociones positivas como la alegría, la satisfacción, el orgullo, la esperanza, etc., ha cobrado gran importancia en los últimos años. Cada vez son más numerosos los trabajos empíricos que se centran en demostrar la relación entre la experiencia de emociones positivas y variables como la salud, el bienestar psicológico, la creatividad, la resiliencia, etc. En este artículo se exponen algunos de estos trabajos y se enmarcan dentro de la Teoría abierta y construida de las emociones positivas, propuesta por Barbara Fredrickson para explicar el valor adaptativo de estas emociones. Finalmente se describen dos estados emocionales positivos, la elevación y la fluidez, que suelen pasar desapercibidos y que sin embargo tienen importantes beneficios psicológicos y sociales.
Palabras clave: *emociones positivas, elevación, fluidez.*

The scientific study of positive emotions has traditionally been considered as a frivolous activity, and as such has been deemed to warrant little attention by researchers (Fredrickson, 2003). Moreover, the current interest in positive aspects is considered by many authors as a passing fad, or worse still, as a "rehash" of things that were already well known. This may well be the case, but it is no less true that, however well known the aspects in question, an approach of such vital importance for human beings is indeed applied and practised.

The natural tendency to study that which threatens people's well-being has led research to focus on negative emotions and to ignore the value of the positive ones. It is also true that the good things are taken for granted (Sears, 1983). It is a general belief that goodness is a characteristic representative of human beings (believing the opposite would make life much more difficult), so that it is considered as normal, and the normal does not seem to require too much explanation; its explanation is certainly not urgent.

However, in recent years this tendency is changing, and numerous psychologists have begun to study the adaptive function of positive emotions within the framework provided by Positive Psychology (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). In this context, the cultivation of these emotions is becoming a valuable and powerful therapeutic resource for transforming the everyday life of many people into something fully satisfying and meaningful.

With a general information approach, though based on research published in scientific journals, the present article reviews the main results that justify the growing interest in this field, where there is undoubtedly much research to be done. The experimental study of such complex phenomena involves considerable difficulties, and many of the studies carried out so far have some methodological limitations: small samples, non-random samples, instruments that cannot measure the target phenomena directly, but only their various effects or expressions, and so on. This makes it essential to interpret the results with caution, but it also encourages those interested in the field to continue researching.

WHAT ARE EMOTIONS?

The biological source of the emotions is a set of nervous structures called the limbic system, which includes the hippocampus, the cingulate gyrus, the anterior thalamus and the amygdala. Apart from its other functions, the amygdala is the principal manager of the emotions, and its lesion annuls emotional capacity. The neuronal connections between these structures located in the reptilian

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brain and the neocortex are many and direct, ensuring a highly adaptive communication in evolutionary terms (Ledoux, 1996). Thus, we cannot really speak of thought, emotion and behaviour as separate entities; however, in practice, research divides them up to facilitate their study.

The task of defining complex constructs such as the emotions is not an easy one. Indeed, there is still intense debate and extensive research in relation to their source, their internal structure, the differences between affective states, and so on (Diener, 1999; Ekman, 1994; Parkinson, 1996, 2001).

In spite of these difficulties, there is a degree of consensus with regard to some of the characteristics of the basic emotions (Fredrickson, 2001), so that it can be considered that the emotions are response tendencies with high adaptive value; that they have clear manifestations at a physiological level in relation to facial expression, subjective experience, information processing, etc.; that they are intense but of short duration; and that they emerge as a result of the assessment of some antecedent event.

Such definitions would appear to be more appropriate for the study of negative emotions (fear, anger, disgust, sadness, etc.) than for that of positive emotions (joy, pride, satisfaction, hope, flow, elevation, etc.), basically because the former can be associated with clear and specific response tendencies, while this is more difficult in the case of the latter (Fredrickson & Levenson, 1998). Thus, for example, when people feel fear in response to something or someone, their automatic alert systems are activated, they rapidly prepare to flee or protect themselves, and their facial expression clearly reflects their feelings and is practically universally recognizable (Ekman, 1989). Such reactions will quite probably have permitted many individuals of our species to save their lives in critical situations, thus reflecting the immediate survival value of negative emotions (Izard, 1993; Malatesta & Wilson, 1988). In this regard, Robert Sapolsky, a neurologist at Stanford University, explains in a recent interview how in the face of imminent threat the body uses all its stored energy to activate the appropriate muscles and increase arterial pressure for accelerating energy flow; at the same time, it deactivates all types of long-term projects. As he light-heartedly adds, if you are being chased by a lion, you will choose another day to ovulate, you will delay puberty, growth will be out of the question, as will digestion, and you will postpone the production of antibodies until night-time... if you are still alive (Punset, 2005).

In contrast, when someone feels happy the response tendency is more ambiguous and unspecific: they may jump for joy, but they may also feel inclined to joke, to help others, to make plans for the future, to flirt, to explore, and so on. The survival utility of these types of response is not so clear, mainly because it is not so immediate, but it should nevertheless not be overlooked. Indeed, it is possible to conceive of other types of benefit derived from positive emotions which, while they may not fit perfectly into the existing models, would justify the development of new specific models (Ekman, 1994).

THE VALUE OF POSITIVE EMOTIONS

Barbara Fredrickson has opened up a research line focusing on positive emotions and their adaptive value (Fredrickson, 1998, 2000b, 2001, 2003; Fredrickson & Branigan, 2000). She recently proposed the *Broaden and build theory of positive emotions* (Fredrickson, 1998, 2001), which maintains that emotions such as joy, enthusiasm, satisfaction, pride, indulgence, etc., although phenomenologically different from one another, share the property of broadening people's repertoires of thought and action and constructing reserves of physical, intellectual, psychological and social resources that are available for future times of crisis.

Experiencing positive emotions is always agreeable and pleasurable in the short term, and for this author they would also have more lasting beneficial effects, insofar as they prepare people for future, more difficult times (Fredrickson, 1998, 2001). Joy, for example, encourages us to play in the widest sense of the word, to push the limits, to be creative (Frijda, 1986) and this in turn permits the development and training of physical abilities (strength, resistance, precision), of psychological and intellectual abilities (comprehension of rules, memory, self-control) and of the social skills necessary for establishing relations of friendship and support. All of these abilities and skills, conceptualized as resources, can acquire considerable value at times of scarcity and of conflict, when access to speed, resistance, friends, capacity for innovation, etc., can make the difference between life and death.

The functions of positive emotions would complement the functions of negative emotions (Fredrickson, 2001), and the two would be equally important in the evolutionary context. If negative emotions solve problems of immediate survival (Malatesta & Wilson, 1988), given their

link to specific response tendencies (anger, for example, prepares us for attack; disgust provokes rejection, the urge to vomit; fear prepares us for flight), the positive emotions solve issues related to development and personal growth and to social connections. Negative emotions bring about ways of thinking that reduce the range of possible responses, while positive ones lead to ways of thinking that widen the range. Thus, positive emotions would have contributed to generating the appropriate conditions for our ancestors to develop the physical abilities necessary for dealing with predators, the psychological abilities for discovering and inventing possibilities, and the social abilities required for generating links between people and for the development of helping behaviours.

In a closer, more accessible context it is also possible to observe in an empirical way some of the benefits derived from the experience of positive emotions, and this is becoming the focus of more and more research carried out from the positive psychological perspective.

POSITIVE EMOTIONS IMPROVE THE WAY WE THINK

Numerous experimental studies have demonstrated that positive affect is related to more open, flexible and complex cognitive organization and to the ability to integrate different types of information (Derryberry & Tucker, 1994; Isen, 1987, 1990, 2000; Isen & Daubman, 1984; Isen, Daubman & Nowicki, 1987; Isen, Johnson, Mertz & Robinson, 1985; Isen, Niedenthal & Cantor, 1992; Isen, Rosenzweig & Young, 1991). The result of this way of thinking makes problem-solving more creative and judgements and decision-making more accurate and sensitive (Carnevale & Isen, 1986; Isen, 1993; Isen, Nygren & Ashby, 1988; Lyubomirsky, King & Diener, 2005).

One such experiment showed that diagnoses on hepatic diseases were more accurate when doctors were made to feel good simply by giving them a bag of sweets beforehand (Fredrickson, 2003). "More accurate" refers in this case to the fact that the doctors took less time to integrate the information on the case and were less prone to basing themselves on initial impressions, and thus, to making premature diagnoses.

Other experiments (Isen et al., 1987) show that induced positive affective states, whether the result of watching a comedy or being given a small edible gift, helped the creative solution of problems. Specifically, they appeared to increase original, unpredictable associations and unusual combinations of elements.

In a similar line, it has been found that people exposed to images eliciting different emotions (joy, calm, fear or sadness) differ in their form of processing visual information. On performing a categorization task with no right or wrong answers, but rather responses that reflect a global or local form of perceiving a configuration of elements, those who experience positive emotions tend to select more global configurations –that is, they see the wood more than the trees (Fredrickson, 2001).

The relationship between positive affect and open, flexible thinking was analyzed specifically in another empirical study (Fredrickson & Joiner, 2002). After taking repeated measures of various positive emotions and indictors of open and flexible thinking, these researchers observed a mutual reinforcement between the two variables: the presence of positive emotions predicted future open and flexible thinking, while open and flexible thinking predicted subsequent positive affect.

All such results suggest that, in general, positive emotions facilitate receptive, flexible and integrative patterns of thinking, favouring the emission of novel responses. It is quite possible that this form of thinking, and not the opposite one, preceded the great discoveries and those achievements widely accepted as the most important in the history of humankind. It is difficult to imagine Michelangelo annoyed as he painted the Sistine Chapel, an irate Newton under the apple tree, or Edison, Marie Curie or Pasteur feeling depressed in their laboratories. On the other hand, it is easy to imagine them thinking about possibilities and alternatives, combining apparently incompatible elements, absorbed in their task, and excited at the prospect of their progress towards a desired goal that is highly meaningful for them.

POSITIVE EMOTIONS ARE RELATED TO HEALTH

If we consider that health is something more than the absence of illness, and that positive emotions are also something more than the absence of negative emotions, we can conceive of the utility of positive emotions for preventing illnesses, for reducing their intensity and duration and for attaining high levels of subjective well-being (Lyubomirsky, King & Diener, 2005).

Stating that positive emotions are related to levels of subjective well-being or happiness surprises no-one; on the other hand, that they prolong life is a more conjectural assertion, which requires more substantial proof.

In this context, a revealing study, which moreover in-

cludes excellent experimental control conditions, analyzed the state of health and longevity of 180 nuns who, in 1932, just before entering their religious order, wrote brief autobiographical sketches on their lives and on their future expectations (Danner, Snowdon & Friesen, 2001). The rationale of this study was that, given the homogeneous conditions in which the nuns had lived, the only variable to which the differences observed in their state of health and longevity could be attributed was the presence of positive emotions in the accounts they had written before taking their vows. Those nuns whose accounts reflected positive emotions (joy, desires, happiness) enjoyed better health and lived a mean of ten years longer than those who practically did not express emotions. Ninety percent of the nuns from the "happier" group were still alive at 85, in contrast to 34% of the other group.

In another important study, researchers assessed the health and emotional state of 2282 persons aged over 65 and followed them up over a period of two years. The results showed that the experience of positive emotions protected older people from the more negative effects of ageing and from disability; more importantly it successfully predicted who would live and who would die (Ostir, Markides, Black & Goodwin, 2000).

In a recent study, 334 healthy volunteers aged 18 to 54 were assessed in relation to their tendency to express positive emotions (happiness, satisfaction and calm) and negative emotions (anxiety, hostility and sadness). Subsequently, all were nasally administered drops containing the common cold virus. The results showed that those with a positive emotional style had lower risk of contracting a cold than those with negative emotional style (Cohen, Doyle, Turner, Alper & Skoner, 2003).

A possible explanatory mechanism of this protective effect on health derives from the hypothesis that positive emotions undo the physiological effects provoked by negative emotions (Fredrickson, 1998, 2003). A specific response tendency associated with the experience of negative emotions is an increase in cardiovascular activity (blood pressure, heart rate, peripheral vasoconstriction), which over time is directly related to numerous illnesses. Several experimental studies have shown how cardiovascular recovery in people who had seen clips from films inducing fear was quicker when they were subsequently shown clips that elicited a positive emotion (joy or surprise) than when they saw film extracts that were emotionally neutral or that provoked sadness (Fredrickson & Levenson, 1998), and how participants who smiled spontaneously as they watched an extract from a sad film recovered some 20 seconds before those who did not smile at all.

In another experiment the researchers provoked anxiety reactions in a group of students on telling them that in one minute they would have to give a speech on camera about why they considered themselves good friends, and that this speech would subsequently be assessed by their colleagues. In these conditions, four groups were formed: two watched films that elicited positive emotions (joy, satisfaction), one watched a film that elicited sadness, and a fourth group served as controls. The results (Fredrickson, 2003) showed that cardiovascular recovery in the participants who had watched the films eliciting positive emotions was more rapid than that of the control group, and much more rapid than that of those who watched the sad film.

Another possible action mechanism through which positive emotions would protect people from illness and disorders is that proposed by Aspinwall and cols. in a study which concludes that people who considered themselves happy were better at seeking out, assimilating and remembering information about health risks (Aspinwall, Richter & Hoffman, 2001).

Taken together, these data appear to indicate that positive emotions undo the negative effects generated by negative emotions, and that this would be associated with less wear on the cardiovascular system and a better state of health (Fredrickson & Levenson, 1998). This, combined with the fact that the experience of positive emotions predicts a high level of subjective well-being (this being understood as the average of positive and negative emotions) (Diener, Sandvik & Pavot, 1991), and that it also increases the probability of feeling good in the future (Fredrickson, 2001; Fredrickson & Joiner, 2002), makes it feasible to assign a leading role to positive emotions, at least in the areas of health and subjective well-being.

POSITIVE EMOTIONS INCREASE ONE'S CAPACITY TO COPE WITH ADVERSITY

Positive emotions also contribute to making people more resistant in the face of adversity, and help to build psychological resilience (Aspinwall, 2001; Carver, 1998; Lazarus, 1993; Lazarus, 1993; Lyubomirsky, King & Diener, 2005). Resilient people, those who in the face of adversity bend but do not break, are capable of experi-

encing positive emotions in stressful situations. Various studies have shown that more resilient people tend to experience high levels of happiness and of interest at moments of great anxiety generated experimentally (Fredrickson, 2001; Tugade & Fredrickson, 2004). The presence of positive emotions at times of adversity makes it more probable that people will make future plans, and such plans, together with the positive emotions, predict better psychological adjustment twelve months after having experienced a traumatic event (Stein, Folkman, Trabasso & Richards, 1997).

Likewise, positive emotions protect against depression, even in the wake of a truly traumatic experience. In a study using measures taken before and after the September 11th attacks in New York it was found that persons who, together with the dominant emotions of anguish, fear, disgust and contempt, also experienced, after the attacks, positive emotions of gratitude, interest, love, hope, pride, etc. presented fewer depressive symptoms and more optimism, life satisfaction and calm. Positive emotions appeared to be an essential active ingredient which, in addition to helping resilient people not to sink into depression, contributed to increasing their psychological coping resources (Fredrickson, Tugade, Waugh & Larkin, 2003).

Just as a negative affective state leads to pessimistically-focused thinking, and in turn to a still more negative affective state, in a spiral of reciprocal influence that can eventually lead to clinical depression (Peterson & Seligman, 1984), a positive affective state, favoured by the experience of positive emotions, would lead to open, integrative, creative and flexible thinking that facilitates effective coping with adversity and at the same time increases future levels of well-being (Fredrickson, 2001; Fredrickson & Joiner, 2002).

THERAPEUTIC APPLICATIONS

Psychology has prioritized the study of all that which impedes, restricts or hinders people's development, and has devised effective strategies for correcting many deficits and disorders. While the experience of negative emotions is inevitable, and at the same time useful from the evolutionary point of view, it is no less true that such emotions lie at the heart of many psychological disorders (O'Leary, 1990; Watts, 1992). The conscientious interest of psychologists in studying them and manipulating them has made a notable contribution to reducing the suffering of many people, but the need to continue improving the effectiveness of psychological treatment obliges us to explore new paths, and in such a context it does not seem outlandish to propose a more active role for the positive emotions in the prevention and treatment of numerous disorders. Indeed, it is even reasonable to suggest that part of the effectiveness of many of the psychological intervention techniques and strategies already developed is attributable to the fact that they generate positive emotional states, or create the conditions necessary for such states to emerge (Fredrickson, 2000a). Relaxation techniques, for example, are particularly widely used in the treatment of anxiety disorders, and, according to Fredrickson, are effective because, in one way or another, they bring about the appropriate conditions for contentedness (internal calm, perception of oneself and of one's relationship with the world). Imagining pleasant scenes (real or otherwise), acting out an agreeable situation with conviction, relaxing the muscles, and so on, are strategies that encourage a person to savour the present moment and that facilitate the integration of experiences.

Something similar occurs with behavioural techniques that propose an increase in the number of pleasurable activities for treating disorders such as depression. Obviously, doing pleasurable activities chosen by oneself increases the levels of positive reinforcement received and makes more probable the appearance of different positive emotions, which would counteract the presence of negative ones.

Cognitive therapies, for their part, stress the view that it is not the negative events in themselves that lead to depression, but rather people's explanations of them, generally internal, stable and global (Abramson, Seligman & Teasdale, 1978; Peterson & Seligman, 1984), so that they try and substitute these explanations for others that are external, unstable and specific. This strategy, known as learned optimism, has proved to be effective for preventing and treating depressive disorders. The key to its efficacy may lie in the attempt to annul the effect of negative meanings, though this does not necessarily imply substituting them with positive ones. However, it is this aspect on which some authors are beginning to insist, on proposing complementary strategies for finding positive meanings in everyday life, such as the positive reappraisal of adverse events, the positive appraisal of everyday events or the establishment and achievement of realistic targets (Folkman & Moskowitz, 2000; Folkman, Moskowitz, Ozer & Park, 1997). The empirical data

show that such everyday sources of positive meaning predict recovery, in the long term, from depressed affective states and of psychological well-being (Folkman, Chesney, Collette, Boccellari & Cooke, 1996), so that continuing to explore the possibilities of strategies focusing on the positive is highly relevant for research, and quite probably useful for increasing the effectiveness of treatments.

DESCRIPTION OF SOME POSITIVE EMOTIONAL STATES

Despite the fact that in our vocabulary there are more terms for referring to negative emotions than to positive ones (Averill, 1980), and that this probably makes us much more conscious of negative affective states than of positive and pleasurable ones (Avia & Vázquez, 1998), it is nevertheless possible to make an effort of self-observation to identify positive emotional states as a first step towards trying to intensify them.

