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Highlights of this section

Papeles del Psicólogo has been placed at the service of specialists who provide information about some of the recent tendencies and developments in psychological treatments. The idea came from the Executive Committee of the Spanish Society of Clinical and Health Psychology. As a part of its 4th Annual Meeting titled "Opening up Paths to Clinical and Health Psychology" (October 2005), was celebrated a symposium on New Therapies and Clinical Techniques, which I had the honour of coordinating. Participating authors were: Dr. Ana Alarcón, who expounded the most relevant elements of the Valencia model of waking hypnosis; Dr.Miguel Ángel Vallejo, who contributed a very interesting report on mindfulness, and Dr. Carmen Luciano, who talked about the therapy of acceptance and commitment. Likewise, there was a fourth notable participant, the public, which, by means of its questions and considerations, encouraged a fruitful and very interesting debate of the topics that the speakers had discussed. The real lack of time to expound and debate all of them was in the minds of Drs. Serafín Lemos and José Ramón Fernández when they proposed the edition of this monographic issue of Papeles del Psicólogo, whose precedent may be found in the Journal Infocop. That journal covered the symposium and interviewed several of the participants (see the issues of 26/10/2006 and 14/11/06). Therefore, the contributions to this number are written by the same authors (with a co-author in some cases) as those who participated in the symposium, along with a "representative" of the public that encouraged the abovementioned debate. All the authors reflect in their contributions the novel or innovating aspects of the techniques, methods, and therapies they present, as well as their assumptions and empirical support. The representative of the public, Dr. Juan Ignacio Capafons, who played an important role in the debate, presents a viewpoint aimed at providing perspective of the topics discussed. His article develops within the framework of a context in which common aspects, the theoretical-practical relevance of the contributions, and the possible impact on Clinical Psychology are taken into account. In an era in which, again and again, people appear who defend the creation of a new therapy or technique, it is interesting to analyze what is novel, and still more so, the supposed plus benefit of utility and efficacy it may contribute to what there already is.

I trust that reading these works will contribute to the readers' intellectual enrichment. But, above all, I fervently hope and wish that it will encourage them to reflect in depth on the topics expounded, to develop their judgment about the various aspects proposed and, especially, to improve their professional practice.

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THE VALENCIA MODEL OF WAKING HYPNOSIS. NEW OR INNOVATIVE TECHNIQUES?

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The Valencia model of waking hypnosis presents some innovative features that allow an efficient and integrative use of hypnosis. The way hypnosis is presented to patients avoids trance explanations, or pathological-like terms. The hypnotized persons keep their eyes open while talking fluently. Moreover, hypnosis is contextualized as a general coping skill for self-control that uses the self-regulatory functions of the brain. This perspective is more permissive than the old conceptions of waking hypnosis, and involves the client more in the psychotherapy process. In addition, the model is integrative, as it has developed suggestion procedures to change the meaning of the patients' "symptoms", and their attitudes toward them. Thus, it is an approach that includes ideas from other psychotherapeutic perspectives. Experimental research shows that the Valencia model procedures are efficient and powerful to promote suggestions. Nevertheless, empirical evidence for its clinical applications is very scarce, and consequently, more research in needed.
Key words: *waking hypnosis, suggestion, psychological treatment, psychological intervention, cognitive-behavioral, psychotherapy.*

El Modelo de Valencia de Hipnosis Despierta presenta varias características innovadoras que permiten un uso eficiente e integrador de la hipnosis: la forma de presentarla al cliente evita un lenguaje tranceático o palabras "patologiformes", mostrándola como una estrategia general de afrontamiento y de auto-control, que usa las propiedades auto-regulatorias del cerebro. El paciente hipnotizado está con los ojos abiertos y conversando fluidamente. Esta perspectiva es más permisiva con el cliente y le responsabiliza más sobre su papel en el tratamiento que las perspectivas clásicas de hipnosis despierta. Además, trata de integrar distintas formas de intervención clínica, desarrollando procedimientos para el cambio del significado de los "síntomas", y de la actitud hacia ellos. La investigación experimental muestra la potencia y eficiencia de estos procedimientos para promover sugestiones, pero todavía carece de evidencia empírica en cuanto a su aplicación clínica.
Palabras clave: *hipnosis despierta, tratamiento psicológico, intervención psicológica, cognitivo-comportamental, sugestión, psicoterapia.*

Habitually, whenever we mention our interest in hypnosis, people bombard us with questions such as: Is hypnosis real? Could I remember things about my infancy under hypnosis? Could I have access to my subconscious under hypnosis? If, in addition, we say that it is not necessary for the hypnotized person to close his eyes and he can go on talking fluently, or walking, they are really surprised, and the amount of questions increases exponentially. What most laymen, and even professionals from psychology and medicine, intuit about hypnosis does not correspond to its experimental reality and its clinical application, due to the weight of the myths and erroneous beliefs about hypnosis. Perhaps that is why hypnosis is a technique that is not used very much in Spain by psychology professionals (Capafons & Mendoza, in press). These researchers indicate that, out of almost 800 psychology professionals interviewed, only 15.2% said they used hypnosis regularly, and only 7.6% knew about waking hypnosis (all those who responded referred to the Valencia model), and 9.2% knew about active-alert hypnosis. However, the psychologists who do use waking hypnosis consider it a useful technique, and easily and agreeably accepted by patients (Capafons & Mendoza, in press). Capafons and Mendoza also reviewed references of waking hypnosis in the current databases, finding very few clinical and experimental studies about it. This lack of information about and interest in waking hypnosis in Spain cannot be explained because it is recent—it is not—because Wells published a work on it back in 1924, and, before him, Carpenter (1852). It may more likely be due to the fact that it has been ignored in the research and clinical application in the Anglo-Saxon world. Probably, in the field of hypnosis, little attention has been paid to its "waking" variety

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because it was not in accordance with the general idea of hypnosis as a state of trance and sleep-walking (Sarbin & Coe, 1972). Therefore, we can answer the question posed in the title of this work about whether the Valencia model of waking hypnosis is a new technique. According to the Royal Academy of Language, *new*, among other things, means recently made or manufactured, what one sees or hears for the first time, repeated differently from what went before or from what one had learned, or that is added to what there was before, repeated or reiterated to renew it. Except for the last two definitions, the Valencia model of waking hypnosis, according to the rest of these definitions, is not a new technique. However, the word *innovative*, which, according to this Academy, means to change or modify something, introducing novelties, and, strangely enough, to return something to its former state, could define the model of waking hypnosis we are presenting. To sum up, our model is more innovative than new, like almost everything that is presented as "new" in psychology since the decade of the 80s. We defend that the Valencia model of waking hypnosis is innovative with regard to Wells' (1924) original use because it introduces novelties, such as, for example, that it is not so authoritarian, it revolves around self-hypnosis, and it promotes a different vocabulary to describe and use hypnosis than the one used by Wells, and also by authors who study active-alert hypnosis or some Ericksonian approaches. In this sense, it is also innovative and different from other more recent approaches to waking hypnosis (Iglesias & Iglesias, 2005), as our model of intervention and hypnosis is cognitive-behavioral.

WHAT IS WAKING HYPNOSIS?

The word "waking" refers to methods where the person does not need to be relaxed or to close his eyes in order to benefit from the suggestion. It is a way of differentiating these suggestion methods from the traditional methods, without meaning that the hypnotized person is not awake in the traditional methods by relaxation. We also use the word hypnosis to clearly designate that an induction ritual that is labelled *hypnotic*. Therefore, waking hypnosis can be considered as merely waking suggestion, which is used without this series of induction rituals. In contrast, it is important to clarify that when we talk about the Valencia model of waking hypnosis, we refer to a clinical procedure, and to a series of methods to change attitudes and use suggestions, with the following characteristics:

1. The person remains with eyes open.
2. Drowsiness or relaxation is not suggested, but instead activity and mental expansion.
3. The hypnotized person can talk fluently, walk, and perform daily tasks while experiencing the hypnotic suggestions.
4. It avoids suggesting trance, altered states of awareness, etc., paying attention to the vocabulary used to present hypnosis as a general coping strategy

These characteristics differentiate it from alert and active-alert hypnosis, because in waking hypnosis, it is suggested from the beginning that the person keeps his eyes open and that he talks naturally and fluently with the therapist, in addition to being presented as a self-control and coping strategy (Capafons, 2001a).

WHY WAKING HYPNOSIS?

We can consider two chief reasons: firstly, because it is a hypnotic technique, and, in this sense, it is highly probably to reveal the advantages of such techniques. When used as a single intervention, hypnosis does not seem effective to treat medical and/or psychological problems (Flammer & Bongartz, 2003). But when used as an adjunct, it seems to increase the efficacy of some psychological and medical interventions, especially in the case of pain, in which it is a well established treatment (Montgomery & Schnur, 2005). Hypnosis can also increase the efficiency of some treatments. In fact, Green and Lynn (2000) consider it an efficient technique to reduce the consumption of cigarettes, and Schoenberger (2000), an efficient adjunct in cognitive-behavioral treatments. Secondly, waking hypnosis has a series of added advantages over traditional hypnosis. Wells (1924) mentioned some of them: it avoids the appearance of being a mysterious procedure; it is faster and easier, both for the therapist and for the patient, and it can be used successfully in a higher number of subjects.

Thus, the Valencia model of waking hypnosis presents some advantages that justify its use:

- Like the waking hypnosis proposed by Wells (1924), as the person keeps his/her eyes open, there is less fear of losing control. Although control is not lost under any hypnotic condition, not closing one's eyes reinforces this idea. In this sense, it offers more possibilities as it is quicker, more accessible, and pleasant for a larger amount of subjects.
- Moreover, in contrast to Wells' model, which was very authoritarian and promoted the person's passivity

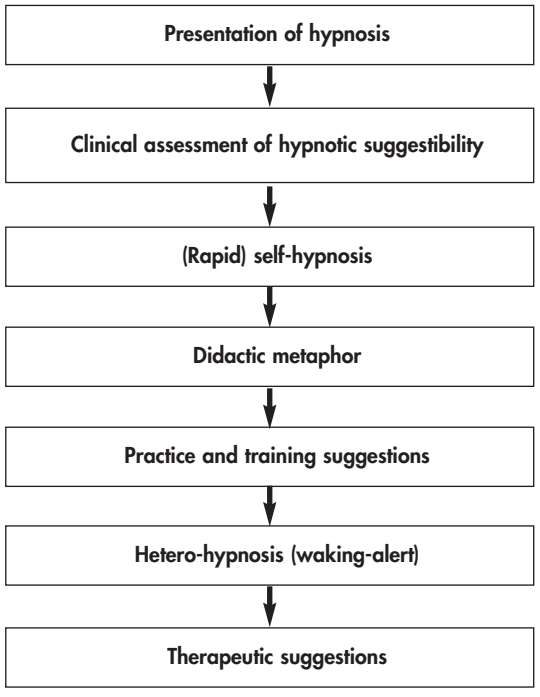
(John F. Chaves, personal communication to the second author, 12-1-2005), a strong characteristic of the Valencia model of waking hypnosis is that it favors the person's active participation while increasing the possibilities of therapy action (it is more versatile), because the hypnotized person can carry out any kind of habitual behavior, including in this behavioral repertory those behaviors required for therapy functioning: role-playing, in vivo exposure, etc. (Capafons, 1998b). Motivation for treatment and expectation of success are thus promoted (Capafons, 2001a).

- Lastly, the Valencia model presents waking hypnosis as a general skill strategy, for coping and self-control (Capafons, 1998b; 2001a), beyond a context of trance, in contrast to Wells' (1924) model.

ELEMENTS AND PROCEDURE OF THE VALENCIA MODEL OF WAKING HYPNOSIS

This model is based on the socio-cognitive or cognitive-behavioral paradigm of hypnosis. This is the first time that the topic of waking hypnosis is approached disregarding the concept of trance and defending the continuity between hypnotic and habitual behavior, resorting to variables such as expectations, motivation, attitudes, beliefs, etc. (Capafons, 1999; Lynn & Kirsch, 2005; Spanos & Coe, 1992). However, perhaps the most innovative aspect is the sequence we propose to manage the hypnotic suggestion, and which guides the practice of hypnosis, either waking or otherwise (Figure 1).

FIGURE 1
CLINICAL INTERVENTION SEQUENCE OF THE VALENCIA MODEL OF WAKING HYPNOSIS



Modified from Capafons, A. (2001a) Hipnosis [Hypnosis]. Madrid: Síntesis

Implicit in this sequence is our concern with generating efficient methods that are pleasant for the patient, quick, easy to learn and to apply (both for the patient and for therapist) and that reduce the percentage of dropouts as much as possible (Alarcón, Capafons, Bayot, & Cardeña, 1999). In this study, empirical evidence indicates that the efficiency of a therapeutic program to which is added hypnosis, may depend in particular on the induction method employed (Capafons, 2001b). Induction methods are efficient, depending on their own characteristics, the explanation of hypnosis offered to patients, and the expectations hypnosis generates in them (Capafons, 2001b; Lynn, Nash, Rhue, Frauman, & Sweeney, 1984). Hypnosis seems to help more when it promotes realistic expectations and positive attitudes (Schoenberger, 2000). Therefore, the Valencia model of waking hypnosis attempts to merge methods of changing attitudes towards hypnosis with induction methods and ways of dealing with the suggestions that enhance the pleasure and involvement of the person to be hypnotized in the intervention process.