There are more positive emotions than we might at first imagine, and they may revolve, according to Seligman (2002), around the past, the present and the future. Examples of positive emotions referring to the past are satisfaction, indulgence, personal accomplishment, or pride. Those referring to the present are, among others, joy, ecstasy, calm, enthusiasm, euphoria, pleasure, elevation and flow. Finally, positive emotions referring to the future are optimism, hope, faith and confidence. There follows the description of two positive emotional states referring to the present that tend to be overlooked, but which nevertheless involve significant psychological and social benefits.

Elevation

Elevation is a positive emotion experienced as a strong feeling of affect in the chest (Haidt, 2000, 2002). It occurs when we are witness to acts that reflect the best in human beings, and provokes a desire to be better people. It is what one feels when (with unfortunate infrequency) the news media report the story of an anonymous person who forgot about their own interest and risked their life for someone else, or, less dramatically, acted out of consideration for the good of others, and not their own. Elevation is what many people probably felt when they saw how, in the wake of the March 11th attacks in Madrid, hospital patients gave up their beds to the wounded, taxi drivers offered their cars free of charge to victims' families, the city's inhabitants volunteered in their thousands to donate blood, and so on. Elevation is what we feel even on recalling such things.

The experience of this emotion makes it more probable that we want to be with, cooperate with and help other people (Isen, 1987; Isen & Levin, 1972; Oatley & Jenkins, 1996; Seligman, 2002), and this brings substantial psychological and social benefits. On the one hand, people who after feeling this emotion decide to take action and help others can feel proud of their good intentions and satisfied with their actions. And at the same time, the people being helped can feel another important positive emotion, gratitude, and those who are simply witnesses to this helping relationship can experience elevation, which will provoke further desires to be better people and to help others. This positive spiral has beneficial social effects in terms of solidarity, altruism, cooperation, etc., and contributes in an effective way to creating social support networks and to strengthening the social fabric. In sum, it makes for improved quality of life in communities, groups and organizations (Fredrickson, 2001).

Flow

Flow is a positive emotional state (Csikszentmihalyi, 1975, 1990; Csikszentmihalyi & Csikszentmihalyi, 1988) felt at times when we are totally involved in the activity we are doing, to the extent that nothing else seems to matter to us. People experiencing flow feel that they are in control of their actions and masters of their destiny; they feel a sense of jubilation and of profound satisfaction, beyond simple fun or recreation. This experience is in itself so pleasurable that it leads one to continue with the activity, despite the presence of costs and obstacles.

Flow occurs when the person's capacities or skills are in equilibrium with the challenges of the activity. In such circumstances, attention is focused on the achievement of a realistic goal, the feedback obtained on performance level is immediate, and one actually forgets oneself. A colloquial expression that neatly sums up this state would be of the type: "while I was doing... time just flew by".

Numerous activities are capable of producing flow: playing chess, painting, climbing, running, composing and playing music, dancing, writing, and so on. It is easy to see the beneficial social and cultural effects of total involvement in such activities: works of art, pieces of music or sporting achievements that go down in history, and which, in sum, come to reflect what distinguishes human beings from the other animals. But moreover, it is

possible to experience flow in the course of activities that have not been freely chosen, or that are reinforced extrinsically (by a salary, for example), and which at first sight would not appear to be chiefly motivated by the pleasure of doing them. Csikszentmihalyi (1990) describes fantastic experiences of flow in surgeons, assembly line workers, scientists, mothers looking after their children, concentration camp prisoners, and so on. The point is that some individuals manage to transform routine tasks, boring jobs or truly adverse circumstances into subjectively controllable experiences, from which they can extract some degree of satisfaction, and which on occasions have brought about discoveries, innovations or creations that changed the course of history.

For the positive perspective within psychology, which we would qualify as, while perhaps not new, certainly important and necessary, there is a great deal of work ahead. First of all, it must overcome the limitations involved in research on emotional processes. Psychology, as Ruut Veenhoven points out, has been more successful in understanding thought than in understanding emotion, and while it is clear that events and their appraisal evoke affective experiences, the internal production of such experiences is still barely understood (Veenhoven, 1994). Moreover, it is necessary to identify the antecedents, the elicitors of different positive affective states, to make progress in the development of valid and reliable measures, to gather evidence about their effects on different variables, and to explain the precise mechanisms that lead to such effects.

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POSITIVE EMOTIONS: POSITIVE HUMOUR

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Laughter and humour deserve an important role within positive psychology, defined as the study of positive emotions, states and institutions. Laughter produces one of the most pleasurable feelings of human experience, and stimulates positive behaviours such as play, learning and social interaction. The sense of humour, as a personality trait, is one of the basic signature strengths of human beings. Many have attributed to both of these phenomena important physical, psychological and social benefits. However, few theorists and researchers within positive psychology have investigated them in detail, partly because laughter and humour continue to resist theoretical definition and because their empirical study presents serious methodological problems. In this paper, the authors examine the relevance of laughter and humour, particularly positive humour, and review the current state of knowledge regarding these phenomena.
Key words: *humor, humour, laughter, emotions, positive psychology, strengths, stress, broaden and build.*

La risa y humor merecen un importante protagonismo dentro de la psicología positiva, definida como el estudio de las emociones, los estados y las instituciones positivas. La risa produce una de las sensaciones más placenteras de la experiencia humana, y estimula comportamientos positivos como el juego, el aprendizaje y la interacción social. El sentido del humor, como rasgo de la personalidad, es una de las principales fortalezas del ser humano. Se les atribuyen a ambos importantes beneficios físicos, psicológicos y sociales. Sin embargo, aun son pocos los investigadores y teóricos de la psicología positiva que han tratado estos fenómenos en detalle, en parte porque la risa y el humor siguen resistiéndose a una definición teórica y al estudio empírico. En este artículo, los autores examinan la relevancia de la risa y el humor, especialmente el humor positivo, a este campo, y revisan el estado actual del conocimiento sobre estos fenómenos.
Palabras clave: *humor, risa, emociones, psicología positiva, fortalezas, risoterapia, estrés.*

"Life is too important to be taken seriously"

-Oscar Wilde

Sense of humour is a unique capacity of human beings that is highly valued in many, if not all cultures. Numerous psychological benefits (states and sensations of joy, well-being and satisfaction, reduction of stress, prevention of depression) are attributed to it, as well as physical benefits (tolerance of pain, activation of the immune system, improvement of the cardiovascular system) and social ones (improved motivation, communication and social order and harmony). Research in the nascent field of humour studies has provided certain empirical support for some of these assertions, even if there are still many unknown quantities and contradictions in the literature.

What is beyond any doubt is that laughter and sense of humour merit a leading role within positive psychology, defined as the study of positive emotions, states and institutions. Laughter produces one of the most pleasurable sensations of human experience, while sense of humour is one of the principal strengths of our species, and figures, indeed, in Seligman and Petersen's VIA Strengths classification. In the laboratory experiments of positive psychologists such as Barbara Fredrickson, comedy videos are an essential tool, given the ease with which they can elicit positive emotions in subjects. However, few researchers and theorists within positive psychology have examined these types of phenomena in detail, partly because laughter and humour continue to be resistant to theoretical definition and empirical study. Almost two thousand years ago, Quintiliano already lamented the fact that "nobody has managed to explain laughter in a satisfactory manner, even though many have tried" (cited in Eastman, 1921: 132). Today, despite having much more data on the laughter of animals, the structure of

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**http://www2.uah.es/humor_salud*
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jokes or the neurochemical processes involved, we are still practically in the same situation.

In this article, and despite these difficulties, we look at what is known and what is not known about sense of humour and its benefits, concentrating on its relationship with the field of health and well-being.

DEFINITION OF HUMOUR AND RELATED CONCEPTS

The term "humour" has more than one meaning (more relevant in Spanish, but also to some extent in English); at the same time, even agreeing on a broad definition, researchers and theorists working in "the study of humour" have not reached a consensus on the definitions of the different concepts and phenomena in this field. This is in part due to the failure of psychology and other sciences to explain the mechanism of laughter, one of the oldest mysteries of human behaviour.

In this article we shall avoid use of the word "humour" in the sense of "mood" (as in the expressions "good humour" or "bad humour"). A substantial part of positive psychology refers to different emotions or states that characterize good mood or "good humour" (joy, satisfaction, gratitude, hope, optimism, calm), but what interests us here is something more specific.

When researchers in Positive Psychology such as Martin Seligman talk of **sense of humour** as one of the human strengths, they refer to a **capacity for experiencing and/or stimulating a highly specific reaction, laughter** (observable or not), and thus achieving or maintaining a positive mood[11] Christopher Peterson and Martin Seligman define the strength "Playfulness and humor" in the following way: "You like to laugh and to make others smile. It is easy for you to see the funny side of life." (Seligman 2002a).

. Laughter is also the (only) linking element between the heterogeneous researchers of the multidisciplinary International Society for Humor Studies, and the scales developed in this field to measure sense of humour have always referred to laughter as a starting point.

We define laughter, in turn, as a **psychophysiological reaction** characterized [1] externally by repetitive vocalizations (typically transcribed as ha-ha, hee-hee, etc.), an easily recognizable facial expression (mouth in a closed or open smile, commissures of the eyes wrinkled), certain characteristic body movements (of the abdomen, shoulders, head, and in cases of intense laughter, the whole body) and a series of specific neurophysiological processes (respiratory and circulatory changes, activation of the dopaminergic system and other neurochemical circuits, etc.); [2] internally by a recognizable subjective sensation (which we shall call **hilarity**), pleasurable to a greater or lesser extent.

Laughter can be considered a positive emotion, or at least the cause or external reflection of a positive emotion (hilarity). The pleasure it provides has been compared with sexual orgasm and other pleasurable reactions of the organism, and indeed it activates the dopaminergic mesolimbic reward system, associated with diverse hedonic sensations (Reiss, Mobbs, Greicius, Eiman & Menon, 2003)

We shall reserve the term **humour** to refer to the various causes of laughter, which is the commonest meaning in ordinary language (black humour, blue humour, harmless humour, satirical humour, ironic humour witty humour, crude humour, absurd humour, oral humour, literary humour, graphic humour, physical humour, improvised humour, etc.). We shall also consider as humour cases of **non-intentional humour**, such as slip-ups, blunders or clumsy mistakes, since, although they are not usually thought of as "humour", it is difficult, in practice, to distinguish them from intentional humour. In sum, we shall define humour as **any stimulus that can provoke laughter in a subject**: games, jokes, funny stories, cartoons, embarrassing situations, incongruences, practical jokes, tickling, and so on. As we already pointed out, there is no commonly accepted theory to explain how humour provokes laughter, what types of humour can be distinguished or how to describe the relationships and differences between these types. Of the numerous monocausal theories proposed, the most well known are those that identify the stimulus of laughter with feelings of superiority, with incongruence, with the release of cognitive/emotional tension, or with play (see Jáuregui, 1998).

Within the great variety of humour there are many types in which laughter is hostile or aggressive (one person laughing at another), or people take lightly matters that are considered tragic, serious or sacred by others,

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provoking discomfort or offence. Some theorists leave these types out of the definition de "humour", reserving the term to refer exclusively to inoffensive and well-intentioned types of humour. We have preferred to include them in the idea of "humour", first of all because students of humour also analyze satire (sometimes caustic), black, blasphemous and obscene humour, and aggressive laughter; and second, because the line between "aggressive" and "inoffensive" humour is subjective and changeable –what offends me today may make me laugh tomorrow, and what I find funny (or inoffensive) may be offensive to you. Even so, we shall adopt the term **positive humour** to refer to the **type of humour that provokes inoffensive laughter, at least in its intention**, distinguishable from **negative humour** (aggressive, offensive, etc.). We can also speak of a **positive sense of humour**, which seeks to provoke laughter in oneself or others without offending or attacking anyone, as opposed to **negative sense of humour**, which seeks to provoke laughter even at the expense of others.

THE STUDY AND APPLICATION OF HUMOUR

Laughter and humour are topics that have aroused the interest of philosophers and scientists since at least the times of Ancient Greece. Plato and Aristotle developed some of the first known theories on comedy and mockery, and since then some of the most brilliant minds of our intellectual tradition have pondered on the nature and functions of humour, among them Hobbes, Kant, Schopenhauer, Bergson, Spencer and Koestler (Jáuregui, 1998).

Today, and especially since the 1970s, research on humour is being carried out in different disciplines, including psychology, medicine, nursing, physiology, biology, sociology, anthropology and education, as well as in areas such as information technology, cinema studies, history, linguistics, literature, mathematics and philosophy (Carbelo, 2005). Contributions to the literature on humour include theoretical works, empirical research, applications in specific areas such as therapy, education or business, and of course notes, replies to journal articles and letters to editors. Numerous books have also been published in the field. The International Society for Humor Studies (ISHS) publishes: Humor: International Journal of Humor Research, and has been organizing an International Conference since 1976 (Cardiff, Wales), originally held every three years, then every two, and now annually. In 2008 it is due to be held at the University of Alcalá, in Spain.

Also on the increase is the number of people and organizations working in the application of humour in different contexts. Of the organizations involved in therapy it is important to mention the American Association for Therapeutic Humor (AATH), whose members are committed to advancing, understanding and increasing knowledge about humour and laughter in relation to curative aspects and the generation of well-being. The AATH also holds an annual conference to present the results of recent research, and organizes seminars and courses run by different universities on theoretical and practical aspects of sense of humour. The basic objectives of this Association, created with a view to helping health professionals learn about the potential practical uses of humour, are the promotion and development of behaviours that contribute to well-being based on laughter and good humour.

In Europe, and in Spain in particular, there are a growing number of initiatives related to the study and application of humour. Since 2004, the *Fundación General* at the University of Alcalá (Spain) has organized an annual multidisciplinary meeting on the subject, in collaboration with several other Spanish universities: *Humor Aula*. There are now university courses in Spain on subjects such as graphic humour, therapeutic humour and humour in communication (Carbelo, 2005: 204). Associations such as *Payasos sin Fronteras (*Clowns without borders*), Fundación Teodora, La Sonrisa Médica* (The Medical Smile)*, Pallasos d'hospital* (Hospital Clowns) and others are dedicated to improving the well-being of children (and their families and caregivers) in war zones or in hospital. Furthermore, various consultants, companies, health professionals and alternative therapists offer sessions and courses for helping their clients to generate and apply laughter and sense of humour with diverse aims.

METHODOLOGICAL ISSUES

Laughter and humour present significant challenges to scientific study and analysis. Laughter is a phenomenon that flourishes precisely in contexts far removed from those of control and measurement that characterize the experimental paradigm: informal meetings, bars, the lovers' bed, play. Psychologists who have tried to study these topics in the laboratory have found it practically impossible to generate authentic bursts of laughter in that

environment (Chapman, 1983: 137). This explains why the majority of experiments in this area have used self-report scales in which participants assess the intensity of their internal humour reaction, indicating how "funny" they find a joke, etc.

Another problem is that the cause of laughter is a perception, the result of a cognitive evaluation whose nature continues to evade scientific understanding[22] It could be argued, as have some theorists (Nussbaum, 2001; Sartre, 1971; Solomon, 1993), that an emotional reaction such as laughter is not "provoked" by cognitive events such as mental perceptions or appraisals, and that laughter is a unitary emotion that reacts directly to external stimuli, constituting in itself a value judgement. In any case, it would be necessary to identify these causes and the relationships between them.

. There are a multitude of events that provoke or can provoke laughter and hilarity, but we cannot observe directly which specific aspect of such events triggers this reaction, which would explain the relationship between a witty joke, a humorous blunder and tickling, to mention just three examples.

From the point of view of positive psychology, one of the most relevant methodological problems is the measurement of "sense of humour". A reliable measurement would allow researchers to establish relationships between this trait and diverse aspects of well-being and of mental and physical health. There are currently available various instruments created with the aim of quantifying the degree of development of an individual's sense of humour. These scales, all in English, are designed to reveal the extent to which, and in which situations, individuals tend to laugh, smile, create/share humour, accept/reject the humour of others, and so on. There are scales that measure attitudinal or behavioural aspects of humour, such as the Sense of Humor Questionnaire (SHQ, Svebak, 1974), the Coping Humor Scale (CHS, Martin & Lefcourt, 1983), the Situational Humor Response Questionnaire (SHRQ, Martin & Lefcourt, 1984) or the Multidimensional Sense of Humor Scale (MSHS, Thorson & Powell, 1991, 1993a, 1993b; Thorson, Powell, Sarmay-Schuller & Hampes, 1997).

The SHQ scale (Svebak, 1974), with later developments leading finally to the SHQ-6 scale (1996), includes skills for perceiving humour, and is made up of self-descriptive statements response options correspond to a 5-point Likert scale and go from "totally agree" to "totally disagree". Some examples are "I easily recognize….a hint or a change in intonation that indicates humorous intention", or "People who are always trying to be funny are actually irresponsible people who cannot be trusted."

Martin and Lefcourt's CHS scale proposes the measurement of the individual use of humour as an adaptive response to stressful life events. It contains statements with which respondents indicate their level of agreement, scoring on a 4-point Likert scale. Typical items are "I sometimes lose my sense of humour when I'm having problems" and "I normally look for something funny to say when I'm in tense situations" (see Idígoras, 2002).

These authors extended the original questionnaire to cover situational humour responses, designing an instrument (the Situational Humour Response Questionnaire, SHRQ, Martin & Lefcourt, 1984) through which they tried to measure the frequency with which people laugh or smile and find things funny in different everyday situations. This instrument requires respondents to indicate what their response would be to 21 hypothetical situations. An example of the situations (see Idígoras, 2002) is: "if you arrive at a party to find that another person is wearing exactly the same dress or suit as you: A) I would not find it funny. B) I would find it funny, but I would not show it. C) I would smile. D) I would laugh. E) I would laugh out loud."

The two instruments developed by Martin and Lefcourt have acceptable internal consistency, and are referred to in many studies in which the measurement of humour in specific situations or in relation to other indicators has particular relevance.

The Multidimensional Sense of Humor Scale (MSHS), by Thorson and Powell (1991, 1993a, 1993b), was developed, validated and employed in applied studies in which humour was linked to certain personality dimensions, to anxiety control or to depression, and also in cross-cultural studies. Its authors consider the instrument

[2] It could be argued, as have some theorists (Nussbaum, 2001; Sartre, 1971; Solomon, 1993), that an emotional reaction such as laughter is not "provoked" by cognitive events such as mental perceptions or appraisals, and that laughter is a unitary emotion that reacts directly to external stimuli, constituting in itself a value judgement. In any case, it would be necessary to identify these causes and the relationships between them.

to assess humour from various points of view, which explains the inclusion of the term "multidimensional": the creation or generation of humour, the use of humour for coping with life, the sense of play, the recognition and appreciation of humour, attitudes towards humour and the practice and use of humour in social situations. Each person's humour is determined by the scores obtained for each one of the elements and for their sum total.