Thus, the Valencia model of waking hypnosis includes three procedures to establish a good rapport, from a cognitive-behavioral viewpoint of hypnosis: the cognitive-behavioral presentation of hypnosis, clinical assessment of hypnotic suggestibility, and a didactic metaphor about hypnosis. Two methods of waking hypnosis are added to these procedures (Rapid Self-Hypnosis and (hetero) Waking-Alert Hypnosis), conforming the method we shall develop below. It is a structured but flexible sequence, whose central axis is Rapid Self-Hypnosis (RSH) (Capafons, 1998b). The ultimate idea is that the patients can inconspicuously activate the therapeutic suggestions in everyday situations where they need them (Capafons, 1999).

COGNITIVE-BEHAVIORAL PRESENTATION OF HYPNOSIS

When using hypnosis as adjunct of a treatment, it is advisable to appraise the patient's beliefs and attitudes

(Capafons et al., 2005), as inadequate expectancies modulate response to suggestion negatively (Kirsch, 1999). Therefore, some therapy time should be spent clarifying erroneous concepts so as not to generate false expectancies and to offer accurate information that corresponds to research. The goal of the cognitive-behavioral presentation is that patients experience for themselves certain reactions that help them to understand what can be expected from hypnosis. Therefore, the presentation includes a motor exercise with the Chevreul pendulum that illustrates the difference between "automatic" and "involuntary," reinforcing the concept of "interference," which is essential for the patient to begin to understand hypnosis as a self-control technique. Also, a comparison between going to the movies and being hypnotized is established, so that a piece of fiction can determine automatic and intense, but voluntary, responses (Capafons 2001a).

This presentation is an attempt to transmit the following ideas: a) responses to suggestions are actions of the user, the therapist only helps; b) these actions are automatic, but voluntary, although they are experienced as happenings; c) whatever occurs during hypnosis depends on the client using similar resources to other everyday actions (for example, letting himself be carried away by a piece of fiction, like in the movies); d) hypnosis involves everyday reactions that are activated or deactivated voluntarily; e) therefore, hypnosis is a way of self-control; f) being hypnotized does not mean being in a trance or the like, but having one's mind prepared to use the resources that, also in daily life, cause responses we perceive as automatic.

The presentation reveals hypnosis as a voluntary process of the client, avoiding words such as "trance," "dissociation," or "altered awareness," that may be associated with the idea of loss of control, generating fear or even direct rejection in some patients (thus losing efficiency). The experimental results indicate that when making this, or a neutral, presentation, there are significantly less dropouts among people who openly reject hypnosis if they are offered hetero-hypnosis than if hypnosis is labeled as a state of trance (Capafons et al., submitted for publication). However, if offered self-hypnosis, dropouts disappear and there are no differences between the three types of presentations (neutral, trance, cognitive-behavioral) when changing negative attitudes towards hypnosis (Capafons et al., 2005). The explanation could be that self-hypnosis may reinforce the belief that they will not lose control, thus increasing the client's sense of security and confidence. Therefore, the cognitive-behavioral presentation is far from mysterious or "pathologiform" conceptions of hypnosis, and this will be used during the rest of the intervention to motivate the client to experience the suggestions.

COGNITIVE-BEHAVIORAL ASSESSMENT OF HYPNOTIC SUGGESTABILITY

In this model, the attitude towards hypnosis and towards the therapist, and whether the person collaborates within a context of trust are assessed. For this purpose, classic hypnosis exercises are used, granting them a different meaning. As there is a high correlation between giving the same suggestions under hypnosis and out of hypnosis (Hilgard, 1965), the initial assessment is performed out of the hypnotic context (Capafons, 2001a). Thus, we facilitate the client's becoming more familiar with waking hypnosis. For example, in the first exercise of postural swaying, it is suggested that, while the person remains with closed eyes, feet together, and body relaxed, his body starts to sway. If upon listening to this suggestion, the patient sways slightly, this means he is not interfering, because this movement is expectable without the intervention of any suggestion. If the patient sways ostensibly, we assume he is collaborating and experiencing the effect of the suggestion and, therefore, his attitude is positive and his expectation is adequate. In the second exercise (falling backwards), the first step is to show the patient that he has complete control to prevent the therapist from letting him fall backwards without catching him. For example, the person is asked to throw himself backwards to verify that the therapist can catch him. Subsequently, the therapist talks to the client (who has his eyes closed) from various places so the client can make sure from the therapist's voice that he knows at all times that the therapist is at the right distance and place to be able to catch him. Then, and in the same position as the swaying exercise, it is suggested to the patient that he will notice a lack of balance and will fall backwards. If the patient falls backwards, we conclude that he clearly trusts the therapist. If he also felt the lack of balance, we assume that he experienced the suggestion. But if, despite noticing the lack of balance, the patient interferes with the fall, we can conclude he has a negative attitude, especially if he really fell backwards when asked to do so to verify that the therapist could catch him. He may have

a negative attitude towards hypnosis and not towards the therapist, because otherwise, he would have refused to fall backwards in this test. Finally, we proceed to apply a few more exercises, more or less along the same lines, and that we will not comment upon to save space.

As can be seen, the way we use and interpret these classic exercises is different from the habitual way, innovating when assessing attitudes and expectations qualitatively, and hey are very useful to determine the patient's predisposition to collaborate and become involved in therapy. In fact, the way these exercises are used is an attempt to generate expectations of success in the client, so he will accept the high probability of responding to the therapeutic suggestions. Lastly, all the exercises are valuable also because they provide information about the steps that are a part of the different self-hypnosis methods that are used in the intervention.

THE METHOD OF RAPID SELF-HYPNOSIS (RSH)

This is the main axis of the Valencia model (Capafons, 1998a, b). Other elements of the model (presentation of hypnosis, assessment, and didactic metaphor) are useful for any kind of hypnosis, especially if used from a cognitive-behavioral and self-control perspective. For this purpose and depending on the circumstances, clients, problem, etc., the adequacy of each element should be assessed. However, RSH is essential to apply the Valencia model of waking hypnosis coherently. As indicated by Lynn, Kirsch, and Rhue (1996), defining the hypnotic experience as self-hypnosis decreases clients' reticence and involves them actively in the therapeutic process. There is also experimental evidence showing that to start with self-hypnosis facilitates subsequent response to the suggestions and to hetero-hypnosis (Jonson, Dawson, Clark, & Sikorsky, 1983). Specifically, RSH has the following characteristics (Capafons, 2004): a) speed, essential so it can be used efficiently in situations where the patient needs it; b) inadvertence and structuring of the steps to be performed; c) easy to learn, facilitated by its connection with the exercises to assess suggestibility, which also facilitates the expectations that these steps will be effective; d) the self-suggestions are given with open eyes (Capafons & Mendoza, in press).

There are three steps (pressing hands, falling backwards, and arm immobility) in RSH, designed to instigate sensations of relaxation, heaviness, and body immobility (this is explained to the client), although some people may experience sensations of weightlessness and levitation. In this case, the procedure is adapted to match the patients' needs. The rationale offered to the client is that these exercises are designed to activate the brain so it can function rapidly and efficiently. The therapist models the steps over the entire learning process, including the process of fading the clear and visible movements in the long version of RSH (Capafons, 2001a; 2004). Compliance with a challenging suggestion (difficulty to raise one's arm) is the sign that the person is under self-hypnosis. At first, the client may go through the learning process with open eyes if he so prefers. Once he has learned, he is instructed so he can activate the whole process without the need of the first two steps, and with open eyes. He will only have to reproduce the sensation of his hand being stuck to his leg or something similar (dissociation from his arm) to "activate" his brain. For this purpose, the therapist should explain the concept of sensory/emotional recall (Kroger & Fezler, 1976). By using arm dissociation as a method of induction-confirmation of being self-hypnotized (short version), we are already using waking hypnosis. The person feels activated, with open eyes, maintaining a "natural" body position and fluent conversation, with all the advantages this has for generalization to daily life of the advances achieved in therapy (Capafons, 2001a). The experimental results in RSH reveal its efficacy to promote responses to suggestions, and show it to be more efficient (pleasant and preferred) than Spiegel and Spiegel's (1978) eye-roll method. In contrast, the short version of RSH is more powerful, pleasant and preferred than the long version (Martínez-Tendero, Capafons, Weber, & Cardeña, 2001; Reig, Capafons, Bayot, & Bustillo, 2001).

THE DIDACTIC METAPHOR. CONSOLIDATION IN CHANGING ATTITUDES

Once the client has experienced self-hypnosis, he is presented with a metaphor whose purpose is to consolidate the following ideas: hypnosis is not dangerous, effort and perseverance are required to achieve behavioral change, and it is an important instrument, but it is an adjunct. The metaphor is used as a didactic resource that helps the client to consolidate and remember the information about hypnosis (Porush, 1987). Once self-hypnotized, the client is asked to imagine himself facing a series of fictitious difficulties (surviving in a jungle) that he solves successfully, thanks to his effort and the correct use of a machete that represents hypnosis (Capafons, 2001a). Research shows that, after

listening to the metaphor, most of the participants change their opinion about hypnosis, accepting it as an adjuvant technique for self-control (Capafons, Alarcón, & Hemmings, 1999).

Hetero-Waking-Alert Hypnosis (WAH) (alert hand)

(Hetero)-Waking-Alert Hypnosis (WAH) is used in this model as a complement and support to RSH, especially with patients who present more difficulties with self-hypnosis because they prefer to be hypnotized by the therapist (Capafons, 1998a; 2001a). The therapist may hypnotize the patient in order to reinforce the efficacy of the self-suggestions administered using self-hypnosis (Capafons, 2001a; 2004). Normally, it is suggested that RSH is more efficient to activate the client's resources, and it will be successful in modulating, regulating, and producing therapeutic change (Capafons & Mendoza, in press). In contrast, with this technique, the patient is encouraged to keep his eyes open, to adopt the appearance of an active person, and even to be able to carry on a conversation with the therapist (similar to RSH). WAH requires a slight physical exercise (moving the dominant hand rhythmically until the movement becomes automatic) that helps evoke a general activation, so the client can walk while he remains hypnotized. This induction method includes suggestions of an expanded mind, increased heart-beat, breathing, and speed of brain functioning. Research indicates that WAH has certain advantages over other techniques such as active-alert hypnosis (Bányai, Zseni, & Túry, 1993) because: a) it is more pleasant (Cardeña, Alarcón, Capafons, & Bayot, 1998) and it promotes a higher level of suggestion (Alarcón, Capafons, Bayot, & Cárdena, 1999); b) it includes prior exercises to prevent patients from confusing being activated with being anxious, which could otherwise occur (Ludwig & Lyle, 1964); c) it is less bothersome than the Bányai method, as it does not require an ergonomic bicycle or a very large room; d) the WAH-hypnotized person keeps his eyes open, which does not always occur with the active-alert Bányai method; e) it produces a lower number of dropouts than the active-alert method.

THE CLINICAL PROCEDURE OF THE VALENCIA MODEL OF WAKING HYPNOSIS

The essential idea is to convince the client, by using hypnotic suggestions, that he has more possibilities of overcoming his problem than he thinks. This is to increase the expectations of personal efficacy and of results (Kirsch, 1985; 1986), promoting the client's motivation to engage in the intervention. This is common to the use of traditional hypnosis (Barber, 1985). In our case, it goes one step further, to the extent that the suggestions are given with open eyes. This allows us to set up a game with the patient, who begins to verify that a series of stimuli (pencils, watches, or any object, even imaginary ones) can provoke reactions that they would not naturally produce. For example, it can be suggested to the patient that to see or touch a clock can provoke heaviness. After some time, the opposite reaction can be suggested, so that the patient experience a sense of weightlessness when seeing or touching a clock. These exercises allow us to ask the client three key questions:

1. "How can some objects evoke different reactions, when there is no reason for them to provoke any of them naturally?" The answer is obvious: the way of thinking and talking about them (giving oneself suggestions), and allowing the brain to put its self-regulatory mechanisms into practice (a correct passive attitude, in terms of Frankl's [1985] logotherapy).
2. The next question is also obvious: "Can the magnitude, form, characteristics, etc., of your problem (for which the patient comes to therapy) depend on your not using your language and thinking correctly, thus hindering your brain's self-regulatory functions?" The answer is also simple: it seems affirmative, because the person has experienced different emotions depending on the self-suggestions.
3. Finally, the third key question is asked: "If, with the help of hypnosis, you managed to notice weightlessness, and a little later, heaviness, and later immobility, to finish with extreme activity, don't you think you could experience other things that would help you to overcome your problem?" The answer is also in this case, affirmative.

People usually answer these three questions appropriately, and the meaning of their "symptoms" changes: they are no longer something immobile that occurs out of their control, but instead, it is their attitude and understanding of the problem which modulates and even determines part of it, or at least its maintenance. In this sense, our model merges the behavioral tradition, the humanist-experiential traditions of Logotherapy, and even Ego Psychoanalysis (Korchin, 1976), in which the meaning

and attitude towards one's "symptoms" are elements that promote the symptoms and prevent their diminution. Therefore, with our model, we try to modify the interpretation of the meaning, but using a basically behavioral terminology and procedure, derived rigorously from experimental research. In this sense also, the Valencia model of waking hypnosis is innovative, but not "new." We believe that the strategic tradition, even ego psychoanalysis or logotherapy (Hutzell & Lantz, 1994) would find points in common with our model. If we point out to these authors that we use metaphors, we promote a correct passive attitude when necessary (to stop fighting the symptom uselessly), we use the person's own strategies, etc., this might make them think that we are discovering the Mediterranean. Perhaps the most innovative aspect of the Valencia model is that the suggestive exercises performed are fun (efficiency), the language and behavioral intervention strategies employed, and that it systematically adheres to the principles and results obtained in experimental research on hypnosis.

CLINICAL RESEARCH

A large part of the efforts of the research team of Valencia were aimed at the experimental validation of their model of waking hypnosis. However, there are very few studies about its clinical efficacy (Capafons & Mendoza, in press). There is currently only one study published (Mendoza, 2000), that uses an $N = 1$ design, which suggests the efficacy of the model in smoking cessation. Moreover, a preliminary investigation (Martínez-Valero et al, in preparation) shows that a cognitive-behavioral treatment plus hypnosis and medication is more effective than the same treatment without hypnosis, and than only medication, in the treatment of fybromyalgia.

In general, clinicians' experience with waking hypnosis is positive, observing a great potential as an adjunct (Capafons & Mendoza, in press). For example, we relate the case of a patient, a lyrical singer, whose aim was to increase his self-confidence and assurance when facing his public, as he had physical difficulties performing to his full potential. Among other aspects, negative thoughts about anticipatory anxiety were addressed, and he was instructed in RSH. The patient, pleasantly surprised, said that this was a great help to him right when acting. He was capable of practicing the technique in very few seconds and of administering the chosen self-suggestions when facing his public. Moreover, he commented that knowing that he could use RSH at any time made him feel very secure. At follow-up, this patient used the technique to get on with his mother, with whom he used to have arguments, to sleep calmly the night before a gala performance, or to rehearse his songs more efficiently and without getting nervous. To sum up, this patient had learned a useful way of self-control. This experience is in accordance with that of other clinicians: RSH promotes the generalization of responses, which reveals its value as a general coping strategy.

CONCLUSIONS

In general, it is very difficult to create something absolutely new. Surely, "to discover or rediscover" is different from "inventing something." Perhaps this is one of the novel contributions of the Valencia model of waking hypnosis: to rediscover waking hypnosis 70 years after its birth, but providing it with a new perspective, starting out from behavioral-socio-cognitive assumptions of hypnosis (Sarbin & Coe, 1972; Kirsch & Lynn, 1998) and under the support of empirical research. The model suggests some directions to follow, but allowing one to adapt flexibly to the characteristics of each case. This approach to waking hypnosis is very careful in its use of language. No reference is made to trance or altered states of awareness, to prevent scaring or discouraging clients. Moreover, it emphasizes self-control and perseverance. Finally, it is an attempt to integrate different perspectives of clinical psychological intervention, using hypnosis as a central argument, but also as an adjunctive technique. Therefore, this model considers waking hypnosis a possible alternative and complement to the traditional use of hypnosis, using techniques and suggestive, pleasant, useful, easy to learn and to teach, and, ultimately, efficient practices. Only future research will indicate whether the Valencia model is also an efficient clinical way to use hypnosis as an adjunct. For the time being, the professionals' experience, always heuristic, is affirmative.

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ACCEPTANCE AND COMMITMENT THERAPY (ACT). BASIS, CHARACTERISTICS AND EVIDENCE

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This paper describes Acceptance and Commitment Therapy (ACT) as the most complete of those included in the third wave of behavior therapies (Hayes, 2004). ACT has a functional philosophical position as well as being based on a new theory of language and cognition (the relational frame theory -RFT), and it offers an alternative to mainstream psychopathology: the functional dimension of experiential avoidance; and it promotes basic research and controlled trials in many areas. This paper addresses: first, the course of behavior therapy. Second, the characteristics of the human condition and what culture is promoting. Third, a brief description of RFT is provided. Finally, the methods and components defining ACT are provided, indicating the available empirical evidence in several respects.
Key words: *Behavior Therapy, Acceptance and Commitment Therapy, Relational Frame Theory, Experiential Avoidance, Verbal Regulation, Derived Relations.*

La Terapia de Aceptación y Compromiso (ACT) es la más completa de las incluidas en la Tercera Generación de Terapias de Conducta (Hayes, 2004). Se enmarca en una posición filosófica funcional, se asienta en una nueva Teoría del Lenguaje y la Cognición; ofrece una alternativa a la psicopatología tradicional: la dimensión funcional de la Evitación Experiencial; y promueve la investigación básica y los ensayos controlados. Este artículo se articula en varios apartados. El primero dirigido a los avances en la investigación y el curso de las terapias. El segundo contempla las características de la condición humana y lo que la cultura promueve. El tercero concierne a una breve descripción de la Teoría del Marco Relacional. Finalmente, se describen los métodos y componentes de ACT y la evidencia disponible.
Palabras clave: *Terapia Conducta, Terapia Aceptación y Compromiso, Teoría del Marco Relacional, Evitación Experiencial, Regulación Verbal, Derivación de Funciones.*

Among the range of therapeutic options for treatment of psychological disorders, psychology distinguishes therapies with some scientific value from others that, although popular, do not have these characteristics. Recently, Hayes (2004) differentiated three waves of therapies. The first wave refers to classic behavior therapy, based on direct behavioral change by means of contingency management, mainly using techniques from basic research of contingency management. Despite the enormous advance of the procedures and the successes achieved—still in effect—it was not efficient in the treatment of some adults' problems. The need to focus on the cognitive dimension was encouraged and the clinical approaches known as cognitive-behavioral therapies were formalized. These make up the second wave of therapies, which assume techniques focusing on behavioral change of contingencies by assigning an essential role to cognitive events as the causal and mechanical axis of behavior. They postulate direct treatment to modify the patient's behavior. These therapies have been successful but they have important limitations. The main problem is that the explanation and the way they change the problems are functionally equivalent to those established culturally, although they are presented with special attire. However, to date, they have not provided any experimental basis about the formation, derivation, and change of private events, or of the conditions in which the relation between cognitive events and actions is established and changed, or the experimental basis of most of their clinical methods. Despite these black holes in the basic knowledge about psychological functioning, cognitive-behavioral therapy enjoys good health and is the most successful therapy in the area of psychological treatment of adults. This standard understanding of the functioning of the human being, extensively disseminated by second-wave therapies—and shared by pharmacological therapies—implies that people's actions are regulated by their thoughts and emotions, so that in order to change inefficient functioning, we must somehow control whatever generates discomfort, as well as the discomfort

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itself. Therefore, the second-wave therapies are aimed at changing cognitive events as a means of changing the actions of the person who presents psychological disorders. Among the limitations of these therapies is the fact that their active principles are unknown, in other words, when significant changes are produced, we do not know what caused them nor why. The effectiveness of these therapies has been more closely related to their behavioral components than to their cognitive ones, which implies a contradiction with their assumption, and, at the same time, a lack of knowledge of the true role of direct intervention in cognitive events. Many questions about the conditions in which these therapies are effective and, in contrast, why they are not effective, remain unanswered.

The emergence of the therapies grouped into the third wave (Hayes, 2004) occurred for several reasons: (a) the lack of knowledge about why cognitive therapy is, or is not, successful; (b) the existence of radically functional conceptions of human behavior; and (c) the increasing amount of basic research on language and cognition from a functional perspective. This offered an opportunity to band together ways of performing therapy, many of them taken from "nonscientific" therapies, and to make new methods.

The third wave of therapies represents a qualitative leap because the techniques it includes are aimed, not at avoidance/reduction of symptoms, but at the fact that people should assume responsibility for their personal choices and at the acceptance of the private events that this procedure implies. Among these therapies are Linehan's (1993) dialectic therapy, Kohlenberg and Tsai's (1991) functional analytic psychotherapy, the integrative couple therapy of Jacobson, Christensen, Prince, Cordova, and Eldridge (2000), Segal, Williams, and Teasdale's (2002) mindfulness-based therapy, and Hayes, Stroshal, and Wilson's (1999) acceptance and commitment therapy (ACT). All these therapies involve—and this is the main difference—a change on a different level from the one proposed by the previous therapies. They do not focus on eliminating cognitive symptoms so as to change the patient's behavior, but instead they aim at changing the function of the symptoms by changing the context in which these cognitive symptoms are problematic.

In all, these therapies are linked to some others considered non-scientific, for example, existential and experiential-type therapies (see Pérez-Álvarez, 2001). ACT is the most complete of these new contextual therapies and we will focus on it. It has the following characteristics: (1) it starts out from a global framework of the advantages and disadvantages of human condition; (2) it uses a contextual-functional philosophy; (3) it is coherent with a functional model of cognition and language (the relational frame theory); and (4) it presents a new perspective of psychopathology in which the functional concept of destructive experiential avoidance is central. From this viewpoint, it is understood that the connection between basic research, psychopathology, and clinical methods is crucial to advance in the prevention and modification of psychological disorders. In the following paragraphs, some of these characteristics are commented on.

THE HUMAN CONDITION AND WHAT CULTURE PROMOTES

ACT does not formulate a new philosophy of life. It gathers the philosophy of life that was pronounced by many studies of the human being long before we knew about the source of self-knowledge and its pros and cons. The experience of the suffering-pleasure dimensions has been historically accepted as an intrinsic part of life from various religious traditions and by various anthropologists, doctors, philosophers, and literary authors (Hayes, Stroshal, & Wilson, 1999; Luciano, 2001; Wilson & Luciano, 2002). Experience shows that suffering and pleasure are the on the same dimension, that is, they are the two sides of one coin. One cannot exist without the other, which means that it is unavoidable to be able to enjoy something (for example, to remember something pleasant), without also having the possibility, sooner or later, of remembering situations that bring negative feelings to the present. The suffering-pleasure dimension, which supports positive and negative reinforcement, extends its possibilities when organisms become verbal. The experience we all share—in some way and to a greater or lesser extent—is that we look for pleasure, comfort, and we try to move away from pain and discomfort (in short, punishment, death). We share the fact that our actions do not just occur, but that they are aimed at something and that "something" can be in the most basic context (pleasure and eliminating immediate pain) or in "something else," which is more relevant and which symbolically impregnates every act we carry out. For example, actions involving honesty, respect for others, fidelity, knowledge, and a feeling of transcendence. This

repertory comprises part of self-knowledge that only a verbal organism can enjoy but which also causes the organism more suffering than if it did not possess it. It is also important to assume that there is no going back: once we have learned to behave verbally, we behave within the framework of the demands of each moment, depending on the regulation of our own history (logically, this does not mean that we cannot change the way we behave).

Taking these into account characteristics that define the human condition, the messages and ideas that are promoted in "advanced" communities as the "right" way of life may be counterproductive. The rules "innocently" offered are formulas to live that tell us: "no anguish, no painful memories, no sadness, no low self-esteem, no pain, etc., they are all obstacles for living." These formulas warn us to "avoid as much as possible all this misery, remove it from your life as soon as it appears," and "look for immediate pleasure and quickly eliminate the slightest sign of discomfort." Following this logic, the media, and often, the professionals provide diverse remedies, such as all kinds of psychological therapies and pharmacological treatments which, while pretending to be a solution, may end up becoming a bad remedy to live in a balanced and satisfactory way. The predominant logic of "all together against discomfort and pain" and functioning this way are difficult to change as long as certain powerful economic and social sectors and "what people want immediately" match perfectly, like two pieces of a puzzle. The problem is when, over time, these two pieces do not match, and more important: they do not match what people really value in their lives.