The MSHS is made up of 24 items, and Thorson and Powell (1993a) collected data in a first round of the study with 264 participants aged 17 to 77, of whom 153 were women and 111 were men, with a mean age of 32.3 and a standard deviation (SD) of 13.5. Cronbach's alpha coefficient was 0.89. Thorson and Powell (1993b) also collected responses to the scale from a sample of 426 people in the state of Nebraska (USA), aged 18 to 90 years, with a mean age of 37.9 and an SD of 21.7. Scores ranged from 31 to 96 points, with a mean value of 71.8 (SD = 12.9) and a median of 72 points. Cronbach's alpha for this sample was 0.91, with 61.5% of variance explained by the four factors. No significant differences were found for age or gender.

The MSHS has been employed in analyses of the relationships between humour and other personality traits (Hampes, 1993; Hampes, 1994; Humke & Schaefer, 1996; Thorson & Powell, 1993c) as well as in cross-cultural comparisons (Thorson, Brdar & Powell, 1997), and factorial studies have reproduced a factor structure similar to the original one by means of orthogonal rotation.

Each of these scales represents one (or various) possible definitions of the term "sense of humour". Which one is the "sense of humour" that is supposedly beneficial to mental, physical and social health? This is one of the unresolved questions in the field of humour studies.

THE EFFECTS OF HUMOUR ON HEALTH

The notion that laughter and humour are beneficial to health is not a new one, though in recent decades some famous cases of "cures" through the consumption and/or production of comic material (Cousins, 1979), the proliferation of diverse therapies and clinical interventions related to humour, and the scientific study of these phenomena have generated considerable media and public interest in the topic. As for empirical evidence, it can be said that there are currently some indicators of the therapeutic value attributed to humour, but it is still too early to assert that laughter is "the best medicine". As some researchers have pointed out, for example, not all medical studies support the thesis of a therapeutic effect, such studies are often methodologically deficient, the majority of them are carried out on a small scale, and in any case it is not clear what is the mechanism that produces the hypothetical benefits (Martin, 2004). It is probable that humour, and especially positive humour, has beneficial effects for health, but it has still to be adequately demonstrated what they are, how they work, in which cases they occur, and their weight, scope and limits. A greater research effort is required in this area, with more wide-ranging and scientifically rigorous studies (not to mention the essential funds to finance them).

In general, it can be said that the therapeutic effects for which there is most evidence refer to short-term psychophysical benefits, more preventive or palliative in nature. Laughter is capable of reducing the stress and anxiety that directly reduce quality of life and indirectly affect physical health. Sense of humour promotes good mood, which in turn helps people to get through periods of illness and can prevent depression. The enjoyment of comedy is capable of raising tolerance to subjective pain for at least half an hour –a finding replicated in numerous studies (Zweyer, Velker & Ruch, 2004). Sense of humour may even contribute, as we shall see later, to a subjective perception of better health, which is no small matter.

The hypothetical longer-term benefits have been attributed to diverse mechanisms that can influence physical health. Each one of these models deals with different aspects or components of humour and different conceptualizations of sense of humour. First of all, one model focuses on the act of laughter itself, and on physiological changes in the musculo-skeletal, cardiovascular, endocrine, immunological and neuronal systems associated with it (Fry, 1994). For example, laughter is associated with changes in the circulating catecholamines and in cortisol levels (Hubert & de Jong-Meyer, 1991, Hubert, Moller & de Jong-Meyer, 1993), which in turn may have a substantial effect on various components of the immune system (Dantzer & Mormede, 1995). Likewise, the hypotheses proposed in relation to the possible beneficial effects of vigorous laughter refer to the reduction of muscular tension, increased levels of oxygen in the blood, exercise of the heart and circulatory apparatus, and the production of endorphins (Fry, 1994). According to this model, the

act of laughing is a crucial component, and the same health benefits cannot be expected from perceived humour and fun without the laughter element. Indeed, there exist, for example, "laughter therapy" techniques, based on the idea of forcing laughter in the absence of humour (Kataria, 2005).

A second possible mechanism through which humour can affect health involves the positive emotional state that accompanies laughter and humour (Argyle, 1997). Thus, positive emotions, regardless of how they were generated, can have analgesic effects, stimulate immunity or have the effect of neutralizing the adverse consequences of negative emotions (Fredrickson, 1998). Humour and laughter can thus help to neutralize negative emotions, together with positive emotions such as love, hope, joy or happiness.

A third potential mechanism is related to the hypothesis of the moderating effect of humour on stress. In this case, the benefits of humour refer to stress control or coping through the cognitive appraisal provided by sense of humour as a perspective or view on life (Martin, Kuiper, Olinger & Dance, 1993), as well as the reduction of stress that laughter brings (Yovetich, Dale & Hudak, 1990). Thus, more than having effects on physiological health, humour has an indirect effect, interacting with stress level and reducing the level that can have a negative effect on health. There is evidence that stressful experiences can have adverse effects on various aspects of health, including the immune system (Adler & Hillhouse, 1996), as well as increasing the risk of infectious diseases (Cohen, 1998) and cardiac problems (Esler, 1998), through activation of the hypothalamic-pituitary axis and the sympathetic-adrenal system. According to this model, the important element is the cognitive dimension of humour, rather than laughter as such. Sense of humour can be a moderating variable of stress, bringing a new perspective to stressful situations, in an adaptive strategy similar to that of positive reinterpretation. This means that the beneficial effect of humour would occur in times of stress and adversity, being less relevant for health in non-stressful circumstances. This view also introduces the possibility that some forms or styles of humour may be more adaptive and stimulating for health than others. For example, sarcastic or cynical humour that serves as a defence mechanism of evasion or denial may be less appropriate for adaptation to stress than the more positive forms of humour.

Finally, the hypothetical beneficial effect of humour on health may be mediated by social support. Thus, people with a strong sense of humour may be more socially competent and attractive, leading to closer and more satisfying social relationships. This higher level of social support may in turn have inhibitory effects on stress and stimulatory effects on health –effects that are indeed demonstrated in numerous studies (Cohen, 1988; Cohen, Underwood & Gottlieb, 2000). In this model, the focus is on the interpersonal aspects of humour and the social competence with which the individual expresses humour in a relational context, more than simply on the laughter response or the stimulatory aspect of comedy.

One of the reasons for exercising caution in this field is that not all research has found a positive relationship between humour and health. One of the largest-scale studies in the area, for example, in which 65,000 people participated, was unable to find any correlation between sense of humour (measured with the SHQ scale) and diverse objective measures of health (Svebak, 1996). It is interesting, however, that this study, like certain others (e.g., Kuiper & Nicholl, 2004), did detect a relationship between sense of humour and subjective perception of better health, which may help to explain the popular notion that humour is healthy.

Some studies have even actually found a negative relationship between humour and health: that people with more sense of humour suffer more illness and have a higher mortality rate than more serious people (Friedman, Tucker, Tomlinson-Keasey, Schwartz, Wingard & Criqui, 1993; Kerkkanen, Kuiper & Martin, 2004). Analysis of the results of these studies suggests that persons of a happy, optimistic and funny disposition may have a greater tendency to participate in risky activities and to pay less attention to physical pain, which would in turn contribute to poorer health.

Some researchers have begun to adopt a more sophisticated approach, trying to find interactions between sense of humour and other personality variables, or differentiating between different "senses of humour". For example, a recent study with 1000 participants found an interaction between sense of humour and general attitude to life, in relation to medical symptoms. In the case of participants who put a high value on their life, more sense of humour was related to better health, while for those who valued their life less, the relationship was in the opposite direction: more sense of hu-

mour was associated with poorer health (Svebak, Gotestam & Naper, 2004). Different relationships have also been found between health and different types of "sense of humour". For example, Kuiper, Grimshaw, Leite and Kirsh (2004) found a relationship between positive humour practices (to overcome obstacles and problems, to laugh at life's absurdities, or to make others laugh) and better mental health (less depression and anxiety, and positive emotions; higher self-esteem and positive emotions). But this relationship did not emerge in the case of some negative humour practices (aggressive or offensive humour), and it was inverted in the case of others (self-criticism in front of others to make them laugh).

In conclusion, humour can undoubtedly play an important role in the therapeutic process, but the effects confirmed by research so far are somewhat localized, short-term and preventive or palliative (tolerance of pain, reduction of stress, coping with illness and a more positive view of it, etc.). It is possible, and even probable, that a relationship will also be confirmed between sense of humour and health, but the most recent studies suggest that the benefits may depend on the sign (positive or negative) of the sense of humour, and/or on its interaction with other personality aspects, such as the value people attach to life.

HUMOUR IN RELATION TO PSYCHOTHERAPY

Various psychologists have recommended the use of humour in the consulting room, arguing that it can provide substantial benefits in the development of the psychotherapeutic relationship and of patient growth (Forsyth, 1993; Fry & Salameh, 1987, 1993, 2001). According to these professionals, humour can serve to establish an appropriate therapeutic relationship, to guide diagnosis, to facilitate the expression of the emotions and emotional work, and to help patients observe themselves and distance themselves from their problems.

First of all, humour can be employed simply to smoothen the contact between patient and therapist. For example, it can help to establish communication between them, to strengthen the therapeutic link, to reduce potential hostility or anxiety that may occur during the session, and to make therapy a more gratifying experience. Brooks (1994, cited in Bernet, 2004: 141-142) recounts a dramatic example of the use of humour at the start of his first meeting with a conflictive fourteen-year-old:

> They brought young Jim because of his poor school results, his petty shoplifting and his hostility towards his family. On entering the therapist's consulting room for the first time, Jim said "You're the ugliest psychologist I've ever seen in my life." Brooks rapidly considered his options and chose one that was as humorous as it was disconcerting for his new patient: he proposed doing the interview from inside the wardrobe so that Jim didn't have to look at him! In the second session they followed the same procedure –Jim still thought the therapist was ugly, and Jim asked him to get into the wardrobe. At the start of the third session, Jim said "You're not as ugly as I thought you were at first. Today you don't have to get in the wardrobe."

Secondly, an analysis of the patient's use of humour can facilitate the diagnosis. Since Freud (1905), various psychologists have asked their patients to tell them their favourite joke so as to delve into their subconscious, with the idea that, as in the case of dreams, important themes in the patient's mental life are expressed through the jokes they tell. Likewise, excessive or nervous laughter, or a cruel, sarcastic or simply non-existent sense of humour can give the therapist clues when it comes to discerning their problems. Furthermore, the most sensitive topics can often be recognized through the lack of humour expressed in relation to them, while the ability to laugh about a problem may be a sign that the patient is getting over the situation.

One of the most widely cited advantages is the capacity of humour to transmit messages that are potentially volatile, threatening or difficult, and which regularly arise in the therapeutic context. Humour favours a framework that encourages expression of the emotions, and in particular makes expressions of hostility and of other negative emotions more acceptable. It can also serve to break down patients' defences, permitting them to change their attitude, express themselves or acknowledge a truth without feeling threatened. Waleed Salameh, one of the most prolific authors in this field, has developed a complete "self-improvement system" based on the use of stories, proverbs and humorous parables that succeed in transmitting a relevant message to the patient in a way that is both entertaining and pertinent (Salameh, 2004). Patients may be offended or may show resistance if the therapist tells them their behaviour is absurd (for exam-

ple, that they are seeking the solution to their problems in the wrong place). But if the therapist tells the patient the joke about the idiot who looked for his keys under the streetlamp (not because he lost them there, but because there is more light there), he might help his patient to grasp the message better, first by laughing (at the character in the joke, and perhaps at herself), and then by considering the therapist's proposal with more interest.

There are also certain therapies that have used humour as a tool with a highly specific function. One example is the use of humour in the treatment of phobias developed by Ventis, Higbee and Murdock (2001) as a variation of the classic progressive desensitization paradigm. The therapist asks the patient to make up jokes and cartoons related to the object of his fear –spiders, snakes, the dark, etc.– in order to help him replace the negative emotions associated with his fear with the positive emotion of laughter. Using this method, Ventis has obtained results at least as good as those obtained with more traditional methods.

Finally, sense of humour can permit patients to observe themselves in a more objective and distanced way without feeling threatened, helping them to overcome their drama and see it from the comical point of view. It can help patients to create a psychological distance between their problems and their personal identity, creating a more resistant and healthier self. Albert Ellis (1980), in his Emotive Rational Therapy, recommended confronting the client with her irrational beliefs, exaggerating them to the point of absurdity, so as to provoke a comic perspective on her own behaviour and dysfunctional ideas. In the "12 Steps" programme of Alcoholics Anonymous, participants recount instances of their absurd and incoherent behaviour whilst under the influence of alcohol, to the laughter of the whole group, which helps them to create a divide between their former personality and the new, sober person they wish to be (Brown, 2004).

Various therapists have expressed serious doubts about the idea of using humour in the consulting room, and indeed, the majority of those who recommend this practice acknowledge that it may have contraindications. In 1971, Lawrence Kubie wrote an influential article entitled "The destructive potential of humour in psychotherapy", in which he pointed out some of these possible dangers. According to Kubie and other authors, humour can be employed to avoid communication about painful feelings, resulting in inhibition or stagnation of the therapeutic progress. If the patient interprets the therapist's use of humour as sarcasm or lack of respect for her, her family or another social group she may interpret it as a form of attack, which could generate conflict or hostility. If we allow the patient to use self-destructive or negative humour, we may contribute to the problem instead of solving it. Furthermore, excessive use of humour may give rise to doubts in the patient and a loss of confidence in the professional. With regard to these dangers, the professionals who recommend the use of humour in therapy warn that they mean "positive humour", as we defined it above: constructive rather than destructive, integrative rather than aggressive, aimed at the solution of problems, and above all suited to the moment, the patient and the therapist's style. They also admit that errors may sometimes be made, but stress that it is worth the risk. Albert Ellis, on being asked whether he had had experiences in which humour had the opposite effect to the desired one, replied: "Yes, but I have also had experiences in which seriousness had the opposite effect to the desired one" (cited in Chance, 2004).

SENSE OF HUMOUR IN THE HEALTH PROFESSIONS

Positive humour is relevant not only to the health of physical and mental patients, but also to that of their carers –doctors, psychologists, nurses, therapists, family– who have to attend to their needs and work for their recovery and well-being. Healthcare can often be highly stressful, since, in addition to the pressures, scarcity of resources and problems associated with any job, health workers and carers have to cope with dramatic emotional situations, highly unpleasant scenes, extreme responsibility, life-threatening situations and other elements liable to affect their mental equilibrium.

A large proportion of such stress is due to a lack of adaptive strategies (Decker & Borgen, 1993). In undergraduate and postgraduate training of health professionals, many important aspects –such as the development of self-control, self-esteem and self-motivation and forms of improving one's mood– are given far less attention than they deserve. The learning, cultivation and development of positive and creative attitudes are not high-priority items in study programmes. Terms such as joy, solidarity, optimism and good humour do not appear on syllabuses, either as theoretical or as practical subjects.

However, diagnosis, care and treatment in relation to the health of others require high doses of energy, espe-

cially if the professionals involved are expected to be models of optimism and good humour for human beings who are suffering. Insofar as sense of humour is capable of infusing professionals with this mental energy and helping them to control and overcome their impotence, it can be highly beneficial for everyone involved in the healthcare context.

The relationship between the stressful elements of work and adaptation strategies for professionals is a crucial one with regard to the perception and interpretation of problems. Better adapted people perceive themselves to have fewer problems, and suffer less stress. Recent research suggests that one of the strategies that best supports good adaptation is the use of sense of humour at work (Mornhinweg & Voigner, 1995; Decker & Rotondo, 1999; Cohen, 2001; Spitzer, 2001; Yates, 2001).

Health professionals should attend not only to the demands of patients, but also to their own need for care. Experiences teaches that one must learn to maintain a healthy and optimistic mood and to transmit coherence and empathy, that it is more positive for the work environment not to get angry with one's work team, not to exaggerate problems, and to devote time to having fun and enjoying life, and that it is unhealthy to dwell too much on day-to-day events.

THE ROLE OF LAUGHTER IN THE BROADENING AND BUILDING OF THE INDIVIDUAL REPERTOIRE

Fredrickson (1998; 2000) proposes that positive emotions can broaden the individual's repertoire of thoughts and action and promote the construction of resources for the future. This "broaden and build" theory has interesting applications in the case of laughter.

On the one hand, various researchers and theorists have stressed the cohesive power of humour (or at least of positive humour, since the negative kind can have the opposite effect) (Martineau, 1972). Laughter is a predominantly social phenomenon, and when shared produces an effect of bringing together and reducing distances, or even of diminishing conflict and hostility. Thus, laughter can help to build the interpersonal and group links that all individuals need for survival, self-development and self-realization as a person and as a member of society.

Perhaps the most interesting aspect of the phenomenon from the "broaden and build" perspective, however, is that of play, a practice intimately associated with laughter since its evolutionary origins. Recent research has confirmed the presence of laughter not only in some apes but in all (or at least many) mammals, including dogs and rats (Panksepp, 2005). This "proto-laughter" (inaudible or unrecognizable as such by our species) occurs in situations of play-fighting, chasing, tickling, etc. In the human context, those who laugh most are children, and they laugh most precisely in situations of play. Play stimulates laughter, and laugher (or rather the emotional reward of the pleasure it provides) stimulates play. Play, the practice of future skills, in turn permits the child to grow and develop as a person and as a member of society. Children, who still have everything to learn, play with their environment, their peers and their carers so as to learn how to move, how to perceive, how to relate, how to communicate, and how to carry out all the routines and activities required by their culture.

Laughter can be interpreted in this context as a sign that "what is happening is not real, not dangerous, not important, not appropriate". A playful attack by a lion is difficult to distinguish objectively from a potentially deadly one, but the "laughter" sign transmits that there is no need for concern. At the same time, such play-fighting or horseplay permits lions to develop their attack and defence skills, which are essential for hunting and defending their territory.

In humans, learning through play also begins with such horseplay and chasing, but it goes far beyond that, extending to other areas such as social, sexual and linguistic competence. Children, for example, play with words to test meanings, laughing at incorrect usage of their own or others in order to check whether they have understood the true meaning. Later on, adolescents joke around with the concepts of sex in order to test and explore themselves in relation to this area of life to which they are beginning to accede. In each phase of life, new challenges and contexts provide new opportunities for learning through play and humour, up to the time of death, perhaps the greatest to challenge of all.

It is noteworthy that in recent decades various authors have proposed greater integration of humour and play in educational practice, arguing precisely that such methodology is that which fits best with our natural manner of learning (Fernández Solís, 2002).

SENSE OF HUMOUR AS A STRENGTH

In 1999, inspired by the incipient 'Positive Psychology'

concept, Martin Seligman and Christopher Peterson started out on an ambitious project to try and discover first of all if there existed a series of human virtues recognized in all or almost all cultures, and secondly to identify them. The result was a classification of six principal virtues and 24 "routes" for practicing them –the so-called signature strengths.