This kind of sayings coincides with the conceptions that are at the bottom of most psychological disorders and the second-wave therapies. In this sense (Luciano, 2001; Pérez-Alvárez, 2001; Szazs, 1960), the logic that underlies the psychological and psychiatric models of "illness and mental health," culturally established in developed societies, is radically against addressing and facing the fact of the human condition in all its extension. In fact, the maxims offered for living go against the human condition and, if the individual learns to behave according to them, then in order to live, he will not really live, but will be trapped in a "logical" functioning according to what is socially constructed ("suffering is bad, so I will act to eliminate my suffering…"), but, over time, far away from what is important, and, consequently, with "less life and more suffering."

Knowledge about this paradoxical functioning is not new. However, it is along the varied paths of research in verbal behavior that the roots of the fact of being verbal are clarified, and therefore, explanations are provided of what our elders knew very well, and which contemplate fruitful life philosophies. The whys of this functioning that traps the person are found in the characteristics shared by humans with a verbal/relational repertory and the rules of the culture in which such repertories are developed. Research in this area has led to the formulation of a functional theory of language and cognition that we shall comment on briefly.

THE RELATIONAL FRAME THEORY (RFT)

Like any theory, RFT has a philosophical framework, in this case, functional contextualism, which merges with Skinner's radical behaviorism and Kantor's interbehaviorism. Very briefly, (see Dougher & Hayes, 2000; Hayes & Wilson, 1995; Luciano & Hayes, 2001), psychological analysis conceptualizes the organism as a whole that is always in action, and where the functions that control behavior predominate. This is a monist, non-mentalist stance, a functional, non-reductionist stance, and an ideographic stance. It states that private events (such as whatever cognitive contents and schemas that may exist) are conformed in the individual history, and that the relations between private events and the organism's actions (verbal regulation of behavior) respond to socially promoted arbitrary relations and not to mechanical relations. From this philosophy, the validity criterion of any theory will be that it should be effective, useful to achieve an objective (typical emphasis in the scientific disciplines), but not only to predict but also to control or influence, providing the conditions that allow the prevention or modification of behavior.

The relational frame theory is a continuation of the laws established in research on the basis of functional analysis of behavior, but with a qualitative development. It is a theory aimed at the functional analysis of language and cognition, aspects that had hardly been analyzed previously at an experimental level on a functional-analytical plane. In this sense, this is not a break, but a continuation that extends the available knowledge about the emergence of new behaviors, as it proposes laws that establish the conditions for the formation and modification of functions, by indirect procedures, in contrast to the well-known and established direct procedures of contingency management to establish and modify reinforcing, aversive,

motivational, and discriminant approach and avoidance functions. RFT takes into account the effect of contingencies, but the focus of analysis is language and cognition, conceived as relational learning. It maintains that relational learning is an operant response that consists of learning, from very early ages and through numerous examples, to relate events conditionally until the abstraction of the contextual frame that links them is produced and it is applied to new events that are different from those that led to the abstraction. This allows: (1) the organism to respond, on the basis of the abstracted frame, to one event in terms of another event with which it does not share common physical elements; and (2) the functions of the former event to be transformed in relation to the latter, based on the application of the abstracted frame. For example, if, after the most basic relational repertory is established— the abstraction of the contextual frame "is" or "is like" or "is the same as"—we are told that MARIA tells stories the same as PEDRO, and we very much like the way PEDRO tells stories, in the absence of PEDRO, we might ask MARIA to tell us a story (in other words, we respond to Maria as we would respond to Pedro). If, in addition, they tell us that PAULA is "better then" María or Pedro, and we had to choose one of the three to tell stories, we would probably choose Paula, although we had no experience of her. We say that, in the area of stories, María is in a relation of equality (which we call Crel) with Pedro, and that both of them are in a relation of comparison (another Crel) with Paula, and therefore, the functions (called Cfun) of each one of them will change (although in different ways according to the Crel) after just one experience with Pedro as a good story-teller. The relational frames we learn are numerous and allow many functional transformations, taking into account that they are always contextual. The most basic frames are coordination/equivalence ("X is like Z in certain conditions"), comparison ("In some conditions, X is more than Z or Z is less than X"), opposition ("In certain conditions, X is the opposite of Z"), distinction ("X is different from Z"), spatial ("X is near to Z or far from Z"), temporal ("X is before or after Z or at the same time"), hierarchical ("X belongs to Z"), causal ("if X occurs, then Z occurs"), deictic, and perspective-taking (here-there, you-me, and here-me versus there-you; me-here-now and me-there-before, etc.).

The characteristics of relational learning imply deriving new relations and functions. For example, if one learns that the product PU is like CO, and that RA is like CO, and that DI is like PU (three explicitly learned basic relations), then one derives that CO and PU are equivalent (CO-PU), as are CO-RA, and PU-DI (they are called mutually entailed relations), suggesting other combinatorial entailments: for example, PU-RA and DI-RA and DI-CO. If, in addition, an aversive effect can be produced with the product PU (instead of curing an illness, it makes it worse), then none of the products related to PU will seem useful to treat that illness. The aversive and discriminant avoidance functions of those products, for that kind of circumstances, would have been generated by verbal or relational means insofar as they proceed from: the aversive function (Cfun) directly acquired by PU and the relational context that entails all the elements (in this case, an ES type Crel). Responding to one stimulus in terms of another and the parallel transformation of functions is essential to understand the striking suffering of verbal beings. For example, once the comparison, temporal, and deictic frames have been learned, it is no longer possible to escape from the transformation of functions that occurs when comparing the events—and oneself—in the here, the now, and the symbolic future. Fear of the future, for example, is a product derived from one's personal history, the emergence of which at some time is not under the individual's control; what one *can* control is one's personal reaction to that fear.

These characteristics of relational learning have advantages and disadvantages. For example, they allow the derivation of positive memories but also of negative ones; they allow us to understand, reason, and derive conclusions that make us successful in controlling the environment, but also the conclusions that regulate actions with dangerous and maladaptive effects. They also explain how moods —and motivations—are derived and how they change "for no apparent reason," they explain how we can think positively about someone or something, or change our appraisal of someone or something, without having had any experience that would justify it. Relational learning is the basis of publicity, politics, clinical methods, and many other human activities aimed at actualizing and changing psychological functions by verbal means. And it is essentially relevant because of its economy, because with few contingencies, new relations are produced and functions are formed and changed. And mainly because, without relative relational learning, verbal regulation of behavior (formulating, understanding, and following rules) is not feasible.

RFT functionally differentiates three kinds of behavior regulation: pliance, tracking, and augmenting. Pliance regulation or behavior is controlled by a reinforcement history in which the relevant consequences are mediated by others. A generalized repertory of pliance regulation is limiting as it generates extreme dependence on others and produces insensitivity towards the consequences of one's actions. Tracking regulation is controlled by a reinforcement history in which the consequences proceeding directly from the form of the actions predominate (i.e., brushing one's teeth under the control of the taste or the effect produced by the toothbrush on the teeth instead of the rewards or punishments provided by others). A tracking repertory that is generalized or applied in areas in which it cannot work is problematic (for example, to act following the rules "I don't want to be sad" or "Don't think about being sad"). Augmenting behavior is regulation under the control of transformed stimulus functions. For example, if the behavior of studying increases after placing studying in a temporal and conditional frame with valued aspects ("a title is—means, allows me—to be independent or to exercise a profession that is good for X" and "a title implies studying today and each one of the subjects"), this behavior is an augmenting behavior that occurs because studying has acquired reinforcing functions by verbal means. Augmenting regulation has many possibilities: some that allow the person to adapt to life by carrying out actions because of their moral value and/or transcendence (behaving in a certain way despite pain, or because of moral principles that go beyond the contingencies that significant others can provide, etc.) But it can also be problematic if an action has an immediate reinforcing consequence but generates maladaptation regarding long-term life contingencies. For example, if sadness is placed in a frame of opposition to life ("sadness and negative thoughts are bad, I can't live with them"), and under some circumstances, discomfort and negative thoughts emerge, then the sadness and discomfort of the person's thoughts would become more intense and could fulfill discriminant avoidance functions. This intensification would be caused by situating discomfort/negative thoughts in temporal opposition to valued actions (with a positive symbolic function), because the transformation of functions by the frame of opposition turns the positive into the negative and—as a additive effect—increases the negative value that sadness might already have. Consequently, in absence of a new frame to contextualize all these elements, the person would undertake actions to avoid/escape from this mood. This is the regulation that defines the experiential avoidance pattern whose persistence can become destructive if it produces a limitation in one's personal life, even to the extreme of becoming total avoidance: suicide.

Summing up, the RFT research affects most human actions and necessarily concerns psychopathology and psychological therapies (see, especially, Hayes et al., 2001, and also Barnes-Holmes, Barnes-Holmes, McHugh, & Hayes, 2004; Hayes et al., 1999; Luciano, Rodríguez, & Gutiérrez, 2004; Wilson, Hayes, Gregg, & Zetle, 2001; Wilson & Luciano, 2002). We emphasize: (1) the establishment of many contextual frames or relations among stimuli as generalized operants and their derived characteristics; (2) deriving relations (by mutual and combinatorial entailment) and transformation of functions—that is, formation and change by verbal means of aversive, reinforcing, and discriminant functions; (3) functioning by adding the relational network and rebound effects when faced with direct changes; (4) reappearance of related events; (5) the establishment and modification of pliance, tracking, and augmenting regulations and insensitivity to contingencies; (7) the analysis of multiple contextualized relations among stimuli, and the corresponding derivation or transformation of functions. All this leads to a broad range of applications for the analysis of many complex phenomena. For example, understanding, analogical reasoning, problem-solving, self-efficacy, locus of control, abstract thought, social categorizing, self-concept, attitudes, stereotypes and stigma, discrimination of emotive functions and mood, and thought, among others. Summing up, basic and applied research on the relational frame theory is very extensive and goes way beyond its implications in the clinical field.

CULTURE, LANGUAGE, AND DESTRUCTIVE EXPERIENTIAL AVOIDANCE

As mentioned, a product of the advances of science and technology, the economic-political powers offer a kind of life in which there is no room for discomfort and pain. The meaning of wellbeing is to enjoy right now, the more the better, without any difficulties or problems, and at the same time without generating —and this is the big problem—conditions for action where one is responsible for long-term goals that transcend one. In short, the most

basic and individual predominates, and pain is demonized as ABNORMAL—in contrast, it is natural in the verbal being. We have mentioned that the human being cannot escape his verbal condition, and that means that, just as we can remember past situations —or imagine future ones—that are charged with positive emotions, we can also, without wanting to, remember or imagine situations that cause discomfort. Being verbal means establishing comparisons, seeing ourselves and other things as far or near, placing events in the before, the now, or the afterwards, it involves offering explanations and regulating ourselves by them. It means we can see ourselves as a psychological entity but at the same time, we can distance ourselves from our cognitive events without interpreting their contents literally; it means being able to build valued directions in our life, etc. In short, self-knowledge is the possibility of learning to be aware of all this and, sometimes, the resulting regulation does not necessarily match the reinforcing consequences that maintain us. For example, we can learn to be trapped by the literalness of verbal functions, and to get lost in them, and thus, not be present and aware of everything in the here and now, which is what our values would require. Being trapped frequently by the verbal functions of events means acting in disperse directions with a tendency to generate psychological disorders.

Consequently, the true nature of the human condition is verbal, doubtless, within the framework of the culture in which the person developed and is educated. Thus, when "ALWAYS FEELING GOOD" is the primary goal (the key element to be able to live in a valued direction), and as long as the language traps are inevitably present due to derivation (that is, given certain relevant frames depending on the person's history, they will have thoughts, memories, and feelings with aversive and positive functions), then the conditions will exist for the person to act to reduce or change his private events, as a necessary goal to be able to live. This persistent search for positive private events, or for the control of the negative ones, in order to be able to live is a fundamental trap because, although the derivation of thoughts and many functions is unavoidable, behaving to control what cannot be controlled *is* avoidable. Consequently, when the benefits of this strategy are an increase and extension of discomfort, and a reduction of the capacity to fully live, then the person is in a paradoxical spiral. This way of functioning is called destructive experiential avoidance.

The Experiential Avoidance Disorder (EED; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Luciano & Hayes, 2001) is an inflexible pattern that consists of acting under the need to control and/or avoid the presence of thoughts, memories, feelings and other private events in order to be able to live. This inflexible pattern is made up of numerous responses with the same function: to control discomfort and the private events as well as the circumstances that generate them. The permanent need to avoid discomfort and to attain immediate pleasure in order to live forces the person to behave in such a way that, paradoxically, he cannot live. The problem is that such behavior provides immediate relative relief at times, but it has a boomerang effect (that is, the discomfort returns, sometimes more intensely and more extensively, and relief is short-lived). This "makes" the person carry on ceaselessly in the attempt to make discomfort go away, which, in turn, makes it more and more present because of the boomerang effect. In the end, the days become nothing more than doing things to make discomfort disappear, and the result is that the person abandons all actions in valued directions.