Strengths and virtues are lasting personality traits, and specifically positive characteristics that provide pleasurable sensations and gratification. We should take into account that feelings are states, momentary events that are not necessarily repeated. They come and go according to our experiences and the way we interpret them. Traits, on the other hand, are positive or negative characteristics that make temporary feelings (of the same sign) more probable. The negative trait of paranoia increases the likelihood that the momentary state of fear will appear, in the same way that the positive trait of the appreciation of beauty makes more probable the experience of moments of aesthetic pleasure.

Sense of humour is a positive trait because it means that the person who has it can more frequently experience laughter, the subjective pleasure associated with it, the different psychophysical benefits derived from it and the gratification of making others laugh. Seligman and Petersen include it in their inventory of 24 strengths, on fulfilling the three criteria they employed in drawing up this list of positive traits:

- It is valued in practically all cultures.
- It is valued for its own sake, not as a means to other ends.
- It is malleable.

It should be made clear, however, that probably what is valued in all cultures is a positive sense of humour, given that negative humour often leads to rejection and social censure.

From the point of view of positive psychology, sense of humour is not merely a factor for preventing or helping to overcome illness, but rather a virtue that promotes better well-being and enjoyment of life, and even, as we have seen, growth towards greater humanity and fullness. In this regard it is interesting to note that diverse cultures consider positive sense of humour to be both the result and the cause of high levels of wisdom or emotional maturity.

In Eastern mystic disciplines, a cheerful, smiling disposition is considered the sign of a highly developed person (Jáuregui, 2004). Artistic representations of Buddha, for example, show the master of this tradition smiling placidly or even laughing heartily, a laughter associated by diverse Buddhist texts with the great illusion (joke?) of appearances that according to Buddhism deceive the human being. In the tradition of yoga, one of the eight most important moral precepts is Santosha, the duty to cultivate a playful and joyful attitude. Indeed, some of the most well known and venerated spiritual leaders in Asia, such as the current Dalai Lama or Mahatma Gandhi, have demonstrated an admirable sense of humour, despite lives replete with great personal tragedy, weighty responsibilities and all types of difficulties.

At the same time, these very traditions, and many others, have recommended the use of positive humour for overcoming negative emotions and the bonds of the ego, and thus achieving wisdom. Zen paradoxes, for example, force the person to confront the absurd so as to overcome the limitations of language and thought, trying to provoke a moment of illumination or satori through laughter. Closer to our own experience, the festivals and rites celebrating laughter, creative madness, play, satire, jokes and tricks exist in practically all cultures (in the Spanish case we would be thinking especially of *fiestas* such *Las Fallas* in Valencia, of New Year, or of *el día de los inocentes*, the equivalent of April Fools Day), providing an escape from the mental rigidity that characterizes a large portion of our lives.

A positive sense of humour, in its fullest expression, permits human beings to cope with the problems and upsets of life because it puts one's whole life in perspective. The ego and all its bonds are seen from a distance, as though the world were a great theatre and the individual could enjoy the show from the stalls. We can laugh at ourselves and at everything, because we understand that nothing is as important as it seems. From this point of view, problems small and large, errors and imperfections, disasters and threats – none of these frighten or intimidate us. From such a state of wisdom, all is vanity, all is farcical, and humanity's greatest achievements and exploits are nothing more than the work of minuscule and naive ants in a universe that totally escapes their limited understanding. As Charlie Chaplin remarked, "Life is a tragedy when seen in close-up, but a comedy in long-shot". And this is indeed the point of view of the Buddha, the jester and the party animal at Pamplona's *Sanfermines* festival of the bulls.

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CREATIVITY

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This article belongs to the field of Positive Psychology, and defends the view that creativity is not something extraordinary, within reach of only a few chosen people. Different psychological research lines on creativity pursued over more than half a century appear to be converging now in some basic premises that will help to dispel some of the myths and encourage researchers to explore personal creativity in a more general way and in everyday contexts.
Key words: *creativity, positive psychology.*

Este trabajo se enmarca en el contexto de la Psicología Positiva y en él se defiende que la creatividad no es algo excepcional al alcance de unos pocos elegidos. Las diferentes líneas de investigación en las que la Psicología viene trabajando desde hace más de cincuenta años parecen converger hoy en algunas premisas básicas que animan a quienes pensaban que la creatividad era un campo vedado a superar algunos mitos y a explorar la creatividad personal cada día.
Palabras clave: *creatividad, psicología positiva.*

Creativity is a research topic of the utmost importance, given its personal, social, cultural and even economic consequences. It is concerned with people's performance in a wide range of contexts and with their optimum functioning, with innovation, with the solution of all types of problems, with scientific and technological advances, with social changes, and so on. In sum, creativity can be considered one of the most important characteristics of human beings, and therefore of their productions.

Beyond these few general ideas, it is difficult to discuss creativity without some degree of confusion. Indeed, we find, somewhat disappointingly, that works in this field are either a compilation of unverifiable beliefs and opinions or, in contrast, deal with scientific issues so specific as to be irrelevant to the majority of people. The study of creativity, by its very nature, often appears incompatible with the requirements of a science, at least of a predictive science (Popper, 1956), but this does not mean we do not perceive the phenomenon everywhere, and feel the need to explore it in greater depth.

Despite its complexity, psychology has dedicated great efforts to unravelling the mysteries of creativity over many decades. There is some consensus on the view that modern interest in the topic can be traced back to the work of J. P. Guilford, the eminent American psychologist who in 1950 gave a brilliant lecture to the American Psychological Association entitled quite simply "Creativity" (Guilford, 1950).

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RESEARCH ON CREATIVITY

An overview of the research lines developed within psychology reveals that creativity has been studied from different perspectives which, rather than conflicting, can be considered as complementary and convergent (Sternberg, 1996).

Early approaches to the topic focused on the study of the biographies of people considered as creative geniuses (Cox, 1926; Galton, 1869; Gardner, 1993; Simonton, 1975a), though the technical and methodological difficulties involved in this approach make it advisable to judge its results with caution. Researchers have also analyzed the characteristics and personality traits of normal, everyday people, applying paper-and-pencil tests to them on the assumption that creativity is a normally distributed trait (Guilford, 1967; MacKinnon, 1965, 1978; Nicholls, 1972; Runco, 1991; Torrance, 1988). Another important and fruitful line of research has looked at the cognitive processes of perception, reasoning and memory involved in problem-solving. From this perspective, creativity is the extraordinary result of the functioning of ordinary processes and structures, and can be reduced precisely to processes of association, synthesis, analogical transference, use of broad categories, data recovery, and so on (Boden, 1991; Finke, 1990; Finke, Ward & Smith, 1992; Johnson-Laird, 1988; Newell, Shaw & Simon, 1958; Smith, Ward & Finke, 1995; T. B. Ward, Smith & Vaid, 1997; Weisberg, 1993).

To a lesser extent, research has turned its attention to the possible environmental, social and cultural determinants of creativity, such as cultural diversity, war, the

availability of models and resources (Lubart, 1990; Simonton, 1975b, 1984, 1998), external and internal rewards (Amabile, 1982, 1983), or the disciplinary context in which creative productions occur (Csikszentmihalyi, 1996).

More operative approaches have studied the characteristics of the creative product, such as its novelty, aptness, utility, quality or parsimony (Amabile, 1985; Barron, 1955; Besemer & Treffinger, 1981; Bruner, 1962; Getzels & Csikszentmihalyi, 1976; M. I. Stein, 1969).

Finally, perhaps the most well known approach is that which has focused on the development of creativity in applied contexts. Commercially successful techniques such as "brainstorming" (Osborn, 1963) or "thinking hats" (De Bono, 1971, 1985, 1992), which stress the need to propose as many ideas as possible and to suspend their judgement for later, have helped improve results in a wide variety of fields.

Obviously, such a diversity of approaches has not produced a single, unified definition of creativity; in fact, each approach contributes its own definition, none of which manages to avoid the problem of the lack of an objective criterion that could lead to a consensus. In these circumstances, Teresa Amabile (1983) advocates omitting the search for totally objective definition criteria and adopting an operative definition based on reliable subjective criteria. She proposes working with definitions such as the following one:

"A product or response is creative when appropriate observers independently agree that it is. Appropriate observers are those who are familiar with the domain in which the product was created or the response was articulated" (Amabile, 1982) (p. 359).

Another conceptual definition by the same author that helps us to understand what observers are analyzing when they assign degrees of creativity is the following one:

> "A product or response will be judged as creative insofar as it is a novel, appropriate, useful, correct or valuable response to the task at hand, and the task is heuristic rather than algorithmic in nature." (Amabile, 1982) (p. 360)

These types of definition that rely on intersubjectivity as a criterion of objectivity are useful for researchers because they make it possible to start out from a basis of consensus that facilitates reliable comparisons between results. However, for the vast majority of people, who have no interest in applying the scientific method to their everyday lives, what matters is to know how to develop and appreciate creativity in their immediate environment. Therefore, in the present work, which falls within the framework of Positive Psychology, we shall argue that creativity is within reach of all, that its development is possible and that it has substantial positive effects.

WHAT IS CREATIVITY?

Opting for a minimal definition that maximizes the consensus among students of creativity and its potential for development, we propose that creativity is, above all, a form of change.

From an evolutionary point of view, human beings feel a certain ambivalence toward change. On the one hand, we appreciate it, because it has permitted us to adapt in spectacular ways to all the environments in which we have lived, and on the other, we are somewhat resistant to it, because it always brings with it uncertainty, instability and disorder, and makes it more difficult to make predictions about our environment and to control it. We thus find ourselves between two extremes with regard to change, where the most adaptive approach is to function mainly in the middle ground. Applying this idea to the specific question of creativity, we might say that we appreciate it, but not in excess. It is adaptive and progressive to introduce novel aspects into fields in which we deploy our intelligence, but always on the basis of solid foundations and socially validated knowledge, because, in the absence of a better criterion, social consensus is essential.

More specifically, it can be asserted that to create is to invent possibilities (Marina, 1993), it is an exercise of freedom that in the animal kingdom only the human brain can develop, because it is determined not by external stimuli, but by the projects and goals it creates itself. Indeed, the human brain creatively constructs *itself* (Edelman, 1987); it comes unprogrammed, and must be programmed in order to survive, and this could be considered the most significant and vital exercise of creativity. If this be the case, then artists recognized for their magnificent works, scientists who discovered the invisible, people who have gone down in history for their discoveries, have simply extended this capacity to exploit potential that all of us possess.

From this broad perspective, creative people are those who see in a set of stimuli what they had not seen before, or what nobody had seen before. The creative process is that which leads to the formulation of a new theory, to

the production of an original work of plastic art, to the development of an ingenious product that solves some practical problem, and so on. The creative product, response or idea is that which combines characteristics of novelty, originality, utility, applicability to a given problem, and so on. And also creative is the process of perceiving all this, for on looking at a painting one person may perceive a group of splodges of colour, while in another person the image may stimulate them to see the world in a different way. People may see the work of Dalí as meaningless eccentricity, or as the height of provocative originality; often lack of creativity is more a problem of those who have to appreciate it than of those whose contributions attempt to express it. Csikszentmihalyi suggests in this regard that what restricts creativity is not always a lack of products, ideas, or novel and original works, but rather the lack of interest expressed by observers. It would be a question, therefore, not so much of creative supply, but of demand, and it seems ironic that the majority of attempts to stimulate or promote creativity focus on the supply side (Csikszentmihalyi, 1996).

WE ARE SURROUNDED BY CREATIVITY

Creativity pervades all fields in which human intelligence is deployed. We can find abundant examples in the fashions of each season, in advertising campaigns, in the inventions that have revolutionized our everyday life (from the washing machine to the computer, via post-its, sticking plasters, etc.), in technological innovations, in the scientific discoveries that have even taken us into space, in haute cuisine, in literature, in painting, in sculpture, in theatre and cinema, in music, in interior and exterior design, and so on. We may never achieve a total consensus on which specific creations and which persons merit such recognition – we may have to wait some time and make retrospective judgements – but what seems clear is that changes are happening all the time, that new combinations of elements continually surprise us, and that if we look back even just a few years we see that such things have transformed everyday reality. As Boden remarks, "we believe in creativity (...) because we find it in practice" (Boden, 1991) (p. 51).

WHO IS RESPONSIBLE FOR THE CREATIVITY THAT SURROUNDS US?

First of all it is people who possess a biological information processor called a brain, the vast majority of whom go or have gone unnoticed, and who set in motion, more or less consciously, ordinary, everyday cognitive processes (Smith et al., 1995; Weisberg, 1993). Psychological studies developed in this field show up the mystery of divine inspiration for what it is, and substitute it with scientific knowledge on processes of association, verification and residual activation (Bowers, Farvolden & Mermigis, 1995), visual image processing (Finke et al., 1992; Martindale, 1990; T. Ward, Smith & Finke, 1999), divergent thinking (Guilford, 1967), and so on. Thus, creative thinking is accessible to anyone, and by extension, so are creative results (Simonton, 2000).

Who has not done something they hadn't done before, or in a way different from how other people around them had been doing it? Who has not had a new idea in a specific situation, which moreover has won the approval of others, and which has helped us to improve our capacity for adaptation to the environment and that of those around us? Who has not made a daring combination of elements in the kitchen, in one's wardrobe, in the decoration of one's house, or in the organization of one's work? If such actions have not been judged as creative by others, it is not so much because they are not actually creative, but rather for practical reasons: if we are all creative, then creativity is a human characteristic and it does not make much sense to talk about it. Creativity is precisely what is expected.

To say that we are all creative is like saying nothing, and the truth is that our purpose and intention here is precisely to say *something* about this important element that has made such a notable contribution to our survival. Indeed, we tend to identify and describe creative people, we rank them, we investigate their lives in search of explanations for their creativity, because it seems this has turned out to be useful for our adaptation. We judge as creative that individual – it is not yet clear from which species – who first saw the potential for a cutting edge in a simple stone, the one who observed the cycle of the seasons and acted in consequence, the one who planted a seed in the hope that an edible plant or fruit would grow from it; more recently, we consider as creative people Michelangelo, Darwin, Edison, Mozart, Picasso, Marie Curie, Bill Gates, and so on. Those people who, for the contributions they are recorded to have made, are today called creative geniuses, are particular examples of our species who have built on the observations, the knowledge and the productions of others and have contributed something more definitive – we might say they have "dotted the i's and crossed the t's", or taken

the product to a new level of perfection or quality – and that is why they merit such a label, and why they deserve to be remembered and studied.

Creative people are not made of special material, though saying that they are is intended to make it easier to understand them. We are all made of the same stuff, and we all have great creative potential. Creativity is a question of degree (Amabile, 1983; M. Stein, 1974, 1975; Sternberg & Lubart, 1995), and some will be in the right place at the right time and with the necessary resources to make important discoveries that merit consideration as creative. But for this to happen the person also has to be prepared, adequately trained and ready for something exceptional to happen at any moment.

From the point of view of those who perceive creativity and have to judge it, it is necessary to take into account the significant limitations of human perception and memory (Kahneman & Tversky, 1982). We cannot pay attention to, or remember, or therefore appreciate all those that have stood out, and even less all those who made smaller contributions but necessary ones so that others could make more important discoveries. In such circumstances, it is more practical to select a few, label them as creative, study their characteristics and try to learn from them.

For this practical reason we begin by discussing creativity as a differential characteristic, which some have and others do not have. We ask ourselves about the characteristics of those whom we have decided to label as creative, how they lived, what made them different from others, and so on. But this is no more than a strategy that allows us to go deeper and to learn more from those who have stood out most. It is not a reality: the reality is that we are all creative. And we are creative because we have no choice, because even if we do not want it to, our brain discovers, invents, tests and makes associations, and through this it creates new possibilities and constantly changes the environment (Marina, 1993), for good or ill.

MYTHS ABOUT CREATIVITY

Research on creativity has been dominated for many years by the approach focusing on traits, in an attempt to identify the personality characteristics of creative people (Nicholls, 1972). As a result, some other important areas have been neglected, such as the influence of the physical, social and cultural contexts in which those considered as creative have produced their creations (Amabile, 1983). Furthermore, it has generally been assumed that creativity cannot be altered, and also that creative people can produce creative work at any time and in any field. Neither of these assumptions appears to be true. Creativity can be developed, and those who concentrate on specific fields are obliged to neglect others (Csikszentmihalyi, 1996), since being creative requires effort, which is, unfortunately, a scarce resource that we have to measure out with care.

Studies focusing on the process of the development of creativity seem to indicate that exceptional creative talent is made (Ericsson, 1996), and that manifesting creativity in any field requires a previous period of learning (Hayes, 1989; Simonton, 1991). Creative ideas do not come out of a void; rather, they emerge from people who have developed a wide range of skills and who have access to a rich body of relevant knowledge, previously acquired in favourable contexts (Simonton, 2000). Moreover, creative ideas and productions, after their creation, pass through stringent processes of selection according to the opinion and judgement of experts in the field, as a result of which only a scant few are considered worthy of passing on to the next generation.

A more serious assumption is that creativity and pathology are related phenomena. Unfortunately, it is easy to dismiss as crazy those whom we simply do not understand. Moreover, the widespread tendency to overestimate the degree to which two events occur together, especially when one of them has great emotional impact, may be at the root of this unfounded association. Today, many authors assert unequivocally that this relationship is purely accidental (Amabile, 1993; Csikszentmihalyi, 1996; Rothenberg, 1990; Simonton, 2000). There are many more people considered as creative that have enjoyed good physical and mental health (Cassandro & Simonton, 2002). The capacity for discovering what one does well, and for enjoying doing it, is the mark of creative people (Csikszentmihalyi, 1996), and not the suffering that romantic notions would have us believe.

COMPONENTS OF CREATIVITY

Creativity does not depend on divine beings or on an exceptional personality; rather, it results from a particular combination of personal characteristics, cognitive abilities, technical knowledge, social and cultural circumstances, resources, and a large dose of luck.

Personality traits

Studies carried out from the traits perspective tend to coincide in suggesting that people judged as creative have

some common characteristics. Among the traits attributed to them are the following: a certain propensity to take risks, nonconformity, a liking for being alone and for setting new rules, independence of judgement, and tolerance of ambiguity (Eysenck, 1993; MacKinnon, 1965; Martindale, 1989; Simonton, 1999; Sternberg, 1985).

Intelligence and capacity for work

People judged as creative tend to be hard-working and steadfast. They have strived over many years to master a specialized field, so that they have access to relevant skills in specific areas of activity. For example, they have precise knowledge of paradigms, theories, techniques and currents of opinion (Amabile, 1983; Csikszentmihalyi, 1996). Obviously, one cannot be creative in nanotechnology if one knows nothing about nanotechnology; nor can one become a creative painter if one does not know that the mixture of blue and yellow gives green. Intelligence is a necessary component for the acquisition of knowledge and skills, but it is not sufficient for guaranteeing creative results (Amabile, 1983; Barron & Harrington, 1981; Sternberg, 1990).