Inflexible experiential avoidance is a central component in many disorders that are differentiated in current classification systems. EED has been detected in affective disorders, anxiety, addictions, anorexia and bulimia, in disorders of control of impulses, in psychotic symptoms, in posttraumatic stress, and when dealing with illnesses, and in processes in which pain plays an essential role (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004; Hayes et al., 1996, Luciano & Hayes, 2001). Experiential avoidance is conceived as a functional dimension that is the base of many disorders and it is a radically different way of presenting and understanding psychological or mental disorders; of understanding psychopathology from a genuinely psychological perspective, very remote from reductionist approaches, in particular, the biological ones.

From RFT, there are several verbal contexts that define EED: the contexts of Literalness, Assessment, Offering Reasons or Explaining, and Control (Hayes et al., 1996; Luciano, Rodríguez, & Gutiérrez, 2004). The context of Literalness is an unavoidable product of verbal behavior and involves responding to one event in terms of another because of the properties of the relational repertory (mutual and combinatorial entailment and the transformation of functions). The verbal context of Assessment is the tendency to judge almost everything, and because of literalness, not to distinguish the intrinsic

properties of an event ("I'm sad") from its socially established arbitrary properties ("being sad is bad"). This involves the difficulty of differentiating the dimensions of the self, socially constructed during a person's development, so that, without differentiating the self as a context for all thoughts, one only behaves by fusing the verbal properties of such thoughts. The context of Offering Reasons is fomented by the cultural viewpoint that behavior is (un)explained by emotions and thoughts (for example, "these thoughts are terrible and I cannot live with them, I cannot work, I cannot be with my children….I must get rid of them, etc."). Finally, the context of Control of Causes is the key context that gives meaning to the other ones as it means behaving according to these paradoxical reasons, for example, fusing troublesome thoughts, interpreted as causes: "if I could get rid of them, I'd be alright; I'd be another person and could do many things." Thus, only if these "causes" disappear will the person be in a position to "give himself permission" to act in the direction of values-based living. This last context is the one that closes the contingency circle by providing the powerful reinforcement of being right (by following the rules to be able to live) which is accompanied by immediate, but short-lived, relief. And all this, despite the long-term cost of such strategies (more discomfort and fewer actions to achieve positive reinforcement). Generalized experiential avoidance is an inflexible and limiting way of functioning that adopts many forms. For example, null or only scarce basic regulation to control impulsiveness and/or frustration tolerance, and mastery of regulation just because of the verbal properties of discomfort, which prevents sensitivity to effective contingencies. For example, when behavior regulated by the transformation of functions by comparison, temporal, causal frames (i.e., "if it were me, they would criticize me", "I will do it poorly", "I made a mistake or they made a mistake", "if I do it, it will get worse, it won't come out right", "if I hadn't done it, this would not have happened", etc.) is predominant. If the person is directly guided by such transformed functions, then this is a regulation without having applied the deictic frames adequately (which would lead to discrimination of the private events and their verbal source, and, therefore, becoming aware that they are not intrinsically disabling). Regulation in which the transformed functions of private events predominate by means of basic frames without application of deictic frames will prevent sensitivity to what is really important, because it does not allow one to discriminate private events from oneself with valued directions (Luciano & Törneke, 2006).

The regulation of experiential avoidance about which the patient consults the therapist is treated in second-wave therapies—including pharmacological ones—following the same logic: trying to directly reduce the discomfort and any other private event with these characteristics (for example, exchanging the irrational thoughts for rational ones, reducing the fear of whatever is feared, sadness, discouragement, memories and feelings of discomfort, voices, increasing self-esteem, etc.). The solutions disseminated for this end coincide in assigning a causal "mechanical" value to the cognitive content and schemas, so that the focus of action is aimed at directly changing such content. The therapeutic approach of RFT, focused on the analysis of the verbal contexts that support destructive experiential avoidance, is radically different.

ACT, AN ALTERNATIVE TO CHANGE EED. BASIS AND EVIDENCE

ACT (Hayes et al., 1999; Wilson & Luciano, 2002; Hayes & Stroshal, 2004) is a radical change of direction in the focus of therapy: on the one hand, it does not attempt to change or reduce troublesome thoughts/feelings/memories but instead to change their function and generate flexibility in the regulation of behavior. On the other hand, the clinical methods appeal to a change of a contextual nature in order to change the function of private events without changing their contents. ACT attempts to generate the conditions so that the patient will become aware of the paradox of his behavior (for which it is necessary to contextualize his functioning in an area that is important for the patient), and attempts to promote clinical interactions that allow the patient to become fully and openly aware of the flow of private events—any events—so that he can use them or not use them to act in valued directions. The methods that are included—some taken from other therapies—have their functioning logic in relational learning. The paradoxes, metaphors, and exercises of full/conscious exposure in the here/now of oneself are essential in ACT and the KEY is that the direction in any of these methods is to accept the private events because this acceptance is at the service of action impregnated with personal values.

BASIC EVIDENCE OF ACT

ACT (Hayes et al., 1999) is not a mere therapy but instead a therapy with a specific theory (The Relational

Frame theory) that merges philosophy and the knowledge of experimental and applied analysis of behavior, in addition to data provided by other areas of psychology about ways of coping and paradoxical effects (for a summary, see Hayes et al., 1996). In addition to the comments about RFT in the introduction, we add here the summary of the basic contributions that support ACT: (1) there is evidence about the emergence of thoughts, emotions, memories through derived tracts; (2) contextualized derivation correlates with high levels of intelligence and facilitates the formation of complex relational behavior; (3) detection of the types of verbal regulation that are limiting (4) evidence of the correlation between fused activity—or literal performance of experiential avoidance—and many problems; (5) functioning by addition of the verbal relations, so that attempts to change its contents have boomerang effects; (6) evidence of the transformation of functions of cognitive contents with methods of contextual change, so that, although the relational networks are intact, they are no longer useful for the same purpose, nor, at long-term, are they experienced as before; (7) the benefits of multiple practice in accepting private experience versus controlling it, especially when discomfort is high but is established in valued directions; (8) the types of transformation of functions in the clinical methods, for example, (a) in the practice of exposure to private events from the self-context; (b) in the use of metaphors; and, (c) in the methods to clarify values (Barnes-Holmes, Barnes-Holmes et al., 2004; Barnes-Holmes, Cochrane, et al., 2004; Dahl, Wilson, Luciano, & Hayes, 2005; Gutiérrez, Luciano, Rodríguez, & Fink, 2004; Hayes & Stroshal, 2004; Luciano, Rodríguez, & Gutiérrez, 2004; O'Hora & Barnes-Holmes, 2004; Wegner & Zanakos, 1994).

BRIEF DESCRIPTION OF THE THERAPY OF ACCEPTANCE AND COMMITMENT

ACT attempts to generate an extensive and flexible repertory of actions aimed at advancing towards goals or objectives in personally valued directions, and not by the presence or absence of certain cognitive and emotional states judged to be negative (pain, anxiety, sadness, fear, etc.). Thus, for example, it maintains that "fear of death," "fear of relapse," or "guilt" are not in themselves incapacitating symptoms, but instead, what ends up limiting life is action fused to the literal meanings of these thoughts. In these cases, the person is not aware of the thoughts and feelings as an ongoing appraising or reasoning process; that is, he does not realize that they are only thoughts and feelings, and that behind them all is a person, or that part of the psychological dimension of the self that contains them and from which he can observe any cognitive content and become aware of what is ultimately important to him. In other words, "behind" any discomfort and all thoughts is the context that provides perspective and from which we can become aware of the part of us that is ultimately like the "manager of all those cognitive products that so easily trap us because of the literalness of verbal functions." To be fused with cognitive contents is to act without the perspective that allows one to be aware of all of them and, therefore, not being in a position from which one can decide to focus on them if this suits one's personal valued direction. Without that perspective—provided by the deictic frames—the person cannot distinguish himself from the content and process of thinking and feeling, and he is fused with his thoughts, responding to positive/negative appraisals.

Summing up, ACT: (a) is a treatment focused on a person's valued actions; (b) it considers discomfort/suffering as normal, a product of the human condition as verbal beings; (c) it states that one learns to resist normal suffering and this resistance generates pathological suffering; (d) it promotes functional analysis of the patient's behavior and, therefore, it is based on the patient's experience as the key to treatment. The message is "what does your experience tell you when you do that? What do you get that is truly important? What would you be doing every day if you could you could devote yourself to doing something else other than remove suffering?"; (e) its goal is to make flexible the reaction to discomfort because the patient's experience tells him to that to resist private events is limiting his life, to focus on them is to lose his way. The chief goal of ACT is, therefore, to break the rigidity of the pattern of destructive avoidance or the excessive or maladaptive regulation by verbal processes that culture amplifies by fomenting the notion that feeling good immediately and avoiding pain are essential to be able live; (f) it involves clarifying values to act in the valued direction, accepting with full awareness the private events that emerge and practicing acceptance as soon and as often as possible; and (g) it means learning to "fall down and get back up, " that is, to choose again to act in valued directions with whatever private events that emerge because of the fall.

ACT clinical methods partially proceed from other therapies (see Hayes et al., 2004; Paéz, Gutiérrez,

Valdivia, & Luciano, 2006; Pérez-Alvárez, 2001) and, partially, from research and adjusting to the patient's needs at each moment and with a clear goal in mind. This means that the key does not lie in the techniques/methods in themselves, but instead in this clearly specified goal: to generate flexible action where was there previously problematic rigidity, that is, to allow thoughts, emotions, etc., to emerge and to chose the way of their acceptance—not control—within the frame of the patient's personal commitment with his values. ACT clinical methods use verbal modalities that are inherently not very literal: the metaphors should be analogies of the problem—whatever is appropriate as long as they get in touch functionally with the avoidance pattern; the paradoxes reveal the verbal traps, and the experiential exercises consist of practicing exposure to private events—the more specific the better—that generate discomfort in situ, just as they emerge at any moment, from the perspective of the self as their context and, necessarily, in the here and now. For example, the metaphor of "a man in a hole with a shovel" not only shows that by digging, he can get out of the hole, but also that by digging, holes can get bigger. This is equivalent to the patient's regulation pattern when, for example, he tries to get rid of feelings of guilt, searching for responses that suppress such thoughts, which may seem right until the person finally has the experience that such feelings have extended (the hole has gotten bigger), and there has been a decrease in the actions that could have procured some positive reinforcement—because all he has done is to dig. This kind of discourse style is to avoid language traps and to favor a verbal context that questions the value of rationality in some areas, validating instead the "truth" of the client's experience and explicitly eliminating any attempt to place the truth in the therapist's logic or values. Therefore, the therapist will not make any demands about what to do, nor will she discuss what may be better or worse, nor what is rational or irrational about the thoughts and feelings, but instead the patient's experience (the benefits obtained following the avoidance strategy) will be the basis on which questions, metaphors, and exercises to clarify values will be introduced and, in that context, many opportunities will be generated for the patient to expose himself from the self—context—at each here-and-now moment—to the obstacles: thoughts, memories, discomfort, etc.

The components of ACT have been presented with slight variations in successive versions (Hayes et al., 1999; Wilson & Luciano, 2002), and we emphasize the most recent one of Hayes and Strosahl (2004) as a practical guide to apply it to various problems, specifically, pain (Dahl et al., 2005). In the latest contributions, the functional analysis of the patient's problem and the goals in ACT mention six central aspects that define psychological inflexibility and its alteration (or the breaking up of the behavioral rigidity of the experiential avoidance disorder). These six aspects are described like six vertices of a hexagon, all interconnected. On one side, the levels both of acceptance of private events and of cognitive defusion. On the other side, the level of clarification of personal values and the level of valued actions; in the upper vertex, the level of contact in the present moment ("being present here and now"), doing what is important, and in the lower vertex the dimension of the self as the context of all cognitive contents. Functional analysis will reveal the characteristics of the inflexible pattern of experiential avoidance and clinical actions are aimed at strengthening the weaker aspects to facilitate flexibility with private events while one steers one's life towards what is truly important. The actions will be directed at (1) clarifying values and commitment with action on the chosen path, which means acceptance or commitment to experience without resisting the cognitive events that emerge along that path and, necessarily, (2) practicing defusion, or discriminating and becoming aware of the thoughts and feelings or memories that appear, in the here and now, from the self as a context when acting responsibly in the chosen direction. It goes without saying that the ACT therapist must adapt the various components of the therapy to the kinds of inefficient regulation that are observed in the functional analysis and, obviously, she must adapt the metaphors—and the exposure content—to each patient.