Also important are other abilities related to working style, such as the capacity to maintain effort over long periods or the ability to abandon unproductive strategies and put persistent problems temporarily to one side (Amabile, 1983).

Motivation

Motivation would be another basic ingredient of creativity. This includes positive attitudes toward the task at hand and sufficient reasons for undertaking it in certain conditions (Amabile, 1983). The presence of rewards, external or internal, is critical for motivation; intrinsic motivation to carry out a task will raise the probability of creative results, while extrinsic motivation will reduce that probability. Indiscriminate reinforcement, prescribed by some professionals for raising self-esteem, may have negative consequences for creativity on balance (Csikszentmihalyi, 1996), first of all because it interrupts the concentration necessary for developing a product, and secondly because it increases the visibility of external rewards, reducing intrinsic motivation (Amabile, De Jong & Lepper, 1976).

Cognitive styles

Creativity has also been associated with a disposition for acting in a particular way, characterized by a preference for open and abstract problems, and by flexibility for adopting different points of view, for exploring alternatives, for keeping response options open, for suspending judgement, for using open categories, for working outside established action scripts, and so on; finally this way of acting is also characterized by accuracy of recall (Amabile, 1983; Eysenck, 1995; Sternberg, 1988).

Heuristics of creativity

Heuristics are simple rules that permit us to make decisions and make value judgements very quickly and with very little cognitive effort. Such clear advantages are sometimes accompanied by error risks in the judgements or decisions, but in other cases this approach may result in the exploration of new cognitive paths. Examples of the latter type of case would be the following heuristics: "when everything goes wrong you have to try something counter-intuitive" (Newell, Shaw & Simon, 1962), "you have to make the familiar unfamiliar" (Gordon, 1961), and "hypotheses must be generated by analyzing case studies, using analogies, considering exceptions and investigating paradoxes" (McGuire, 1973).

External resources

A minimum of resources is necessary for being able to create anything, but beyond this minimum, what may occur is similar to what seems to occur in the case of happiness – that significant increases in resources are not associated with proportional increases in creativity; indeed, at very high levels the opposite effect may be found: "If necessity is the mother of invention, opulence surely seems to be its dysfunctional stepmother" (Csikszentmihalyi, 1996). The more comfortably-off the person, group or society, the fewer their reasons for seeking change, and the less creativity we would expect them to show.

The result of all this mix in specific contexts can give rise to great discoveries or to small revelations that have an impact in the sphere of private life. Creativity with a capital C involves the contribution of something truly new to a symbolic field, and its being sufficiently valued by other people, including experts in the field, so as to be incorporated into the culture. Cultures, it should be borne in mind, are conservative when it comes to incorporating new ideas. There is in fact fierce competition between units of cultural information (memes) to succeed in being transmitted to the following generation (Csikszentmihalyi, 1996; Dawkins, 1976), so that writing a page in the his-

tory of humankind is something reserved for a select few. In such circumstances we should consider that what really matters in the end is not whether your name was linked to some widely recognized discovery, but rather whether you have lived a full and creative life. Developing creative potential in the context of everyday life, creativity with a small c, does wonders for quality of life, but we should not expect others to go into raptures over our contributions, since this depends on other factors which, for our personal happiness, do not matter that much.

WHAT IS THE PURPOSE OF CREATIVITY?

Functioning in life with all the available potential is the optimum and desirable state of affairs. Creativity as a human characteristic is the motor of change, of progress, and in sum, of evolution. Creativity is to cultural evolution what genetic mutation is to natural evolution (Csikszentmihalyi, 1996), and we can all contribute something to cultural evolution, even if we are not remembered for it.

More specifically, creativity can be considered as the antidote to the boredom of everyday life. While creativity may not lead us to fame or fortune, it can do something which from the individual point of view is even more important: it can make everyday experiences more vital, more pleasant and more gratifying (Csikszentmihalyi, 1996). If we learn to be creative in the everyday context we may not change the way future generations see the world, but we shall change the way in which we experience it (Csikszentmihalyi, 1996), and that is a worthwhile goal in itself.

The sphere of personal life contains the rules, habits and practices that define what we do every day – how we dress, how we work, how we go about our relationships, and so on. Reflecting on it, consciously choosing our options and being open to new possibilities are also exercises of creativity related to personal satisfaction, because doing what we do not usually do simply because it does not occur to us, and seeing what we do not usually see because we do not pay attention, at the very least enriches our stimular world and that of those around us, and a little beyond that opens up a world of new possibilities, some of which can be highly advantageous in the continuous process of adaptation to the environment.

Trying consciously to develop creativity in any field involves a degree of reflection which, moreover, serves to counteract automatic behaviour, conditioned behaviour, and processes of conformity and obedience that lead us to do always the same thing, in a routine and predictable way. In the sphere of interpersonal relations, for example, it can lead us to perceive others and what they do from broader perspectives that contribute to improved understanding. Thinking, as we habitually do, that others' behaviour has only one possible cause, which, moreover, annoys us, is not particularly helpful for building satisfactory interpersonal relationships. Thinking, on the other hand, that there may be various reasons why someone does something, looking into them and trying to understand them, at the very least favours communication and constructive interaction, and this could be considered an exercise of creativity aimed deliberately at perceiving what we generally do not perceive, and doing what we do not normally do.

Creativity can also be considered a valuable therapeutic resource with regard to health. It could be hypothesized that people with some psychological disorder are showing a lack of creativity when they react in a rigid way to what is causing them problems, and do not try to modify the conditions, internal or external, that cause them, or try unsuccessfully. Therapeutic strategies of the search for alternatives, of correction of cognitive errors, of behavioural training, etc., constitute techniques that basically seek changes in the way the patient interprets reality and copes with situations, specific changes in behaviour and in attitudes, and so on. In sum, they seek to demonstrate that doing something different from what one has been doing is possible. Therefore, they can be broadly conceptualized as strategies that stimulate or promote abilities closely related to creativity, in these cases for achieving a minimal goal, but also potentially – and why not? – for making life worth living and developing activities that bring into play the best in us.

HOW CAN CREATIVITY BE TRAINED?

First of all, by cultivating curiosity and interest, that is, by assigning attention to things for their own sake (Csikszentmihalyi, 1996). We should question the obvious, not in a spirit of contradiction, but rather with the aim of adding other possible explanations to those already accepted, and other possible solutions to those already implemented. In reality, surprising things happen every day, and it is difficult, if not impossible, to pay attention to them all, but if one of them sparks an interest, paying conscious attention to it is a first step on the road to deploying our creative potential.

Secondly, by extending our capacity for perceptual discrimination. What artists reflect in their work, what a re-

searcher contributes to a given field of knowledge, is not reality, but rather the way in which that reality is interpreted. Before seeing something that nobody has seen before, there clearly occur learning processes that lead to the perception of innumerable differences and nuances in the initial stimuli. We might drink a glass of wine and perceive that we are ingesting a red liquid that is useful for washing down solid foods, or we may experience an amazing richness of smells, tastes and sensations. What professional wine tasters are capable of seeing, tasting, feeling, etc. in a glass of wine are things they have learned. They have learned to recognize parts of a stimulus in a perceptual learning process that naturally requires interest, effort and time, and which many people would be in a position to undertake, if they so wished, though far fewer would be likely to undertake with a degree of success that makes them go down in history. What seems clear is that creativity is associated with learning and with effort, and that we cannot say that people considered as creative "have had no choice but be so", because they were programmed that way.

Thirdly, by exercising our capacities for lateral thinking, that which follows the logic of desire rather than focusing on the viable, the operative, the possible, etc. Before thinking in such terms it is useful to think of as many different ideas as we can: impossible ideas, improbable ideas, unjudged ideas; this tends to open up an unpredictable world of possibilities (De Bono, 1992; Osborn, 1963). Simonton, in a study with 2036 creative scientists, discovered that the most creative ones not only produced a larger quantity of great works, but also a larger number of poor works (Simonton, 1984). In other words, they produced a lot and selected the best.

And fourthly, by relativizing the importance of others' judgements. The judgement of others may be important with regard to going down in history, but for living day-to-day without added pressures and without superfluous restrictions, not so much. To create requires some degree of freedom, at least initially, and if we are constantly preoccupied with what others might think, it will be difficult to set challenges, propose alternatives, investigate possibilities, and so on.

The main obstacle to developing creativity is the belief that we cannot develop it, and there are too many people who consider themselves incapable of doing something creative in any field of activity. What probably occurs is that they confuse initial failure with basic inability, and consider that the first attempt or performance is the measure of true talent (Buzan, 2003). They forget that the great geniuses are remembered not for their early work or for their poorer work, but rather for the heights they attained with some of their ideas.

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THE TRAUMATIC EXPERIENCE FROM POSITIVE PSYCHOLOGY: RESILIENCY AND POST-TRAUMATIC GROWTH

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The ability of human beings to face and overcome traumatic experiences and even to benefit from them has been generally ignored by mainstream Psychology, which has focused all of its attention on the devastating effects of trauma. Although the experience of a traumatic event is undoubtedly one of the most difficult moments some people must face, it is also an opportunity to take stock of and rebuild one's perspective on the world. This may constitute an ideal time to construct new value systems, as a great deal of scientific studies have shown in recent years. Some people tend to weather hard times with an astounding resiliency, and even faced with extreme events there is a high percentage of people who show great resistance and who survive them psychologically unscathed or with only minimal damage.
In this article concepts such as resiliency and post traumatic growth will be examined, concepts that have strongly emerged within Positive Psychology to highlight the human beings' impressive ability to resist and rebuild themselves when faced with the adversities of life.
Key words: *resiliency, post-traumatic growth, positive emotions.*

La capacidad del ser humano para afrontar experiencias traumáticas e incluso extraer un beneficio de las mismas ha sido generalmente ignorada por la Psicología tradicional, que ha dedicado todo su esfuerzo al estudio de los efectos devastadores del trauma. Aunque vivir un acontecimiento traumático es sin duda uno de los trances más duros a los se enfrentan algunas personas, supone una oportunidad para tomar conciencia y reestructurar la forma de entender el mundo, que se traduce en un momento idóneo para construir nuevos sistemas de valores, como han demostrado gran cantidad de estudios científicos en los últimos años. Algunas personas suelen resistir con insospechada fortaleza los embates de la vida, e incluso ante sucesos extremos hay un elevado porcentaje de personas que muestra una gran resistencia y que sale psicológicamente indemne o con daños mínimos del trance.
En este trabajo se revisan conceptos como la resiliencia y el crecimiento postraumático que han surgido con fuerza dentro de la Psicología Positiva para resaltar la enorme capacidad que tiene el ser humano de resistir y rehacerse ante las adversidades de la vida.
Palabras clave: *resiliencia, crecimiento postraumático, emociones positivas.*

"The concept of resiliency has put an end to the dictatorship of the concept of vulnerability"

Stanislaw Tomkiewicz, 2001

The interest in understanding and explaining how human beings deal with traumatic experiences has always existed, but it is in the wake of the terrorist attacks that rocked the world in the last few years that such interest has strongly re-emerged.

Beyond pathogenic models of health, there are other forms of understanding and conceptualizing trauma. In the immediate aftermath of a catastrophe the majority of experts and the general population focus their attention on the weaknesses of the human being. It is natural to conceive of the person who undergoes a traumatic experience as a victim who will potentially develop a pathology. However, from more optimistic models people are understood as active and strong, with a natural capacity to resist and rebuild themselves in the wake of adversity. This conception falls within the framework of Positive Psychology, which seeks to understand the processes and mechanisms underlying the strengths and virtues of the human being.

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The conventional approach to the psychology of trauma has focused exclusively on the negative effects of the event on the person who experiences it, and specifically on the development of post-traumatic stress disorder (PTSD) or associated symptoms. Pathological reactions are considered as the normal form of responding to traumatic events; indeed, people failing to display such reactions have been stigmatized, assumed to be suffering from strange and dysfunctional disorders (Bonanno, 2004). However, the reality is that while some people who experience traumatic situations do develop disorders, in the majority of cases they do not, and some are even capable of learning from and benefiting from the experience.

Concentrating exclusively on the potential pathological effects of the traumatic experience has contributed to the development of a "culture of victimhood", which has seriously biased psychological research and theory (Gillham & Seligman, 1999; Seligman & Csikszentmihalyi, 2000) and led to a pessimistic view of human nature. Two dangerous assumptions underlie this culture of victimhood:

1) that trauma always brings with it serious damage, and
2) that damage always reflects the presence of trauma (Gillham & Seligman, 1999).

In the field of mental health, it is customary to find schematic ideas about the human response to adversity (Avia & Vázquez, 1999), preconceived ideas about how people react in given situations, generally based on prejudices and stereotypes, rather than on verified facts and data. An example of this is the deep rooted belief in Western culture that depression and intense desperation are inevitable when a loved one dies, or that the absence of suffering after a loss indicates negation, avoidance and pathology.

Such ideas have led to the assumption that the response of people who suffer loss or undergo traumatic experiences is one-dimensional and largely invariable (Bonanno, 2004), and to ignoring individual differences in the response to stressful situations (Everstine & Everstine, 1993; Peñacoba & Moreno, 1998).

A pioneering study by Wortman and Silver (1989), summarizing empirical data, demonstrates that such assumptions are incorrect: the majority of people who suffer irreparable loss do not become depressed, intense reactions of mourning and suffering are not inevitable, and their absence does not necessarily mean that the person has a disorder or will develop one. The point to be made is that people tend to resist life's onslaughts with remarkable strength, and even in the case of extreme events there is a high percentage of people who show great resistance and who come through them psychologically unscathed or with only minimal damage (Avia & Vázquez, 1998; Bonanno, 2004).

Positive Psychology reminds us that human beings have a great capacity for adapting to and making sense of the most dreadful traumatic experiences, a capacity that has been ignored by psychology for many years (Park, 1998; Gillham & Seligman, 1999; Davidson, 2002). Numerous authors propose reconceptualizing the traumatic experience from a healthier model which, based on positive methods of prevention, takes into account the individual's natural ability to cope, resist and even learn and grow in the most adverse situations (Calhoun & Tedeschi, 1999; Paton, Smith, Violanti & Eräen, 2000; Stuhlmiller & Dunning, 2000; Gist & Woodall, 2000; Bartone, 2000; Pérez-Sales & Vázquez, 2003).

REACTIONS TO TRAUMATIC EXPERIENCES

People's reaction to traumatic experiences can vary along a continuum and adopt different forms:

Disorder

Mainstream psychology has focused chiefly on this aspect of the human response, assuming that anyone exposed to a traumatic situation can potentially develop post-traumatic stress disorder (PTSD) or other pathologies (Paton et al., 2000), and designing early-intervention strategies aimed at all those affected by an event of this nature. However, the percentage of people exposed to traumatic events that develop pathologies is minimal. Moreover, it should be borne in mind that of the percentage of those who in the early months may be diagnosed with some pathology, the majority recover naturally, and in a relatively short time regain their normal level of functioning.

In a study carried out after the attacks on New York on 11th September 2001 it was shown that, while a first assessment made one month after the events recorded a prevalence of PTSD in the general New York population of 7.5%, six months later this figure had fallen to just 0.6% (Galea, Vlahovm, Ahern, Susser, Gold, Bucuvalas & Kilpatrick, 2003), indicating that the vast majority of people had followed a process of natural recovery in which the symptoms disappeared and they returned to a normal level of functioning. It is important to point out in

passing, though here is not the place to deal with this issue fully, how results such as this call into question the true utility of the PTSD diagnosis, since we are talking about a disorder that gradually disappears over time. It may indeed make more sense to think of this prevalence of 7.5% as the reflection of a set of initial reactions that are normal after an extremely adverse event, and which have mistakenly been considered as pathological symptoms and grouped together to convert them into a psychiatric disorder. It is not surprising that a person exposed, directly or indirectly, to a traumatic event should experience nightmares, recurring memories, associated physical symptoms, and so on. The vast majority of affliction and suffering responses experienced and reported by victims are normal, and even adaptive. Insomnia, nightmares, intrusive memories (some of the behaviours and thoughts taken as symptoms of PTSD) reflect normal responses to abnormal events (Summerfield, 1999).

Delayed disorder

Some people exposed to a traumatic event and who did not develop pathologies initially may do so much later, even years later. However, such cases are infrequent.

Recovery

Traditional psychological approaches have tended to ignore the process of natural recovery; this process initially involves the experience of post-traumatic symptoms or dysfunctional reactions to stress, but over time these disappear. The data indicate that around 85% of people affected by a traumatic experience follow this process of natural recovery and do not develop any kind of disorder (Bonanno, 2004).

Resiliency or resistance

Resiliency is a widely observed phenomenon that has traditionally been paid little attention, and which includes two relevant aspects: resisting the event and rebuilding oneself from it (Bonanno, Wortman et al, 2002; Bonanno & Kaltman, 2001). In the face of a traumatic event, resilient people succeed in maintaining a stable equilibrium, so that their performance and everyday life are unaffected. In contrast to those who recover naturally after a period of dysfunctionality, resilient individuals do not experience this dysfunctional period, but rather remain at functional levels in spite of the traumatic experience. This phenomenon is considered extraordinary or characteristic of exceptional people (Bonanno, 2004), and yet there is a large body of data indicating that resiliency is a common phenomenon among people who have to deal with adverse experiences, and which arises from adaptive functions and processes that are normal in human beings (Masten, 2001).

The accounts of many people reveal that, even having gone through a traumatic situation, they have succeeded in assimilating it and in continuing to manage quite effectively in their environment or context.

Post-traumatic growth

Another phenomenon overlooked by theorists of trauma is the possibility of learning and growing from adverse experiences. As in the case of resiliency, research has shown that it is a much more common phenomenon than we might be led to believe, and that many people succeed in accessing latent and unsuspected resources (Manciaux, Vanistendael, Lecomte & Cyrulnik, 2001) in the process of struggle they have had to undertake. Indeed, many survivors of traumatic experiences find paths leading to benefits from their struggle against the abrupt changes that the traumatic event causes in their lives (Tedeschi & Calhoun, 2000).

In sum, what can be deduced from current research on trauma and adversity is that people are much stronger than psychology has considered them to be. Psychologists have underestimated the natural capacity of survivors of traumatic experiences to resist and rebuild themselves (Bonanno, 2004).

The reasons why the positive side of coping with trauma is continually ignored merit some consideration. Some authors maintain that there is a social process of a cognitive nature, called social amplification of risk, involving a general tendency to overestimate the magnitude, scope and duration of others' feelings (Paton et al., 2000; Brickman, Coates & Janoff-Bulman, 1978). This tendency may go some way to explaining the victimhood applied to people who suffer traumatic experiences.

Mental health professionals themselves, on applying indiscriminately diagnostic concepts such as PTSD reflect a view of human beings as detached from the world around them, and seek in the persons themselves all the keys to the disorder. They ignore the influence of external factors in the origin and maintenance of the so-called disorder of post-traumatic stress – that is, the psychosocial dimension of trauma that situates the sufferer in a social context (Blanco & Díaz, 2004), proceeding as though diagnostic categories were negative realities that

have to be explained. Such beliefs would explain the high rates of incidence of PTSD found in some studies.