Taking into account the primary direction towards which all ACT actions lead, the modus operandi does not follow a strict order or formal protocol for each session. The clinical style is flexible and any activities are valid to focus on the behaviors in session and generate flexibility in the patient's reaction to private events (partially merging functional analytical psychotherapy and ACT along the lines indicated in Luciano [1999] and in Wilson and Luciano [2002]). ACT is presented in different phases with actions aimed at establishing and maintaining a context for the therapeutic relation. In this sense, the ACT therapist will tell the patient in words and actions that, he, the patient, and his experience when he tries to resolve his

life are what matters in the session. The therapist will try to minimize her own function as someone who tells the patient what kind of life to live, or what he should feel or think; she will create the conditions so that the patient will experience the result of his strategy, disabling—because of the results it produces—the adaptation to the rationale that systematically "justifies" or envelops inefficient strategies. She will try to underscore the patient's capacity to choose the valued direction and deal with discomfort; she will show the patient that psychological discomfort is a sign linked to his values. The ACT therapist will present—and ask the client—metaphors or examples, she will reveal paradoxes and will carry out as many exercises as necessary to try to normalize the discomfort that emerges in session, accepting difficult or contradictory thoughts, feelings, and memories, etc., without making any move to free the patient from contact with such private experiences unless he does so in the valued direction. And, whenever she has the chance, encouraging such opportunities in session, she will promote the discrimination of the self-context and the emerging cognitive contents to create the necessary psychological space to let the patient to choose the valued action even in the presence of emotions, thoughts, or memories that previously controlled his action.

In the analysis of the problem, the first phase is to generate the conditions to produce the experience of creative hopelessness (an experience that will be repeated many times during the therapy). These are actions aimed at creating the conditions so that the patient will experience what he wants, what he does to achieve it, and the short- and long-term results. This is a bitter experience, as it makes the patient come into contact with the paradox that, by trying to control private events to eliminate or avoid them, and so be able to live, he verifies that such a strategy does not work (it produces some immediate benefit but ultimately, it produces dissatisfaction because of its personal cost) and it cannot work unless he is willing to pay a high cost in personal areas. From this point, it is necessary to perform clinical actions aimed at making the patient become aware that his strategy of controlling private events to be able to live is itself the problem and not the private events themselves, and that an alternative is the acceptance of such events. The patient learns by metaphors, paradoxes, and experiential exercises that "if you don't want certain thoughts or feelings, you get them anyhow and, besides, they spread to more personal areas." To sum up, he will learn the action of being completely willing to have an unwanted or difficult private content.

The actions aimed at clarification of values are the base of ACT (for a review, see Páez et al., 2006) and, therefore, they are somehow present from the start of therapy, because without that value context, there would be no suffering, nor any problem to solve, nor would the experience of creative hopelessness be possible. The formal clarification of the valued directions involves the introduction of various metaphors and exercises (i.e., the funeral, the epitaph, or the garden) that let the patient discern what he wants in his life and the whys of his choices in terms of values as guides to his life, distinguishing valued directions, goals, and his actions in those directions, and private obstacles that are interposed. This clarification revolves around the detection of the areas of the patient's life that may be important for him (i.e., family, work, social area, and others). Areas are not values, but instead values are socially constructed reinforcers in one's personal life, which lead one in a certain direction, thus perpetuating one of the above-mentioned verbal regulations. This process of value clarification is central and continuous and, in some cases, will be more exhaustive than in others. In short, it attempts to put the patient in charge of his actions, allowing him to discriminate his actions as chosen acts at each moment and always in one direction, and to be willing to have the private events this involves.

Finally, acceptance and, therefore, actions in the valued direction—giving himself permission to have private events—is not possible without some level (necessarily practical) of distance from the private events, which means practicing their observation in situ and as they derive. The patient will learn exercises to de-literalize private contents and will learn to take perspective from them, differentiating the act of having a thought from the thought and the person (himself) who is aware of this. On the one hand, the aim of de-literalizing is to minimize the value of words, reducing the link between words and function, seeing them for what they are and, thus, canceling their functional power. This involves changing the contexts of literalness, assessment, and the great power of reasons that justify actions so that the client will learn to realize—when it occurs—whether he is fusing, trapped by a thought, by a memory; if he "is buying these cognitions" when he behaves influenced by their literalness. The components aimed at differentiating the dimensions of self involve distancing oneself from one's

private events from a safe, unique, untransferible and permanent context (the self as the context of all the private contents and the process of having them). This experience of psychological distancing is only feasible from one's full awareness, as a verbal being, of what emerges at each moment, in the here-and-now, so that, along with metaphors, the patient must practice with many exercises to become aware of the process or, for example, "having the thought of being guilty and its negative appraisal," or "having the thought that I will do it wrong and being very much afraid," or "noticing palpitations," or "noticing anger when thinking about X." This is the experience of becoming aware that one has a thought and realizing that "a person is much more than that, a person is big enough to have all the cognitive contents." The metaphors and distancing and de-literalizing exercises involve transforming the functions of private events by various frames, essentially, the deictic ones. Placing private events in these frames allows one to observe any private content from the self-context, to be present with any content, to detect "being trapped by thoughts or sensations" and practicing the contemplation of these private events, returning to the demands of valued directions at each moment, as many times as one may have "bought" the thoughts. To sum up, the patient will learn to be able to have private events while observing what he wants and, consequently, to chose to respond to such private events, not by their literal function, but by having them fully while acting in the valued direction.

To conclude, we would like to point out that working with ACT requires using all the components more or less extensively. Although in some cases, only a minimum of clarification of the valued directions and a very small dose of practice in acceptance with defusion exercises (de-literalizing and mainly distancing oneself from uncomfortable private events) is necessary to produce relevant movements that are usually maintained, clinical action requires systematic practice on all fronts. Clarification with no defusion practice, or defusion practice without having first clarified the valued directions, in the context of which it makes sense to accept or give oneself permission for such defusion practice, are errors. We underscore the importance of learning repeatedly what we mean by practicing acceptance, over and over, or being open to having private events by openly exposing oneself to them from the perspective of the self-context, while acting in the valued direction (Hayes et al., 2004, Luciano, 2001; Wilson & Luciano, 2002).

Clinical Evidence. ACT has been effective in numerous case studies. In controlled clinical trials (comparing ACT with empirically validated cognitive treatments, placebo conditions, or waiting lists; see reviews in Hayes, 2004, and Hayes et al., 2004, Hayes & Strosahl, 2004)[1]. ACT has been shown to be superior (especially in chronic cases) or equally effective at the end of treatment, but the differences are substantial at follow-up (controlled trials in depression, coping with job stress, psychotic symptomatology, obsessive-compulsive patterns, anxiety and social phobia, drug and tobacco consumption, multiple sclerosis, psycho-oncology, tricotilomania, fears and worries, diabetes, epileptic episodes, chronic pain, acts of self-injury, intervention with parents of discapacitated children, with professionals). It was efficient to prevent chronicity and notably change the course of varied sequelae and symptoms, after having been applied briefly and extensively, in individual and group format, and by different persons, and in many countries. Research in measures of experiential avoidance (the AAQ of Hayes et al.,1999), cognitive fusion (Baer, 2005), and values (Blackledge & Ciarrochi, 2006; Wilson & Groom, 2002) requires more studies; the rapid development of the IRAP (Implicit Relational Assessment Procedure)—a procedure based on RFT adds new possibilities to measure implicit relations (Barnes-Holmes, Barnes-Holmes, Power, Hayden, Milne, & Stewart, 2006).

The analysis of the components and, mainly, of the verbal processes of change involved in the various methods began years ago but still insufficient (Barnes-Holmes et al., 2004; Luciano, Rodríguez, & Gutiérrez, 2004). Despite these limitations, an effect is replicated systematically, both in basic research (Hayes et al., 1999; Gutiérrez, Luciano, Rodríguez, & Fink, 2004) and in controlled studies (for a review, see Hayes et al., 2004), and it is the consistency in separating or disconnecting private events and valued actions, which involves a functional change of the former without reducing their frequency o, necessarily, their emotional impact, at least at short-term.

Consequently, the balance is optimistic but should be considered with the caution and parsimoniousness of a

[1]A list of specific references is omitted but can be requested from the first author.

scientific project that proposes a therapy linked to a theory of language and cognition, a connection that can be considered the missing link between the laboratory studies of experimental analysis of behavior, from the 60s to the 80s, and the functional analysis of cognition, with its clinical, social, and educational implications. It represents a radical behavioral view of private events highly enriched by research in relational learning. Summing up, it is an ambitious basic-applied research project that will improve therapy and allow us to achieve more precise knowledge of the human condition in order to prevent and resolve problems.

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MINDFULNESS

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Mindfulness can be understood as consciousness, encompassing both attention and awareness; it is paying reflexive attention to the present moment. It is an attempt to actively focus on the present, but non-judgmentally, and without interfering with the sensations and perceptions experienced moment to moment. As a therapeutic procedure, it seeks acceptance and the full experience of emotional aspects or any other kind of non-verbal processes, without avoiding or attempting to control them. Control of uncontrollable events that are being automatically processed requires mere experience and natural exposure, with the least possible interference. Although mindfulness has become somewhat notorious, especially in the USA, in relation to eastern meditation values, it refers to some aspects that are well-known in psychology: exposure and self-regulation based on biofeedback techniques or the use of hypnosis, where perceptive and sensory phenomena are revealed as they really are. Its chief usefulness, beyond the specific techniques it provides, may be to contrast with a psychology that proposes control, wellbeing, the elimination of stress, anxiety, etc,, by means of procedures that, unless they are naturally experienced, may contribute to their perpetuation.
Key words: *mindfulness, acceptance, exposure, behavior therapy*

El mindfulness puede entenderse como atención y conciencia plena, como presencia atenta y reflexiva a lo que sucede en el momento actual. Pretende que la persona se centre en el momento presente de un modo activo, procurando no interferir ni valorar lo que se siente o se percibe en cada momento. Como procedimiento terapéutico busca, ante todo, que los aspectos emocionales y cualesquiera otros procesos de carácter no verbal, sean aceptados y vividos en su propia condición, sin ser evitados o intentar controlarlos. El control sobre sucesos incontrolables, sujetos a procesamiento automático, requiere de la mera experimentación y exposición natural con la menor interferencia posible. Aunque el mindfulness ha adquirido una cierta notoriedad, sobre todo en USA, de mano de los valores orientales, refiere a algunos aspectos ya conocidos en psicología: la exposición y la autorregulación basadas en las técnicas de biofeedback o en el uso de la hipnosis, donde hay un dejar que los fenómenos perceptivos y sensoriales se muestren como ellos son. Su principal utilidad, más allá de las técnicas concretas que ofrezca, tal vez sea el contrastar con una psicología que propugna el control, el bienestar, la eliminación del estrés, la ansiedad, etc., mediante procedimientos que, a falta de esa experimentación natural, pueden contribuir a perpetuarlos.
Palabras clave: *mindfulness, conciencia plena, aceptación, exposición, terapia de conducta*

Mindfulness is a term that has no corresponding translation in Spanish. It can be understood as attention and full consciousness (or awareness), attentive and reflective presence. The terms attention, consciousness, and reference to the present moment are included in its meaning. It proposes, then, a determination to focus on the present moment, actively and reflectively. An option to live whatever is happening in the present moment, the here and now, as opposed to living in the unreality, daydreaming.

The psychological connotations of the term are evident, although it transcends the merely psychological and impregnates, in a broader sense, a feeling of life, a philosophy of life and praxis, a way of behaving in specific situations and moments. Mindfulness cannot be understood generically, but instead it refers to a specific temporal moment (the present).

To complete the definition of the concept, if only preliminarily, we must add that such attention, awareness, and reflection are of a non-judgmental nature. It is a merely contemplative experience, observing without judging, accepting the experience as it emerges. It is an open and naive observation, lacking criticism and valence. One could say it is a way of being in the world without any prejudice: open to sensory experience, attentive to it and without judging or rejecting, actively and restrictedly, the experience.

The above-described phenomenon is obviously of interest to psychology. It poses in positive terms how to direct attention and activity, openly matching each situation, and it implicitly reveals the problems that can derive from not focusing on the present moment in these conditions. Thus, for Linehan (1993), mindfulness training

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involves instructing patients to observe and describe their bodies, without judging, and focusing on the present.

Mindfulness is considered from diverse perspectives as an end in itself, as a life philosophy, or a way to behave in life. In this viewpoint, mindfulness is considered a kind of meditation inserted in eastern culture, and in Buddhism in particular (Gremer, 2005), the Zen ideal of life of living the present moment. From a psychological point of view, it has also been considered a personality construct. Psychology has attempted to measure how much mindfulness a person "has" and how that may affect various psychological dimensions, as well as specific processes.

Lastly, mindfulness is also considered a technique and a component of the therapies developed in the framework of radical and contextual behaviorism: therapy of acceptance and commitment, therapy of dialectic behavior, or analytical functional psychotherapy.

NOVEL ASPECTS OF THE TECHNIQUE

As mentioned, mindfulness can be understood as a way of becoming involved in various habitual activities, whether or not they are problematic. Therefore, it can be considered a skill that allows not just a different point of view but instead it refers to concrete behaviors.