In this process it is also considered that people who go through a traumatic experience, on being invaded by negative emotions such as sadness, anger or guilt, are incapable of experiencing positive emotions. Historically, the appearance and potential utility of positive emotions in adverse contexts has been considered a less-than-healthy form of coping (Bonanno, 2004) and as an impediment to recovery (Sanders, 1993). Recently, however, research has shown that positive emotions coexist with negative ones in stressful and adverse circumstances (Folkman & Moskowitz, 2000; Calhoun & Tedeschi, 1999; Shuchter & Zisook, 1993), and can help to reduce the levels of anguish and affliction that follow the experience of such circumstances (Fredrickson, 1998).

In this regard, some studies offer novel and conclusive results. In 1987 a group of people with spinal cord injuries were interviewed at different points after having sustained the crippling injury. The results showed that the experience of positive emotions occurred from the very first days after the accident, these positive feelings being more frequent than negative ones from the third week onwards (Wortman & Silver, 1987).

In two studies carried out by Keltner and Bonanno with the same sample of 40 individuals whose partner had died, it was shown that people who displayed genuine smiles (those in which the orbicular muscle of the eye is activated) on talking about their recent loss presented better functional adjustment, better interpersonal relations and lower levels of pain and anguish 6, 14 and 25 months after the loss (Keltner & Bonanno, 1997; Bonanno & Keltner, 1997).

In another study with 29 survivors of accidents with damage to the spinal cord, it was found that although the victims perceived their situation as relatively negative, they also reported that their feelings of happiness had not disappeared, and that they were considerably stronger than they would have expected (Janoff-Bulman & Wortman, 1977).

In a more recent work on the 11th September attacks on New York (one of the few studies on 11-S that have not focused on pathology and vulnerability), it is explained that the experience of positive emotions, such as gratitude, love or interest, after going through the traumatic event, in the short term increases one's access to subjective positive experiences, stimulates proactive coping and promotes physiological de-activation, whilst in the long term it minimizes the risk of depression and strengthens one's coping resources (Fredrickson & Tugade, 2003).

All of these studies demonstrate the incontrovertible presence of positive emotions in contexts of adversity and indicate their potential beneficial effects.

RESILIENCY

Resiliency has been defined as the capacity of persons or groups to continue projecting themselves into the future in spite of destabilizing events, difficult life conditions and traumas that may be serious (Manciaux, Vanistendael, Lecomte & Cyrulnik, 2001).

This concept has been treated differently by French and American authors. Thus, in the French approach, resiliency is related to the concept of post-traumatic growth, based on an understanding of resiliency as being the same as the capacity to come out of an adverse experience unscathed, to learn from it and to improve. The concept of resiliency used by US authors, however, a more restrictive one, refers to the coping process that helps the person to remain intact, distinguishing it from the concept of post-traumatic growth. From the American approach it is suggested that the term resiliency be reserved to denote subjects' homeostatic return to their previous condition, whilst terms such as thriving or post-traumatic growth are used for referring to the obtaining of benefits or to change for the better after the traumatic experience (Carver, 1998, O'Leary, 1998).

The terminological confusion in the use of these words can be attributed to the recency of appearance of the current that studies the potential positive effects of the traumatic experience (Park, 1998), as indeed can the present lack of a standardized vocabulary with which to work and unify interests.

It is important to distinguish the concept of resiliency from that of recovery (Bonanno, 2004), since they represent different processes over time. Thus, recovery implies a gradual return to functional normality, whilst resiliency reflects the ability to maintain a stable equilibrium throughout the process.

Early works on resiliency involved looking at individual behaviours of overcoming adversity that appeared to be isolated and anecdotal cases (Vanistendael, 2001), as well as the developmental study of children who had lived in difficult conditions. One of the first scientific works that promoted resiliency as a research topic was a

longitudinal study over 30 years with a cohort of 698 children born in Hawaii in highly unfavourable conditions. Thirty years later, 80% of those children had developed in a positive way, becoming competent and well-integrated adults (Werner & Smith, 1982; 1992). This study, not actually developed within the framework of resiliency, has nevertheless played an important role in the emergence of the research field (Manciaux et al., 2001). Thus, in contrast to the deep-rooted traditional belief that an unhappy childhood necessarily determines the child's subsequent development towards pathological forms of behaviour and personality, studies with resilient children have shown that there are some scientifically unfounded assumptions, and that a harmed child is not necessarily condemned to be a failure as an adult.

Resiliency, understood as the capacity to maintain adaptive physical and psychological functioning in critical situations, is never an absolute characteristic; nor, once acquired, does it necessarily remain forever. It is the result of a dynamic and developing process that varies according to the circumstances, the nature of the trauma, the context and one's stage of life, and can be expressed in quite different ways in different cultures (Manciaux et al., 2001). As the concept of resistant personality, resiliency is the fruit of the interaction between individuals and their environment. To talk of resiliency in individual terms is a fundamental error: we are not more resilient or less so, as though we had a catalogue of qualities. Resiliency is a process, a becoming, so that it is not so much the person that is resilient as her evolution and the process of structuring her own life story (Cyrulnik, 2001). Resiliency is never absolute, total, achieved once and for all – it is a capacity that results from a dynamic process (Manciaux et al., 2001).

One of the issues that arouses most interest in relation to resiliency is the determination of the factors that promote it, though this aspect has been scarcely studied (Bonanno, 2004). Some characteristics of personality and one's environment have been proposed as being favourable to resilient responses, such as self-confidence and confidence in one's ability to cope, social support, having a meaningful purpose in life, believing that one can influence what goes on around one and believing that one can learn from both positive and negative experiences. It has also been proposed that positive bias in one's perception of oneself (self-enhancement) can be adaptive and promote better adjustment in the face of adversity (Werner & Smith, 1992; Masten, Hubbard, Gest, Tellegen, Garmezy & Ramírez, 1999; Bonanno, 2004). A study carried out with a civilian population living in Bosnia during the Balkan Wars showed that people with this tendency for positive bias presented better adjustment than those without this characteristic (Bonanno, Field, Kovacevic & Kaltman, 2002).

In studies with children, one of the factors that accumulates most empirical evidence in its positive relationship to resiliency is the presence of competent parents of caregivers (Richters & Martínez, 1993; Masten et al., 1999; Masten, 2001; Manciaux et al., 2001).

In the study carried out by Fredrickson (Fredrickson & Tugade, 2003) after the 11th September attacks on New York it was found that the relationship between resiliency and adjustment was mediated by the experience of positive emotions. These appear to protect people from depression and boost their functional adjustment. In a similar line, research has shown that resilient people conceive of and deal with life in a more optimistic, enthusiastic and energetic way, are curious and open to new experiences, and are characterized by high levels of positive emotionality (Block & Kremen, 1996).

At this point it could be argued that the experience of positive emotions is no more than the reflection of a resilient form of coping with adverse situations, but there is also evidence that these people use positive emotions as a coping strategy, so that we could speak of reciprocal causality. Thus, it has been found that resilient people cope with traumatic experiences using humour, creative exploration and optimistic thinking (Fredrickson & Tugade, 2003).

POST-TRAUMATIC GROWTH OR LEARNING THROUGH THE PROCESS OF STRUGGLE

The concept of post-traumatic growth refers to the positive change an individual experiences as the result of a process of struggle undertaken in the wake of a traumatic event (Calhoun & Tedeschi, 1999). For the American current, this concept is closely related to others such as hardiness or resiliency, but it is not synonymous with them, since on talking about post-traumatic growth, those holding this view refer not only to the notion that an individual facing a traumatic situation manages to survive and resist without suffering from a disorder, but also to the idea that the experience triggers a positive change in the person that leads them to a better situation than that in which they found themselves before the traumatic event (Calhoun & Tedeschi, 2000). From the French per-

spective, however, the concepts of post-traumatic growth and resiliency would be equivalent.

The idea of positive change as a consequence of facing adversity is one that already appeared in the existential psychology of authors such as Frankl, Maslow, Rogers or Fromm. Moreover, the conception of the human being capable of transforming the traumatic experience into learning and personal growth has been a central theme for centuries in literature, poetry, philosophy, and so on (Saakvitne, Tennen & Affleck, 1998), but has been ignored by scientific clinical psychology for many years.

It is important to recall that when we speak of post-traumatic growth we are referring to the positive change an individual experiences as the result of a process of struggle undertaken in the wake of a traumatic event, that it is not universal and that not everyone who goes through a traumatic experience finds benefit and personal growth in it (Park, 1998; Calhoun & Tedeschi, 1999).

Research has focused on identifying the personality characteristics that facilitate or impede a development or positive change in the wake of traumatic experiences. Optimism, hope, religious beliefs and extraversion are some of the characteristics that most frequently appear in studies as factors of resistance and growth. Calhoun and Tedeschi (1999; 2000), two of the authors that have contributed most to this concept, divide the post-traumatic growth people can experience into three categories: changes in oneself, changes in interpersonal relationships and changes in spirituality and philosophy of life.

Changes in oneself: it is common in people who cope with a traumatic situation to find an increase in confidence in their own capacity to deal with any adversity that may occur in the future. Having managed to cope with a traumatic event, the individual feels capable of dealing with anything that comes along. This type of change may be found in those people who, due to their particular circumstances, have found themselves subject to very strict or oppressive roles in the past, and who through the struggle they undertook against the traumatic experience have achieved unique opportunities to re-orient their lives. These ideas are consistent with works indicating that political and ideological convictions are the main positive factor of resistance in political prisoners and torture victims (Pérez-Sales & Vázquez, 2003).

Changes in interpersonal relationships: many people find their relationships with others strengthened in the wake of experiencing a traumatic event. It is common to find thoughts of the type "now I know who my real friends are and I feel much closer to them than before". Many families and couples who came through adverse situations together report feeling much more united than before the event. In a study carried out with a group of mothers whose new-born babies suffered from serious medical disorders, 20% of these women reported feeling closer to their families than before, and that their relationship had become stronger (Affleck, Tennen & Gershman, 1985). Also, having coped with a traumatic experience awakens in people feelings of compassion and empathy in relation to the suffering of others and promotes helping behaviours.

Changes in spirituality and philosophy of life: traumatic experiences tend to radically shake up the conceptions and ideas on which one builds one's view of the world (Janoff-Bulman, 1992). This is the commonest type of change. When an individual goes through a traumatic experience he changes his scale of values and tends to appreciate the value of things he previously ignored or took for granted.

Although there is a tendency to assume that the majority of empirical evidence on the existence of resiliency and post-traumatic growth has been based on single-case studies of exceptionally strong or extraordinary people (Masten, 2001), there are indeed systematic studies that analyze large samples and that find results in support of the fact that they are common phenomena. Thus, for example, in a study carried out with 154 women who as children had suffered sexual abuse, almost half of them (46.8%) reported having extracted some benefit from the experience. These benefits could be grouped in four categories, as follows: capacity for protection of one's children from abuse, capacity for self-protection, increase in knowledge about sexual abuse, and development of a more resistant and self-sufficient personality. This study contradicts the traditional belief that the majority of people who suffer sexual abuse in childhood develop a feeling of helplessness that makes them vulnerable, and suggests that many abused women appear to come out of their experience stronger and better equipped to protect themselves and their children (McMillen, Zurvain & Rideout, 1995). In line with the assertions of the authors cited above about the coexistence of positive and negative emotions, 88.9% of the women who perceived benefits from the experience of sexual abuse also reported perception of damage (Calhoun & Tedeschi, 1999; 2000).

In a retrospective study carried out with 36 survivors of

an oil-rig disaster, interviewed 10 years after the event, it was found that 61% perceived some benefit of their tragic experience, such as improved personal relationships, emotional growth and financial security (Hull, Alexander & Klein, 2002).

Other research has focused on individuals facing serious illnesses and long-term hospitalization. In this context, numerous studies provide solid evidence of the existence of processes of growth or learning. In the work by Taylor, Lichtman and Word (1984), people who had been diagnosed with cancer were asked if they had experienced changes in their life, and what specific changes they experienced. Seventy percent responded affirmatively to the first question, and of these, 60% considered the changes to be positive. In the majority of cases the patients reported having learned to look at life in a different way and to get more enjoyment from it.

In another study, carried out with mothers whose newborn babies had spent a long period in intensive care, 70% of these mothers reported that their marriage had been strengthened by the experience they had undergone (Affleck & Tennen, 1991).

Likewise, it has been shown how many heart-attack victims perceive benefits of their adverse experience (Affleck, Tennen, Croog & Levine, 1987). A study with 287 men who had suffered a heart attack, and whose aim was to assess causal attribution and perceived benefit 7 weeks after the attack and eight years later, showed that those individuals who had perceived benefits after the first attack were less likely to suffer a second attack, and showed better recovery 8 years later. The obvious explanation would be that the patients understood the advantages of a healthy life, but the perceived benefits went much further than that. Many of the patients found that the heart attack had caused them to reconsider their values, priorities and interpersonal relationships. The men who had suffered a further attack in the eight-year period tended to perceive more benefits than those who had not relapsed (Affleck et al. 1987)

People who experience post-traumatic growth also tend to experience negative emotions and stress (Park, 1998). In many cases, without the presence of negative emotions post-traumatic growth does not occur (Calhoun & Tedeschi, 1999). The experience of growth does not eliminate the pain or the suffering; in fact, they usually coexist (Park, 1998, Calhoun & Tedeschi, 2000). Thus, it is important to stress that post-traumatic growth should always be understood as a multidimensional construct – the individual may experience positive changes in certain areas of life and not experience them, or experience negative changes, in other areas (Calhoun, Cann, Tedeschi & McMillan, 1998).

For many people, speaking of growth after a trauma, of personal gain, is unacceptable or even grotesque or obscene. However, the successful struggle for survival of the human species must have selected mechanisms of adaptation to extremely unrewarding circumstances that bring with them both benefits and costs (Saakvitne et al., 1998).

The nature of post-traumatic growth can be interpreted from two different perspectives. On the one hand, post-traumatic growth can be considered as a result: the subject sets in motion a series of coping strategies that lead her to extract benefit from her experience. On the other, post-traumatic growth can be understood as a strategy in itself, that is, the person uses this search for benefits to cope with his experience, so that it is more of a process than a result (Park, 1998).

Theories that support the possibility of post-traumatic growth or learning adopt the premise that adversity can sometimes lose part of its severity through, or thanks to, cognitive processes of adaptation, which succeed not only in restoring adaptive views of oneself, of others and of the world – which may have become distorted –, but also in encouraging the conviction that one is better than one was before the event. Thus, it has been proposed that post-traumatic growth takes place from cognition, rather than from emotion (Calhoun & Tedeschi, 1999). In this line, the search for meaning and cognitive coping strategies would appear to be critical elements in post-traumatic growth (Park, 1998).

We might ask ourselves at this point about the role of the psychologist. Bearing in mind that, at least for now, post-traumatic growth cannot be created by the therapist according to an established formula or procedure, we must assume that this has to be discovered by the subjects themselves. The psychologist should be capable of perceiving and identifying in each person the different small, early expressions of this growth so as to channel them and help them to develop (Calhoun & Tedeschi, 1999). Not everyone will be able to learn from their traumatic experience, but some will, and admitting this possibility is already a step in the right direction. In clinical practice, however, there is need for the utmost caution, since pressure to perceive benefits may bring feelings of frustration to people who are incapable of

finding such benefits (McMillen, Zuravin & Rideout, 1995).

The possibility of increasing levels of resiliency and growth after going through highly adverse situations is still a grey area for psychology (Bartone, 2000). Indeed, if we were able to understand how and why some people resist and extract benefit from such adverse events, and if we were able to teach this as a skill, the advantages for the world's health system would be enormous (Carver, 1998). There is a need, therefore, for a great effort of empirical research with a view to clarifying the nature of the processes of resistance and growth.

CONCLUSIONS

Living through a traumatic experience is undoubtedly a situation that changes a person's life, and without wishing to belittle the seriousness and horror of such experiences, we should not overlook the fact that in extreme situations human beings have the opportunity to reconstruct the way they understand the world and their system of values. For this reason, we should build conceptual models capable of incorporating the dialectic of posttraumatic experience and accepting that apparently contradictory elements can coexist.

Psychology is not merely psychopathology and psychotherapy, it is a science that studies human complexity, and should concern itself with all its aspects. There is a need to broaden and reorient the study of the human response to trauma with a view to developing new forms of intervention based on more positive models, focusing on health and prevention, and which facilitate recovery and personal growth. It is a question of adopting a paradigm from a health model that would allow us to conceptualize, study, design and intervene in relation to trauma both effectively and efficiently.

The psychologist's work as seen from the perspective of Positive Psychology should serve to reorient people and help them find ways of learning from the traumatic experience and building on it, taking into account human beings' strength, virtue and capacity for growth.

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THE AMERICAN MODEL OF PSYCHOTHERAPEUTIC CULTURAL COMPETENCE AND ITS APPLICABILITY IN THE SPANISH CONTEXT

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The increasing presence of culturally different clients in Spanish mental health services constitutes an important challenge for the effective delivery of care. Cultural competence has been proposed as a general approach for improving services, which requires changes at both institutional and clinical levels. The vast majority of cultural competence models have been developed in the United States. Clinical cultural competence consists of specific knowledge, skills, and attitudes that function together to provide an individualized, culturally sensitive and appropriate treatment. Despite a highly promising start, cultural competence in mental health needs to be further defined, adapted, and researched for effective application in the Spanish context.
***Key words**: cultural competence; cross-cultural psychiatry; psychotherapy.*

La progresiva presencia de usuarios culturalmente diferentes en los servicios de salud mental constituye un reto importante para la calidad asistencial. Se ha propuesto la competencia cultural como un enfoque general para mejorar estos servicios, lo que implica cambios tanto a nivel institucional como clínico. La gran mayoría de los modelos de competencia cultural se han desarrollado en los Estados Unidos. La competencia cultural clínica consiste en la adquisición de unos conocimientos específicos, unas habilidades y unas actitudes con los que poder ofrecer un tratamiento adecuado, individualizado y culturalmente sensible. Pese a disfrutar de un esperanzador comienzo, la competencia cultural en salud mental necesita hoy en día un mayor impulso que permita su correcta definición y adaptación de cara a su efectiva aplicación en el contexto español.
***Palabras clave:** Competencia cultural; psiquiatría transcultural; inmigración, psicoterapia.*

Setting an objective such as establishing best practice through formalized standards and competencies is typical of North American pragmatism. Guidelines and competencies for working with persons from other cultures and races have been, or are being developed in almost all areas of social and healthcare services. The models usually deal with competence at the structural, institutional and clinical levels. In medicine, more attention has been paid to structural and institutional levels, while in psychology the focus has been on the clinical level. Although here we shall also pay more attention to the clinical level, structural and institutional commitment to cultural and racial diversity is indispensable.