To be accurate, it cannot be said that its proposals are novel. However, let us look at its essential elements and their degree of innovation.

Focusing on the present: This has been the defining characteristic of functional analysis of behavior and, consequently, of behavior therapy. However, in mindfulness, focusing on the present has a different meaning. It means focusing and feeling things just the way they happen, without trying to control them. It is not focusing on a thought in order to change it to a positive one. It focuses on a thought or activity, or whatever one intends, without wanting to control it. What use is this? Accepting experiences and sensations just as they are. One could say that, like in exposure techniques, we ask the person to remain in a certain situation, feeling whatever happens in this situation. This attitude allows whatever is going to happen or to be felt, to occur fully. To live whatever is happening at that moment means to let each experience be lived in its present moment. It means not missing out on the present experience by substituting it with what should happen or what happened and was experienced in the past.

Openness to experience and facts: Focusing on what is happening and on what one is feeling at that moment allows one to center on the emotional and stimular aspects instead of on one's interpretation of them. The power of language, or thought, to filter and dress up what one sees and feels is evident. This influence is such that frequently, the verbal substitutes reality, homogenizing, uniforming, and conforming open experience to predefined and stereotyped frames. This implies, above all, a falsification of experience and losing the richness of the variability of perceptive and emotional phenomena. The person who contemplates a painting is only capable of perceiving (feeling) to the extent that he is capable of remaining open to the things that the painting suggests. This observation should be mainly guided by itself, letting some sensations naturally lead to others. Verbal interference (prejudices) or "being somewhere else" only help to adulterate the experience.

Radical acceptance: The essential element of mindfulness consists of radical, non-judgmental acceptance of experience. This means focusing on the present moment without making any kind of judgment and accepting the experience as such. This has an element of originality compared to the habitual procedure in psychology. The positive and the negative, the perfect and the imperfect in their various degrees are accepted as natural, normal experiences. Obviously, it is pleasanter to experience something positive, but experiencing unpleasant events is just as natural. As mentioned, this means accepting experiences, and one's reactions to them, as natural and normal. The effort not to judge them and to accept them allows one not to reject them: the discomfort, anger, and frustration are not something from which one should flee, but rather they comprise part of the human experience that must be undergone. To a great extent, this contradicts certain types of socially transmitted messages, even coming from the professional practice of psychology: discomfort is negative, anxiety should be reduced, control stress, get rid of negative thoughts, etc.

Choice of experiences: One might think that mindfulness consists of living with attention, reflectively, non-judgmentally, and accepting whatever happens in a rather determinist way. This is not the case. People actively choose what they engage in, what things to take action about, to look at, or to focus on. Each person's goals, projects and values determine what that person will pay attention to,

spend time and interest on. In short, for a situation to be experienced and characterized as mindful does not mean that it is not chosen. It means that once a situation is chosen, it should be lived and experienced just as it is, actively, and accepting everything that happens.

Control: Acceptance means renouncing direct control. It is not an attempt to get the person to control his reactions, feelings, or emotions, but rather for him to experience them just as they occur. Naturally, this does not mean that the elements of emotional, physiological, and behavioral regulation do not occur but that they are not directly sought. It does not involve an attempt to reduce (control) discomfort, fear, anger, or sadness, but to experience them as such; in any case, the effect of this stance on these emotions would be indirect. This aspect contrasts notably with contemporary psychological procedures that attempt to reduce activation, control anxiety, eliminate negative thoughts, etc.

To recapitulate, these are some of the key elements of mindfulness according to Germer (2004): (1) non-conceptual, that is, pay attention and be aware without focusing on the thought processes involved; (2) focused on the present: mindfulness always occurs in and around the present moment; (3) non-judgmental, one cannot fully experience something that one wishes were different; (4) intentional, there is always a direct intention to focus on something and to go back to it if, for some reason, one has left; (5) participatory observation, this is not detached observation, it should deeply involve the mind and body; (6) non-verbal, the mindfulness experience has no verbal referent, but instead an emotional and sensory one; (7) exploratory, open to sensory and perceptive experimentation; and (8) liberating, each instant of fully lived experience is an experience of freedom.

THE SPECIFIC TECHNIQUES

Once the singularities and advantages of mindfulness have been described, how can we find it or apply it in practical terms? Is it positive for a person to be mindful the whole day? There are currently no empirical data that allow us to offer clear answers to these questions. In the future, we will be able to assess more specifically in which cases mindfulness is more suitable. Meanwhile, how can one achieve mindfulness? In general, a type of training has been applied to allow people to practice mindfulness skills. The procedure most frequently employed includes cognitive elements (meditation) along with certain kinds of relaxation, or exercises focusing on body sensations. To a great extent, it reminds one of progressive relaxation training, and also autogenous training (a self-hypnosis procedure), and even hypnosis.

Jon Kabat-Zinn (1994) developed and put into practice a program in which he trains people in the acquisition of mindfulness skills. Like relaxation, through training and practice, some skills are acquired that can be generalized and may have positive effects on one's everyday functioning.

For example, in the case of relaxation, from the perspective of mindfulness, any of the procedures could be suitable once the necessary elements are modified. That is, the person does not control, but rather observes his physiological responses; the person accepts any change, sensation or, for example, movement that is produced; the person is actively involved in the task, attempting to experience and feel everything that happens in it; this active interest does not mean fighting or controlling other competitive activities (for example, if, while attending body sensations, one's thoughts go astray, when becoming aware of this digression, one should not get angry or feel frustrated, but should accept the diversion and simply go back to attending the body sensations and the tasks in which one was engaged). Within this context, the procedure called body scan (Kabat-Zinn, 2002) can be used. It consists of a mere experience of the body sensations associated with an active review of one's body. Another procedure frequently used is breathing. The person focuses on breathing and freely experiences all the sensations that occur within his own respiratory rhythm, insisting at all times that no attempt is made to exercise any control over the body activity. Nor is relaxation sought as something positive in itself or as a coping strategy, but as a way of practicing and experiencing mindfulness.

The specific procedures and exercises may be very diverse. Some of them have been developed with specific goals, such as the program for prevention of depression of Segal, Williams, and Teasdale (2002). In this text can be consulted a detailed program of exercises aimed at the practice of mindfulness during most of the day as a way of preventing relapses in depression.

UTILITY OF MINDFULNESS

The techniques designed so the patient will have experiences of mindfulness seek, above all, for the person to let himself flow with the sensations he perceives. This

implies promoting, as a fundamental reference point, sensations and emotions, letting them act naturally. This helps the person to let certain activities (emotions, physiological changes, etc.) that function autonomously (ANS) be regulated by their natural self-regulation systems. The lack of sensory information, either active (the use of techniques to control, distract, etc.) or passive (not attending such information intentionally), prevents the organism from receiving precise and crucial information so that natural forms of learning take place. Take, for example, sexual behavior. Masters and Johnson (1970) insisted on defining as *spectating* the behavior of those who voluntarily withdraw (by thinking about something else, worrying about other topics, etc.) during a sexual interaction. Supposing that one can control sexual arousal by not attending stimuli that could provoke it, exactly the opposite effect is obtained: it is only possible to "control" sexual arousal when the person receives the sensory information that occurs during such an experience. Learning without performance-related information is not possible. In fact, the more information one has, the more efficient learning will be.

The attempt to block out discomfort, emotions, and stress, contravenes and modifies— either physically (medicines) or psychologically (distraction, restructuring, etc.)—the organism's natural feedback mechanisms that allow regulation. This was a characteristic element in the development of biofeedback techniques and the self-regulation models proposed to be developed (see Schwarzt, 1977). Like in the above-mentioned example of sexual activity, the only way that the organism's servomechanisms (positive and negative feedback) can operate is when the sensory information channels receive and transmit the relevant information efficiently (see Corrigan, 2004).

This does not mean that employing medicines or psychological techniques, such as cognitive restructuring, reduction of physiological arousal, distraction, etc., is not suitable. They are useful and effective procedures with certain problems and at certain times. However, they should be employed with caution. When they prevent the person from really experiencing sensations and emotions related to a certain situation, they may be hindering the solution and worsening the problem instead of solving it. Rationalizing and contextualizing a problem is necessary but experiencing and accepting the sensations and emotions produced by it is essential. This is a well known fact in an especially relevant area of psychological intervention: anxiety disorders. Exposure to situations that evoke anxiety and experiencing its effects is an essential element in their treatment.

THEORETICAL FOUNDATONS

Mindfulness seems to have emerged from western interest in eastern traditions, and specifically, in Zen Buddhism. From this viewpoint, the impulse provided by Jon Kabat-Zinn has emphasized this aspect a great deal: meditation as a way of experiencing and achieving mindfulness experiences. However this aspect is more instrumental than basic. Meditation, or the use of cognitive or physiological (relaxation) procedures, comprises diverse techniques or procedures to achieve the desired effects. Traditionally, it has been considered that, in order to produce a response that is incompatible with anxiety, one can use several techniques, such as relaxation, meditation, assertive training, or the experience of positive situations (listening to music, etc.).

Focusing on more basic and conceptual aspects, the roots of mindfulness as a therapeutic technique are found in the development of the so-called new behavioral therapies. This type of therapies emerges when considering the context as the main element in the explanation and intervention. Hayes (2004) and Hayes, Luoma, Bond, Masuda, and Lillis (2006) called such therapies, which include processes of mindfulness and acceptance among their components, as well as processes of commitment and direct behavioral change, *third wave therapies*. This is where mindfulness merges with other therapeutic procedures, such as, for example, dialectic behavior therapy (Linehan, 1993a, 1993b), acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999; Wilson & Luciano, 2002), or cognitive therapy originally focused on information processing models in relation to depression (Segal, Williams, & Teasdale, 2002).

The essential characteristic of this so-called third wave behavioral therapy (the first wave was characterized by its empirical and experimental nature and its focus on direct behavioral change; and the second wave by the contribution of the cognitive models) is, among others, that it adopts a more experiential perspective and chooses strategies of indirect change, rather than the more habitual direct change from the first and second waves. This means that it takes into account a broader area of change, not linked to concrete elements and aspects. The explanation of this change in the procedure is the relevance of the context and the functions of behavior

rather than its form (topography in classic functional analysis). If what matters are the functions of behaviors and not how they are presented, then it is necessary to take action generically on these functions. This involves a broader and more indirect approach, because in order to influence concrete behaviors, one can take action on other behaviors having these same functions although they are not specifically involved in the problem under consideration. Mindfulness experience, the acceptance of sensations and events as they occur, means choosing to experience functionally different behaviors from those that may be generating the problem for which the person asked for help, in contrast to the attempt to flee from the experiences without having had the chance to experience them. A person concerned with controlling all the unpredictable events at work does not have to focus just on work situations but on any other situations that have to do with unpredictable events.

This broad and open viewpoint is more comprehensive and adaptive than the one focusing on the control of specific elements in a decontextualized way. Therefore, it is not surprising that this kind of third wave therapies have been shown to be more efficient in broader and less defined problems, such as personality disorders (Linehan, 1993a, 1993b). The goal is for the person to be capable of observing and naturally feeling (flowing with) his behavior (mindfulness as observation) and at the same time, committing himself to that activity (mindfulness as commitment). The aim is to be open to one's own activity, an exploration that will allow one to obtain data for subsequent evaluation. Choosing experiences, activities, etc., is not at all incompatible with being willing, at the same time, to experience and feel things as they occur (Robins, Schmidt, & Linehan, 2004). Note that this way of behaving favors flexibility and variability of behavior, an essential characteristic of the adaptive capacity of behavior.

CLINICAL APPLICATIONS

The clinical applications of mindfulness were initially linked to its role as a procedure to achieve physiological-emotional control. Within this framework, the role of meditation and relaxation on diverse psychophysiological disorders is relevant. The works of Benson (1975) in this area, relating relaxation, meditation, and cardiovascular disorders, are paradigmatic (see Gremer, 2005).

However, Jon Kabat-Zinn popularized and lent force to the use of mindfulness meditation as a procedure for the treatment of psychophysiological and psychosomatic disorders. In 1979, he created the Mindfulness Center in the Medicine Faculty of the University of Massachusetts to treat clinical cases and problems that did not respond adequately to conventional medical treatment. From then on, the Center has applied the Mindfulness-Based Stress Reduction (MBSR) program to a large number of people. More than 15,000 patients have followed the program at this Center, in addition to many others who have applied it in other countries. This clinical activity has also provided results in diverse scientific investigations. In these investigations, for example, the program's usefulness to modify certain physiological and immune functions has been reported (Davidson et al., 2003). Since its publication in 1982 of the first work on chronic pain (Kabat-Zin, 1982), there have been studies that indicate its usefulness, for example, in anxiety disorders (Kabat-Zin, Massion, Kristeller, Peterson, Fletcher, & Pbert, 1992) or in psoriasis (Kabat-Zin, Wheeler, Ligth, Skillings, Scharf, & Cropley, 1998).