Clearly, the North American model is not wholly applicable to a multicultural context as different as that of Spain. Nevertheless, the former has more than 30 years of valuable experience in this field, covering multicultural work in psychology, medicine, nursing, etc., and promoting working groups and professional journals such as the Association of Non-White Concerns, the Journal of Black Psychology or the Multicultural Counseling Association. It should be stressed that work in this area did not begin with the arrival in the United States of populations from other cultures and races (these were already present almost from the country's beginnings), but rather with the entry of numerous professionals from ethnic minorities into hospitals, universities and professional associations.

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DEFINITIONS

The North American literature acknowledges that there are serious problems with the provision of social and health services to persons from different ethnic groups. Problems include not only those of nomenclature, but also those related to basic concepts which require clarification before we begin, to ensure that we are talking about the same thing.

Culture

The definition of culture we often use sees it as a series of artifacts, customs, rituals, foods, values, habits, etc., which are essentially products and activities. While adequate as a heuristic, it has some serious limitations when applied to intercultural work. Culture viewed in this way is something fixed in time and space, something which can be known, had and lost. Cultural competence requires a different understanding, which we shall look at shortly.

Another perspective sees culture as a process and a context. According to Jenkins (1996), culture is:

context of more or less known symbols and meanings that persons dynamically create and recreate for themselves in the process of social interaction. Culture is thus the orientation of a people's way of feeling, thinking, and being in the world—their unself-conscious medium of experience, interpretation, and action. As a context, culture is that through which all human experience and action—including emotions—must be interpreted. This view of culture attempts to take into consideration the quality of cultures as something emergent, contested, and temporal, thereby allowing theoretical breathing space for individual and gender variability and avoiding notions of culture as static, homogenous, and necessarily shared or even coherent (p. 74).

In the context of social and health care services, the importance of culture is linked to interpretation. The culture conditions the interpretation of the situation (the illness or problem and its cause, the care relationship, the way the problem is solved) by the client and the professional.

Race

Race is a concept that defines the North American reality, yet the existence of which is denied in continental Europe. Since the model presented here is North American, it would be useful to define it as it is understood within the social sciences there, in the United States.

Hardly anyone views race as a biological phenomenon; race is understood as a social construct used to control access to resources. Janet Helms, one of the pioneers of multicultural counseling, uses the term "sociorace" to emphasize the socio-political aspect of the concept. The basis of the difference is arbitrary – whether by skin color, place of origin, religion or ethnic origin. According to Martínez and Carreras (1998), racism is:

an ideological social construct, sustained by a wide range of outside interests, superimposed on the strictly scientific ones, and conditioned by a specific model of international economic and political relationships that conferred, and still confers, on its advocates some type of benefit through its maintenance and persistence (p. 62).

Racism is a power relationship, and to speak of race therefore implies the recognition of an imbalance of power between different groups.

Immigrant

The United States and Canada are countries made up largely of immigrants and their families. Any person who moves to another country to start a new life is an immigrant, not only those who seek to improve their economic circumstances. The stress factors linked to immigration (the change of culture, leaving one's homeland, feeling different from others, perceived discrimination) can affect any immigrant, though the more resources one has, the easier it is to deal with these stressors. Within the model of cultural competencies, an immigrant is a person who comes from another country to start a new life.

Ethnic group

Ethnic group refers to a more specific group of shared characteristics, distinct from culture, which can relate to a subgroup within a particular culture – for example the Inuits in Canada, or a group which is present in different cultures, such as the Kurds in Turkey, Iraq and elsewhere. According to Helms and Cook (1999), ethnicity can be understood as "the national, regional or tribal origins of one of the oldest remembered ancestors, and the customs, traditions and rituals handed down by such ancestors …" (p.19).

Identity

Within the general context of multicultural societies, identity is playing an increasingly important role. Cultural, racial or ethnic origins can affect individuals in two important ways. The first, and most basic, is in the context of culture: this determines the system of meanings through which the individual makes sense of the world. The second is in the context of identity, or how one sees oneself. Identity refers by definition to constancy over time, and one's racial or ethnic identity is an important part of this process. Research has indicated for example, that ethnic or racial identification moderates drug consumption. (Brook, 1998; Brook, Whiteman, Balka, Win, and Gursen, 1998; Marsiglia, Kulis, and Hecht, 2001).

The greater one's sense of ethnic identity, the less likely drug abuse becomes.

The academic world is increasingly valuing the notion of ethnic or racial identity as extending beyond a simple zero sum equation (one identifies oneself or not with a group in question), and arriving at a definition that considers identity as a process (Helms and Cook, 1999; Phinney, 1990), directly related to resistance skills, vulnerability and mental health. The general idea is that there are many ways to identify oneself with the group, and that the pertinent variables include the degree of identification, the way one identifies oneself, and the way in which one negotiates identity between one's ethnic or racial group and the culturally dominant group. As will be seen, the cultural competence model requires social and health care service personnel to be up to speed on the different models of identity.

The most accepted models start out with the notion that racial or minority/majority identity of a group is fundamentally dialectic. The way in which one relates oneself to one's group is inseparable from how one relates to the "other" group (Carter, 1995; Helms and Cook, 1999). As mentioned above, race implies a power relationship, and it is this relationship which is omnipresent in racial identity.

MEDICAL MODELS OF CULTURAL COMPETENCE

There is, of course, a great variety of medical models of cultural competence, and we cannot attempt a thorough presentation here of each one. Nevertheless, the models tend to share certain basic components. In particular, they tend to place considerable emphasis on institutional and structural competencies (Betancourt, Green, Carrillo, and Ananeh-Frempong, 2003; Health Resources and Services Administration US Department of Health and Human Services, 2001). Competence is essentially defined as the medium for breaking down the barriers that impede access to public health services.

Institutional competence

The second item of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) (Office of Minority Health, Department of Health and Human Services, 2001) in the US health system states:

> *Healthcare organizations should implement strategies for recruiting, retaining and promoting at all levels a team rich in diversity and a leadership that together represent the demographic features of the service context.*

At the institutional or organizational level, the most important barriers are related to the representation of ethnic minority members in leadership positions and in the working population in general. The idea is that diversity in leadership positions and among the working population in general would contribute significantly to the development and implementation of appropriate policies, protocols and systems for the care of minority populations. Indeed, it has been shown that the presence of professionals from minority groups leads to high levels of satisfaction among patients (Saha, Komaromy, Koespell, and Bindman, 1999). As one would expect, patients who can communicate with their doctor in their own language show higher levels of satisfaction. Competence at this level thus implies active recruitment and promotion of professionals who represent minority groups.

The situation in Spain is, of course, different, given its considerably shorter multicultural history. At the same time, there is a series of steps that can be taken, such as facilitating the process of homologation and providing incentives for the younger members of minority groups to take up careers in the biosciences or the fields of health or social work.

Structural competence

The remaining CLAS items are essentially structural guidelines which healthcare institutions must follow to ensure patients from ethnic minorities receive the same level of healthcare as patients from majority groups. Of course, it is also true that existing structural barriers impede access to health services for majority groups, a phenomenon which is more frequent in systems with private and public healthcare, as is the case in the USA and Spain.

Structural competence is a response to the specific barriers that impede access to quality health services. One of the most important barriers is language (Baylav, 1996; Betancourt et al, 2003; Bowen, 2001; Duffy and Alexander, 1999). Naturally, CLAS emphasizes the importance of the availability of interpreters or cultural mediators, of professionals with a minimum of language skills, and of ensuring that signs, leaflets, forms and all written information in general is available in the languages of the main groups served.

Important though it is, language is not the only structur-

al barrier. A barrier is any aspect of healthcare that contributes to its improper use. Structural cultural competence, then, includes adapting the institution to the needs and customs of the client. This may mean extending opening hours, offering the possibility of receiving attention without prior appointment as an option alternative to appointment-only services, the provision of mobile clinics, and so on. The objective is the creation of a healthcare system that guarantees "total access to quality medical services for all its patients" (Betancourt et al, 2003), so that healthcare services adapt to the needs of their users. This idea contrasts with the notion that the user must adapt to the health system, a view shared by many healthcare professionals.

In sum, structural cultural competencies imply that the whole healthcare system and its institutions must prioritize cultural diversity issues. This implies that best healthcare practice models include the availability of cultural experts for possible consultation, the hiring of interpreters or mediators whenever necessary, the provision of training in this area, and guarantees that the physical space of an institution reflect cultural sensitivity.

Clinical cultural competence

In the medical literature, clinical cultural competence normally includes cultural sensitivity and knowledge, specialized knowledge and occasionally cultural humility. In general, the medical literature emphasizes knowledge of some illnesses and communication styles, and even the process of communication itself (Betancourt et al, 2003; Health Resources and Services Administration US Department of Health and Human Services, 2001; Like, Betancourt, Kountz, Lu, and Rios, 2001/2002; Misra-Herbert, 2003). To a lesser degree, and mainly in the field of nursing, the recognition of oneself as a cultural being is considered important (Campinha-Bacote, 1999; Purnell, 2000; Tervalon and Murray-Garcia, 1998; Wells, 2000).

MULTICULTURAL COUNSELING COMPETENCIES

The initial version of Multicultural Counseling Competencies (MCCs) (Sue et al, 1982) was developed in 1982 within the Psychological Counseling Division of the American Psychological Association, and revised in 1992 (Sue, Arredondo, and McDavis, 1992) at the request of the president of the Association for Multicultural Counseling and Development. In 1996, the competencies were developed a little further (Arredondo et al, 1996), to form the basis of the Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (American Psychological Association, 2003). The competencies have been supported by the Society of Counseling Psychology Division and the Study of Ethnic Minorities Division, as well as the Association for Counselor Education and Supervision and six further divisions of the American Counseling Association. At present, although not supported by everyone, the competencies have been very well received within psychology in North America.

What differentiates this model from other approaches to cultural competencies is the emphasis it puts on counselors or therapists being conscious of themselves and exploring themselves at a personal level. Counselors are urged to explore themselves thoroughly as an important step in attaining cultural competence.

In any helping or care relationship, but particularly in the relationship with a counselor, certain tacit or subconscious attitudes or one's own beliefs can profoundly affect the result of the counseling process. Those who attend to the public may have a certain level of knowledge of the cultural group with which they are working, and may even have developed appropriate treatment techniques for these groups, but prejudice, often unconscious, can prevent effective help from being provided. This has been proved in studies which show how doctors prescribe fewer analgesics to non-white patients (Green et al, 2003; Tervalon and Murray-Garcia, 1998), and how mental health professionals more frequently diagnose individuals belonging to minorities as suffering from severe mental illnesses (Bhugra, 2000; Lu, Lim, and Mezzich, 1995).

The issue of prejudice cannot be ignored. In multicultural societies such as the United States and Canada people are highly conscious of it, and know how to talk and behave in a politically correct fashion with regard to the matter. The majority of professionals do not wish to be considered as racist and do not see themselves as such. One of the commonest and most uncomfortable aspects in the multicultural debate, particularly when members of the minority as well as the majority group are included, is that of accusations of racism leveled against majority groups. This is often a blow to those making an effort to be antiracist. Research has frequently shown that there is a preference for groups that share common norms, and

an automatic rejection and stereotyped reactions in relation to members of groups whose norms are different (Banaji, Blair, and Glaser, 1997; Dovidio, Kawakami, and Gaertner, 2002).

As with the majority of competence models, the MCCs are based on attitudes and beliefs, knowledge and skills, each one applied to the following areas (Arredondo and Toporek, 2004; Arredondo et al, 1996; Sue et al, 1998):

1. The counselor must be conscious of his or her own cultural values and intolerance or prejudices.
2. The counselor must be conscious of the client's or user's opinion of the world.
3. Appropriate cultural intervention strategies.

The model is complex because of its application of a 3x3 structure, but this was used to emphasize that the three competencies are applicable to each domain; for example, being conscious of oneself is a skill that requires knowledge.

Counselors must be conscious of their own cultural values and intolerance or prejudices.

The first area is essentially that of being transparent to oneself, and requires counselors to be actively involved in understanding their own cultural situation and how this influences the way in which they relate to the world. The Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists, published in 2003 by the American Psychological Association, summarize this point very well in Guideline 1 (American Psychological Association, 2003):

> *Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves. (p.382).*

Recognition of this requires total commitment when looking at and understanding oneself in relation to one's own cultural dimension. It forces us to take a searching look into our cultural heritage in order to develop a positive racial identity. In short, competence in this field requires that one wishes to get to know one's own cultural dimension in order to understand how this shapes our interactions with others and enable us to take the necessary steps to further the process in a positive way. This self-awareness includes examining how we are affected by racism and discrimination, and how in consequence can hold racist or prejudiced attitudes and beliefs. For members of majority groups, this requires the exploration of privileges and benefits accruing merely through being identified as members of the majority group. Benefits that are the fruits of racism and found in individuals, institutions and culture. This clearly an ability and a will to involve oneself in a process of exploration that is neither comfortable nor socially desirable, but which is considered essential for effective intercultural work. Finally, this competence includes the awareness and understanding of how one's own cultural and racial position affects users.

Understanding the patient's perspective

This area is an essential part of attaining intercultural empathy. The culturally competent counselor or therapist must attempt to understand the user's perspective and, although not always sharing their expectations and perspectives, should at least respect and appreciate them. Competence in terms of attitudes and beliefs implies the above-mentioned self-transparency, as well as the skills that allow negative judgments and emotional reactions towards patients to be observed and controlled.

Understanding the patient's perspective obviously involves having a sufficient level of cultural knowledge, which consists of three parts:

- First, profound knowledge of the patient's culture, cultural heritage and personal history. Given that cultural knowledge is nomothetic, and that belonging to an ethnic or racial group is a demographic, not a psychological fact, the Multicultural Counseling Competencies clearly recognize the use of the identity models described above as a means of individualizing cultural knowledge and giving it greater behavioral and psychological significance.
- Cultural knowledge, in the Multicultural Counseling Competencies, also implies an awareness of how race and culture influence people, not only in relation to general concepts such as psychosocial development, but also to concrete concerns of mental health, such as representations of distress, help-seeking behaviors or expectations regarding the counseling process.
- Finally, competence in terms of cultural knowledge implies an understanding of the influence of socio-political and economic factors on the lives of minority group members.

Competence in skills in this field essentially involve an active search for the education and experiences necessary for developing cultural empathy.

Culturally appropriate intervention strategies

This is the most "concrete" of the three areas, and perhaps that which generates most interest among healthcare professionals, since it determines what one should do when working with patients from different cultures. This area cannot, however, be expected to serve as a "cookbook" in which the professional can find the appropriate recipe for each user depending on his or her cultural or ethnic background. What it actually provides are the attitudes, beliefs and skills necessary for effective interventions, without ever describing the interventions as such.

The starting point for effective intervention is the requirement that professionals respect the user. This implies respect for beliefs regarding the distress or problem as well as the possible solutions suggested by the patient. Competence in this area implies general knowledge of the normal care-giving approaches in the majority group, the institutions involved, and the ways in which these are culturally biased, which can impede efficiency, either because they impede access or because lead to a culturally inappropriate service.

Flexibility is fundamental in any skills competence. The counselor has to adapt to the needs and wishes of the patient, always within the appropriate ethical framework. Culturally competent counselors have no difficulty in applying their knowledge of different communication styles; they have to be experts in correctly interpreting signs, both verbal and non-verbal, and the messages transmitted by patients; and they must be able to respond in a comprehensible manner to their patients. The counselor's intervention should match the needs of the patient, more than the professional's philosophy, although flexibility does have limits, and professionals need to know their own limits and when the patient should be referred. Similarly, the competent professional can discern the difference between cases that require more social or more institutional treatment, and is capable of taking the necessary steps to ensure that the treatment is carried out. Flexible and effective treatment means not only knowing when patient referral is necessary, but also when to consult a representative of traditional/folk medicine, or spiritual or community leaders, in an attempt to adapt the service to the needs of the user. At the same time, the professional obviously needs to ensure that the service is offered in the preferred language of the patient. This may mean making the necessary patient referral or ensuring the availability of cultural mediators.

It is important to emphasize that, although flexibility is important, the services must be consistent with the counselor's competencies; moreover, the services offered, however flexible, should not go beyond the limits of counseling or psychotherapy. It is essential that the professional informs and educates the patient about the nature of the treatment to be carried out and what it involves. Many people have no experience of psychotherapy, and therefore have no idea what it can offer them. Effective communication and treatment require a mutual understanding of what is being done (Table 1).

It is undoubtedly difficult for many of us to adopt the "native's point of view", and there is a tendency to put forward arguments from other perspectives. Cultural competence, however, demands that we do not impose our values on patients, but that we accept them as reasonable and intelligent people.

DISCUSSION

It is important to point out that competencies in multicultural counseling do not replace or substitute the skills already in use in counseling. Despite their critical view of

TABLE 1
APPLICATION OF COMPETENCE IN ATTITUDES AND BELIEFS

The Moroccan couple

A Moroccan woman has an appointment with her psychologist and arrives with her husband. Each question directed by the doctor to the woman is answered by the husband. The woman remains seated with her head down, avoiding any visual contact with the psychologist. How should this be interpreted? It might be seen by many as a clear example of sexism, inherent in Arab and Muslim cultures, and that the husband is a chauvinist trying to control his wife. Applying cultural competence, the psychologist must first of all recognize his prejudices towards the couple and Arab and Muslim cultures, as well as identifying the possible bias of this analysis based on Western principles. Next, the psychologist must try to apply cultural empathy, that is, understand the behavior of the patient from her perspective. Could another explanation be found? Might the husband simply be doing what his culture dictates? Could it be that what the husband is actually doing is taking responsibility for his wife's well-being?

existing Western models, the MCCs do not offer an alternative approach to counseling, other than broadening the role of the counselor. The specific approach has reached the doctor-patient level, but it is not clear, given the nature of the criticisms, to what extent it can serve as the conventional approach. At the same time, it is evident that the MCCs do not propose to sidestep conventional psychology – indeed, the operative system remains a firm part of the traditional approach, though with some modifications. What the multicultural counseling competencies offer above all is an orientative paradigm, allowing counselors to sensitize themselves to aspects which, if effectively covered, can make the service more sensitive to members of ethnic minority groups.

What is clear is that institutional and structural cultural competence form the basis of clinical cultural competence. While it is true that individuals can make the effort to reach this level of expertise using a model such as the MCCs, unless their clinical or therapeutic institution and the health service authorities support the process, cultural competence will simply remain at the individual level, rather than being a phenomenon with the power to truly coordinate and integrate. The availability of cultural mediators, the recruitment of professionals from ethnic minorities, the structural modifications designed to adapt the services to the cultural needs of users, access to cultural consultants and ongoing training in cultural competencies require a serious commitment on the part of the administration and the institution. At an individual level, cultural competence requires something more than a mere accumulation of knowledge and a desire to help interesting people. It also takes the courage to commit oneself to serious reflection on one's own prejudices and bias.

Given the present Spanish panorama, with a marked development towards an increasingly multicultural society as a direct consequence of migratory phenomena in constant progression, there should be a growing realization of the importance of cultural competence. For obvious historical reasons, this has not previously been an issue of concern for healthcare professionals in general or those working in mental health in particular. Nevertheless, the demographic tendency towards multiculturalism demands a rethink, and poses the challenge of offering a similar level of service quality to all users of the healthcare system, independently of their ethnic or cultural background. Consequently, it seems reasonable to consider that any mental health service unit in the Spanish context should soon include cultural competence in its quality criteria. The American model presented in this article need not to be the one to follow. Up to now, no model can be said to have attained perfection, and we therefore have none to serve automatically as a reference point for our context. The features of Spanish society, its ethnic groups, the migratory phenomenon, its geographical location, its health system, and so on, mean that none of the currently available models can be applied just as they are, without an effort of adaptation, flexibility and, indeed, imagination, in line with the contextual conditions.

Note: The article is based on the lecture: "The model of cultural competence (United States and Canada) and its application in the field of drug abuse." 2nd Conference on Cross-culturality at the XAD, Department of Health and Social Security, General Directorate of Drug Addiction and AIDS, Catalan Regional Government, March 2004, Barcelona.

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SHOULD ALL HEALTH-RELATED DISCIPLINES BE REGULATED AS HEALTH PROFESSIONS? Comments on the studies by Professor Buela-Casal and colleagues

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These comments are written with regard to the studies by Professor Buela-Casal and colleagues on the image of Psychology as a health profession. Contrary to the general conclusion of the authors, the results suggest that Psychology and Clinical Psychology are not equally recognized as health professions. Likewise, most of the psychologists polled considered that only clinical psychologists are capacitated to diagnose and treat emotional and mental disorders. Finally, problems in the representativeness of the samples studied, the usefulness of the COPPS questionnaire, and the study approach are discussed, all of which limit the contribution of the Buela-Casal et al. studies to the debate on the regulation of non-clinical specializations of Psychology as health professions.
***Key words**: Clinical psychology, health professions, opinion studies, professional regulation.*

Este comentario se escribe a propósito de los estudios del profesor Buela-Casal y colaboradores sobre la imagen de la Psicología como profesión sanitaria. En contra de la conclusión general de los autores, los resultados sugieren que la Psicología y la Psicología Clínica no son igualmente reconocidas como sanitarias. En el mismo sentido, la mayoría de los psicólogos colegiados considera que únicamente los psicólogos clínicos están capacitados para diagnosticar y tratar los trastornos emocionales y mentales. Finalmente, se comentan algunos problemas en la representatividad de las muestras estudiadas, la utilidad del COPPS y el planteamiento del estudio, lo que limita su contribución al debate sobre la regulación como profesiones sanitarias de las especialidades no-clínicas de la Psicología.
***Palabras clave:** Psicología clínica, profesiones sanitarias, estudios de opinión, regulación profesional.*

In a recent issue of *Papeles del Psicólogo*, Professor Gualberto Buela-Casal and colleagues published the results of four independent opinion studies on the image of Psychology as a discipline and health profession among university teachers and students, psychological association members and the general population (Buela Casal et al., 2005a,b,c; Sierra et al., 2005). The studies are based on the remote administration of a brief questionnaire to large samples.

For recording the opinions in the cases of teachers, association members (psychologists) and students, the authors used the Opinion Questionnaire on Psychology as a Health Profession (*Cuestionario de Opinión sobre la Psicología como Profesión Sanitaria*, COPPS) drawn up ad hoc. The authors conclude in general that the populations surveyed with the COPPS have a favourable opinion of Psychology as a health profession. However, in the factor structure of the first COPPS sub-scale the dimensions that group general Psychology and Clinical Psychology appear separately. All three samples judge as more "health-related" (on the basis of the study's assumptions) Clinical Psychology than general Psychology, from which we would have difficulty abstracting the clinical sub-discipline. This suggests, more than the conclusion reached by the authors, a prior consensus between psychologists about the definition of professional profiles (Colegio Oficial de Psicólogos, 1998).

It is somewhat surprising that in the study with university students no data were collected from students of the UNED (*Universidad Nacional de Educación a Distancia* » The Open University), which has the largest student body (half of all new graduates), and we can assume with characteristics different from those of "normal" universities. (Note that none of the Health Sciences degree courses can be studied by correspondence courses, which are confined to the Social and Juridical Sciences). In the text

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there is no proper explanation of why UNED students were not included, especially when it is well known that the UNED and its associated centres are in close communication with their students. In spite of this, in the conclusions it is asserted that "the selected sample is representative of the Psychology students of Spain". Likewise, the authors describe as a "sufficiently representative" sample that of Spanish psychologists, in spite of the fact that only just over 10% of the initial sample replied to the questionnaire, and that it was limited to psychological association members, which does not cover all Spanish psychologists or even all those currently practicing. We might assume, then, that we are talking about a sample of psychologists (affiliated to associations) who are highly motivated to respond to a questionnaire with direct questions about the health-related status of Psychology. Of these, less than 25% are of the opinion that any psychologist can diagnose and treat "emotional and mental problems that affect health" (7 out of 10 deny it!), as against 96% that consider clinical psychologists capacitated to do so. This finding is of special relevance, given that, despite a widespread misunderstanding, diagnosing and treating are not in themselves health-related activities; what makes them health-related is their relationship to illness (in our discipline, mental illnesses). (On the other hand, if it made any sense with this sample of association members to carry out a contrast of means by professional profile, the study was lacking a post-hoc analysis clarifying the groups between which the differences shown in Table 4 were found.)

With regard to the COPPS sub-scale on the affinity between psychological and medical disciplines, the usefulness of the data it provides is at best questionable. What is the meaning, for example, on a Likert scale of 0 to 4, of a mean of around 2 in affinity between Psychology and Medicine? Is it not reasonable to assume that we all find some affinity between them, and between specializations with such similar names? Do the students know about the medical (and psychological) specializations on which they are giving an opinion? And the teachers and psychologists? How was their knowledge assessed? Do the differences between the means of the different specializations have any meaning? Were they analyzed? In sum, why should we understand, as the authors assert, that "these data would support Buela-Casal's (2004) proposal that other psychological disciplines apart from Clinical Psychology should eventually become considered as health-related"?

Previous studies indicate that the lay population knows something of Clinical Psychology, but is largely ignorant of the other sub-disciplines of Psychology (Fowler & Farberman, 1998). Studies with Spanish population reviewed by the authors in the introduction are said to confirm the "dissociation" between public opinion and the reality of Psychology. Bearing this in mind, and that the questionnaire used with this sample (general population) favours the identification/confusion of Psychology with Clinical Psychology, since the latter is not presented separately, it can be assumed that respondents reply to the questions (referring to Psychology) thinking about the clinical sub-discipline. Are these data, then, favourable to its regulation as a health profession? It would have been more pertinent to sound out the opinion of the population on the possibility of being treated for an illness or its effects by a "health" professional without supervised training.

Psychology's object of study is human behaviour, and this is undeniably related to health. This argument would be sufficient to explain the relationship (to a greater or lesser extent) between health and Psychology if it were necessary. But not all health-related professions (for example, those of alternative medicine) are regulated as health professions (that is, included in the *Ley de Ordenación de las Profesiones Sanitarias* (LOPS; Law for the Organization of the Health Professions). If it is considered that Psychology as a whole should be included, this cannot be justified exclusively by its evident relationship to health. The authors should have taken this into account in their general approach to the project.

In conclusion, while the initiative of approaching the current debate from a different perspective is appreciated, the studies discussed here do not help to clarify the crux of the question: the appropriateness or otherwise of regulating as health professions the remaining specializations of Psychology (educational, social, industrial, and so on) – those that do not deal with illnesses.

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REPLY TO GONZÁLEZ-BLANCH (2006): SHOULD ALL HEALTH-RELATED DISCIPLINES BE REGULATED AS HEALTH PROFESSIONS?
Comments on the studies by Professor Buela-Casal and colleagues

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This article is a reply to González-Blanch's comments about the studies conducted by Buela-Casal's research group on the image of Psychology as a health profession that were published in issue 91 of Papeles del Psicólogo. The comments and criticisms made by González-Blanch are only personal opinions, and are even wrong most of the time, an exampling being his proposal to use different procedures for data recollection in the same study. Furthermore, the author contradicts himself on considering that the samples present problems of representativeness and, at the same time, discussing certain results from these samples that he finds interesting. However, perhaps the most surprising part of his article concerns his interpretation of the data from the study with the general population.
Key words: *image of Psychology, health profession, health disciplines*

Este artículo es una réplica a los comentarios de González-Blanch sobre los estudios realizados por el grupo de Buela-Casal sobre la imagen de la psicología como profesión sanitaria y que fueron publicados en el número 91 de Papeles del Psicólogo. Los comentarios y críticas realizadas por González-Blanch no son más que simples opiniones personales, las cuales en la mayoría de los casos son incorrectas, como por ejemplo, proponer que se utilicen procedimientos distintos en la recogida de información en un mismo estudio. Por otra parte, el mismo autor se contradice al considerar que las muestras tienen problemas de representatividad y al mismo tiempo resalta algunos resultados que parecen interesarle especialmente. Pero quizá lo más sorprendente es la interpretación que él hace de las respuestas del estudio con la población general.
Palabras clave: *imagen de la psicología, profesión sanitaria, disciplinas sanitarias.*

Some time ago I came across a text by González-Blanch criticizing the work of other authors, and the title of his critique began like this: "Publishing hastily and badly …" (published in the journal Siso Saúde); well, now we could adapt this and begin "Making remarks hastily and badly ..." It is beyond doubt that criticism of research, and reply to such criticism, are not only recommendable, but in science are indeed considered essential. However, in order to make comments and criticize it is not sufficient to know how to write; one must also know what to write and how to write it. Therefore, I shall make some remarks about both formal aspects and content-related aspects, with the sole aim of helping this author to improve subsequent texts, and to avoid confusing some of his readers. González-Blanch's (2006) text not only includes some substantial formal mistakes, but also includes erroneous arguments, incorrect interpretations and some logical contradictions. I shall first address some of the formal deficiencies, and I shall follow this with some considerations about the content.

Considerations on formal aspects:

1- I earnestly recommend the author to review the formal aspects of writing texts for publication in scientific journals, beginning with the title. He might consider reading the norms proposed by Bobenrieth (2002) (also recommended are Montero & León, 2005 and Ramos-Álvarez & Catena, 2004), in particular the part referring to titles. In the case of the comments by Gónzalez-Blanch (2006), the title is totally inappropriate, since, in none of the works to which he refers is there any mention in the titles or the objectives of the question "Should all health-related disciplines be regulated as health professions?"; without doubt, only a very biased reading could lead to the conclusion that the published works deal with this question, as the author appears to claim, given the title of his text. As pointed out in Buela-Casal (2005), the authors tried to present the results of the studies in the most descriptive way pos-

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sible. In a previous article by one of the authors of the studies (Buela-Casal, 2004) the title: "Psychology: a health profession with different specializations?" is even followed by a question mark, in an attempt to highlight the speculative tone of the reflection.

2- The author is strongly recommended to follow APA norms, both for quoting within the text and for including references, since in some cases one has to deduce which works he is referring to. As an example, when he writes Buela-Casal et al., 2005a,b,c.: what do these letters mean?

3- It would be preferable to write using more technical and precise terminology to make himself more easily understood. For example: "The studies are based on the remote administration of a brief questionnaire to large samples." I think no comment is necessary, especially about "remote administration".

Considerations about content:

1- According to González-Blanch (2006), it is difficult to abstract Clinical Psychology from Psychology in general, referring to the fact that respondents are questioned separately about Clinical Psychology and Psychology in general. On this point it must be said that logic and common sense lead us to think that this can be done, just as we can assess the attitudes of Spaniards and the attitudes of Europeans; indeed, the factor analysis confirmed that the distinction between Clinical Psychology and Psychology in general occurs in the respondents of the first study (Buela-Casal, Gil Roales-Nieto et al., 2005).

2- The author finds it surprising that the study with university students (Sierra et al., 2005) did not include students from the UNED (*Universidad Nacional de Educación a Distancia* » The Open University), and that the text does not include a proper explanation of why they were excluded. First of all I should say "a word to the wise is sufficient", though as it seems this is not appropriate here, some clarification is necessary: a) depending on the objectives of a study it is perfectly viable to define university as a sampling unit, and it would seem difficult to argue that a study including 70% of universities is not representative; b) in any opinion survey one of the methodological requirements is to always use the same data-collection procedure. If we consider the procedure of the study by Sierra et al. (2005) we see that this cannot be applied to UNED students, and it would not be equivalent to record their opinions using other procedures via the institution's associated centres. Moreover, the author may or may not know that the UNED has more than 60 associated centres, and in cities as far flung as Malabo, Tangiers, Sao Paulo, Miami, La Coruña, Melilla, and so on. In sum, it is clear to any reader why UNED students are not and could not be included in the procedure employed.

3- González-Blanch (2006) also criticizes the representativeness of the study sample of Spanish psychologists, saying precisely: "…in spite of the fact that only just over 10% of the initial sample replied to the questionnaire…". A brief consideration of the study method of Buela-Casal, Bretón-López, et al. (2005) reveals that Gónzalez-Blanch is not correct in what he says. In the sample it is stated that there are 1206 professional psychologists in associations. This author confuses the sample with the e-mails sent, and it is clear that in this case we cannot speak of non-response rate, which seems to be what the author wants to do. Common sense is more than sufficient to realize that the fact that 10,380 e-mails are sent does not imply that these are read by their addressees, who then decide not to reply. It is impossible to know how many affiliated psychologists decided not to reply. In any case, 1206 psychologists is a sufficiently representative sample of psychologists affiliated to associations. Gónzalez-Blanch is also critical that such a sample does not represent all Spanish psychologists, but the reality is that we do not say that it does, and this is made quite clear in the first sentence of the article by Buela-Casal, Bretón-López, et al. (2005): "The aim of this study is to discover the opinion of the members of professional psychological associations…" (p. 16).

4- It is surprising, to say the least, that Gónzalez-Blanch (2006), after considering as inappropriate or unrepresentative the sample for the study with professional psychologists (Buela-Casal, Bretón-López et al., 2005), goes on to support his arguments on certain data that seem to interest him particularly, such as when he states: "less than 25% are of the opinion that any psychologist can diagnose and treat emotional and mental problems that affect health". Could it be that when the participants responded to this they *were* sufficient and representative? And later he writes: "...This finding is of special relevance, given that, despite a widespread misunderstanding,

diagnosing and treating are not in themselves health-related activities" Is it that when certain results emerge on some items there are no longer any problems with the sample, and they can be used as arguments against widespread misunderstandings? The interpretation this author makes of the response to this question in particular is curious to say the least, since the fact that seven out of ten consider that any psychologist can diagnose and treat emotional and mental problems that affect health does not imply that respondents think psychologists can work in other health-related areas, as can be hypothesized if we consider that just 17.5% of the same sample feel that psychologists should not form part of professional teams in hospitals. Could it be to do work other than that related to health? Or perhaps what occurs is that when they answer this item the respondents are not sufficient or representative? Or maybe it is the result of a biased reading and interpretation…?

5- With regard to the comment "the COPPS sub-scale on the affinity between psychological and medical disciplines,… the usefulness of the data it provides is at best questionable," it should be stressed that this is nothing more than a personal opinion, related, without doubt, to the level of analysis each reader may make. As for "Is it not reasonable to assume that we all find some affinity between them, and between specializations with such similar names?" – of course, and for the simple reason that they are similar, as the author himself acknowledges; indeed, nobody would claim a similar resemblance with other disciplines of the social and juridical sciences. But certainly the most surprising thing about Gónzalez-Blanch's (2006) article is that he appears to confuse an opinion survey with a survey of knowledge; and that is not all, for he asks: "Do the students know about the medical (and psychological) specializations on which they are giving an opinion?" "And the teachers and psychologists?" This is brazen, and more than inappropriate: it is difficult to imagine how someone could question whether senior Psychology students, teachers and affiliated psychologists know the meaning of Oncology, Paediatrics, Psychiatry, Forensic Medicine, etc.; but to question whether they know about Psychology specializations themselves is pure insolence.

6- González-Blanch (2006) asks: "…why should we understand, as the authors assert, that "these data would support Buela-Casal's (2004) proposal that other psychological disciplines apart from Clinical Psychology should eventually become considered as health-related"?". If one takes a look at the results the answer is obvious, given that in the vast majority of the comparisons in the first three studies (Buela-Casal, Bretón-López et al., 2005; Buela-Casal, Gil Roales-Nieto, et al., 2005; Sierra et al., 2005) it emerges that there is a considerable affinity between the disciplines compared, in the opinion of respondents.

7- González-Blanch (2006) also makes some comments on the study with the sample of the general Spanish population (Buela-Casal, Teva et. al., 2005), specifically: "the questionnaire used with this sample [general population] favours the identification/confusion of Psychology with Clinical Psychology,… since the latter is not presented separately, it can be assumed that respondents reply to the questions (referring to Psychology) thinking about the clinical sub-discipline,". This is worthy of admiration; for González-Blanch's capacity for interpreting what a sample of the Spanish population really mean, and for helping us to all to understand what, according to him, they really mean, we can only be grateful. We can only show our thanks for such a "disinterested and "objective" interpretation that involves saying something other than what they meant; indeed, one might ask oneself if he will understand one's words or interpret them.

8- González-Blanch (2006) also states: "It would have been more pertinent to sound out the opinion of the population on the possibility of being treated for an illness or its effects by a "health" professional without supervised training." If I might offer the author some advice, he may like to review the work by Virués, Santolaya, García-Cueto and Buela-Casal (2003), and if he does not reinterpret it he will realize that supervised training, as carried out in Spain, is perhaps not the panacea – but of course, this study can also be reinterpreted.

Finally, González-Blanch (2006) reserves another surprise for us when he writes that "The authors should have taken this into account…". One might think the author has some kind of "carte blanche" that authorizes him to say what a research team should or shouldn't do; but we might also ask ourselves whether this author has accred-

ited capacity for directing research. We should not forget that a universal rule in the assessment of scientific research is peer review and criticism, and being peers requires having the capacity and recognition to be peers. Another characteristic of valid scientific research is that it is replicable, and in this case – there are the Psychology students, the Medicine and Psychology lecturers, the affiliated psychologists and the general population, all available so that González-Blanch can replicate these studies, or carry out similar ones, and afterwards be in a position to give an opinion with arguments based on the data he obtains, and not, as he has done in this case, on mere speculation, on erroneous interpretation, or indeed, on some unstated interest.

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