Paul Grossman directs the Institute of Mindfulness Research of the University of Freiburg in Germany, which also focuses on mindfulness as a program to control stress. He has recently published a meta-analysis (Grossman et al., 2004) about the use of these programs in which he reports that, although the number of studies is still small, the results show the usefulness of the procedure both in clinical samples and in normal people. In addition to the works presented in the meta-analysis, there are other more recent contributions that reveal the usefulness of the program in cancer (Galantino, 2003; Tacón, Caldera, & Ronaghan, 2004) and in organ transplants (Gross et al., 2004).

Beyond the use of mindfulness meditation as a stress-reduction procedure, mindfulness has been integrated into three clinical procedures of great interest and that, in addition, have contributed empirical evidence of their usefulness. The first one is dialectic behavior therapy. Marsha Linehan (Linehan, 1993) developed a treatment based on mindfulness and acceptance to address border personality disorder. The results obtained have empirically validated it as a treatment (Crits-Christoph, 1998). The second one is cognitive treatment for depression, more specifically, mindfulness-based cognitive therapy of depression (see Scherer-Dickson, 2004). This was developed when the elements involved in relapse in patients treated for depression were taken into account (Teasdale et al., 2000; Teasdale, Segal & Williams, 1995) and this approach has been shown to be useful (Ramel, Goldin, Carmona, & McQuaid, 2004; Teasdale et al., 2002). The detailed step-by-step application of the program has been

published (see Segal et al., 2002). Lastly, mindfulness has also been integrated into the procedure of acceptance and commitment therapy, mentioned in this work, and which is a part of the clinical procedures of the third wave behavior therapies.

Another research area is the one concerning mindfulness as a construct that is susceptible to being operationalized, assessed, and used as a criterion to relate to other clinical measures. Thus, the Freiburg Mindfulness Inventory (Buchheld, Grossman, & Walach, 2002), which has been studied in relation to the consumption of tobacco and alcohol (Leigh, Bown, & Marlatt, 2005), was developed. A scale for cancer patients has also been elaborated (Carlson & Brown, 2005).

CONCLUSIONS

Mindfulness is a complementary viewpoint to conventional clinical resources. Attention and active involvement in the present moment is congruent with the way that cognitive behavioral therapy is carried out. However, there may be some contradiction in the concern of accepting the sensations and elements experienced versus controlling them. This is especially relevant in the case of emotional responses and in problems derived from psychophysiological dysfunctions. It is particularly evident that some functions are not under verbal control, and therefore, only by truly experiencing them can one learn something about them and this is only possible if there is an adequate experiencing, that is, a proper mindfulness observation.

The voluntary attempt to control breathing will very likely produce dyspnea. If a person has a panic attack or an uncontrollable desire to smoke and tries to control it voluntarily, he will probably achieve the opposite effect. There is only one way to "control" these involuntary and undesired activities: letting them be, letting them occur, observing them with the least possible interference, letting them self-regulate automatically, allowing the biological servomechanisms that are responsible for their activity to perform their task.

There are many possibilities of integrating this technique and this procedure and they are applicable to very diverse disorders. Germer, Siegel, and Fulton (2005) have edited a book specifically dedicated to this topic, in which one can see how to behave and the resources available in diverse intervention areas. Lastly, I would like to remind readers that mindfulness, like dialectic behavior therapy, acceptance and commitment therapy, behavioral activation therapy, and functional analytic psychotherapy, among others, harvest the evolution of behavior therapy. This implies the accumulative recognition of the contributions over the years and also of criticism and new proposals—perhaps not so new, but in any case renewed—in the search of the solution to recurrent problems that may adopt different shapes although they have similar effects.

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IS THERE ANYTHING NEW IN PSYCHOLOGICAL THERAPY? THREE PROPOSALS AND A POSSIBLE ANSWER

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In this paper, some comments are made on three psychological treatments: Acceptance and Commitment Therapy, Mindfulness and the Valencia Model of Waking Hypnosis. Firstly, we expound common aspects of the three approaches and, then, we theorize about phenomenology as one of their possible theoretical bases ("go back to the same things", "let things happen"). Secondly, we assess the innovative or new aspects of such interventions, and finally, their implications.
Key words: *psychological treatment, psychological intervention, cognitive-behavioral, psychotherapy, Acceptance and Commitment Therapy, waking hypnosis, suggestion, mindfulness.*

Se comentan tres acercamientos terapéuticos: la Terapia de Aceptación y Compromiso, Mindfulness y el Modelo de Valencia de Hipnosis Despierta. En primer lugar se expone el posible denominador común de estos acercamientos, y si la fenomenología puede estar a la base de estos acercamientos ("volver a las cosas mismas", "dejar que las cosas ocurran"). En segundo lugar, se tratan los aspectos innovadores o novedosos de estos acercamientos, para finalizar con la valoración de los mismos.
Palabras clave: *tratamiento psicológico, intervención psicológica, cognitivo-comportamental, psicoterapia Terapia Aceptación y Compromiso, hipnosis despierta, sugestión, mindfulness.*

The task entrusted to us by the coordinator of this monographic issue is not at all easy: the public's viewpoint about what's new in psychological therapy. Dr. Antonio Capafons asked us to comment, from the public's perspective, upon the contributions of the three splendid thinkers-researchers who expound the current status of the Valencia Model of Waking Hypnosis, the Acceptance and Commitment Therapy (ACT), and the extremely new Mindfulness. Dr. Capafons has really given us a tough job. We guess that Violante also put Lope de Vega on the spot when he asked him for that famous sonnet ("un soneto me manda hacer Violante" [Violante requires me to create a sonnet]), which Lope subsequently resolved so splendidly ("contad si son catorce, y está hecho" [count to see if there are fourteen, and it's done]). Well, we are in a similar spot with this request: "que en mi vida me he visto en tanto aprieto" [never in my life was I in such a fix].

Let us hasten to state that we are not going to judge our colleagues and their contributions. We are simply not going to judge. Perhaps, if we remove the z [Translator's note: this is a pun: *juzgar* in Spanish is *to judge*, whereas *jugar* —removing the z—is *to play*], we can play a bit with the ideas and reflections. Let us first look at the ideas.

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Do these three works share anything in common?

Obviously, yes, they are all splendid. But beyond a priori compliments, it seems we are talking about different and distant things: Acceptance? Waking hypnosis? Mindfulness?

The therapeutic movement in ACT has been expounded by Drs. Luciano and Valdivia (2006). Therefore, just a note. Born of specialists in the old behavior therapy, ACT wants to play a role in the third wave of scientific psychological therapy. The most genuine aspect of this therapeutic approach is its concern for altering the *function* of thoughts, feelings, or memories, in contrast to changing or reducing them. This contextual change means to alter the function of private events, not their contents. Perhaps this is the only Skinnerian trace in this kind of therapies. In the rest of the strategies, ways of action, and concrete methods it is not easy to find Skinner, Bijou, Ayllon, or Solomon. It is easier to find Victor Frankl, Ellis, Watzlawick, or even Erickson.

With regard to Mindfulness, it reminds us of the classic Europeans, and more specifically of the Spanish mystic era with shades of Far-Eastern culture, always admired in the West. From the Beatles' voyages to the Far East, not forgetting "Little Grasshopper," until the "adoration" of the Zen postulates, in Europe and the U.S.A., we are fascinated by everything from the Far East. At least, an intellectual sector of the erudite and reflective Europe and

America. This fascination led to a multitude of courses, seminars, monographs, articles of dubious scientific value—well, actually of dubious value. However, mindfulness therapy, as proposed by Dr. Vallejo (2006), is not the heir of this low-quality merchandise. Instead, it represents a serious attempt to operationalize what many others already attempted to do in historical periods and circumstances.

The work of Professors Alarcón and A. Capafons (2006) leads us into one of the more classic "Guadianas" [*translator's note: in Spanish, this refers to something that appears and disappears; it has no English translation*] in psychology: hypnosis. Dead, buried, risen, destroyed again, dusted off again, subsequently annihilated, and always sooner or later at the top of the in the social and scientific "hit lists" shortly after dying. Like the old psychoanalysis, hypnosis represents a recurrent theme insofar as it is polemic and indestructible. On this occasion, Drs. Capafons and Alarcón take us to a barely remembered aspect of hypnosis: waking hypnosis. And from an approach that is faithful to the cognitive-behavioral assumptions.

Therefore, what to these contributions have in common: being somehow the inheritors of "behaviorism"? The formation of their authors and their roots…? It could be. But for us, that is not the main aspect they have in common. From our viewpoint, Husserl's famous phrase of "going back to the same things" reflects the common denominator of these approaches and therapeutic techniques ("let things happen," not interfere as a way of "controlling"). Therefore, in our opinion, the merging point of these new fields of action in psychological therapy involves a return to phenomenology.

Does phenomenology triumph over positivism?

For many years, behavior therapy prevailed over many other approaches. Its "daughter," cognitive-behavioral therapy (a term detested both by behaviorists and cognitivists, not without grounds) reigned for a large part of the decade of the 70s, during the 80s and, although constructivism cast some shadow on it, also during the beginning of the 90s. But in that decade, a Copernican turnabout occurred in psychological therapy; models are not used, the flow has dried up, integration has become a series of integrators that do not even integrate among themselves (eclectic integration, theoretical integration, etc.), and the Task Force and handbooks about efficient or useful treatments appear. The world of ideologies gives way to the world of total pragmatism. What works (where and with whom) becomes the key that moves editors, researchers, and even the society that should consume the product, "integral health."

When positivism seems to have provided all it could, when the therapies of "doing and fighting," of promoting change, seem to have given all they could, but not more than they had already given, then the fashion of existence appears, making an enormous effort to distance itself from philosophy on the one hand, and, on the other, also from fraud and hoax. Existence as the "essence" of change and acceptance. It's as though the so-called quantitative paradigm, from its conceptions of "explanation," "prediction" and "control" began to lose its hegemony and were replaced by the terms "comprehension," "meaning," and "action." Or better still, as if one attempted to "marry" the scientific-positivist explanation to Diltheyian understanding. The return to phenomenology, "going back to the same things," turning toward the study of the essence of things. Going back to the study of the basic components of meanings, taking another look at the Hussserlian idea of the conscience permanently directed toward concrete realities (attention as intentionality), and "immanent perception." Restating the self's awareness of its own experiences.

On the one hand, we can also find some allusions to existentialism, especially in ACT, for instance:

- Emphasis on the individual's solitude, Man threatened in his individuality and his concrete reality.
- Every individual should choose a goal and follow it with passionate conviction, aware of the certainty of death.
- Emphasis on choice, freedom, and human responsibility. Choice is fundamental in human existence and it is unavoidable; even the refusal to choose implies a choice. Freedom to choose implies commitment and responsibility. Existentialism stated that individuals—as they are free to chose their own way—must accept the risk and the responsibility of carrying on with their commitment wherever it takes them.
- The individual should live a totally committed existence, and this commitment can only be understood by the individual who assumes it.
- Human life is contemplated in terms of paradoxes, the human being himself —a combination of mind and body—is paradoxical and contradictory.

And also some allusions to intuitionism, especially in

Mindfulness, with regard to its viewpoint of man as a being who can understand what reality truly is through his intuitions. Or that intuitive knowledge offers the human being the possibility of understanding the universe that surrounds him.

None of the three approaches, however, accepts that the only criterion of truth is found in individuals' personal experiences. None of these therapeutic options approves, at least, not explicitly, that the verification of its usefulness, its validity, be investigated apart from the hypothetical-deductive method.

In short, we could say that, with ACT and Mindfulness, and not so much with the Valencia Model of Waking Hypnosis, we are faced with the triumph of phenomenology in the essence of therapy, but maintaining positivism in the search for truth. Although perhaps they would not hesitate to assume that the test of the truth of a proposition is its practical utility, the purpose of thought is to guide action, and the effect of an idea is more important than its origin.

The million-dollar question is: what's new (old!)?

Well, probably what's new is an attitude, more than a series of "techniques." They are not new, in the sense of being unpublished or not existing previously. Nor is it a case of old dogs with different collars. In our opinion, it is a case of a new attitude and sense of technology.

In 1969, the film "Queimada" (in English, "Burn!"), directed by Gillo Pontecorvo, an old militant of the Italian Communist Party, premièred. In this film, not very well-known by most people, they tell about the attempt by the British government to destroy the Portuguese monopoly of the sugar commerce. Queimada is an imaginary island in the Antilles that was set afire towards the end of the 18th century by colonial troops in order to quash a slave rebellion. At one point in the film, the leader of the black slave revolt says to the English spy, William Walker (interpreted by Marlon Brando), "the white man knows how to go, but he doesn't know where; we blacks know where but we don't know how." This may be the quid of the question: the "white" therapy (positivist therapies) is learning from the "black" one (existentialist, phenomenologist, and experiential therapies, and counseling) that they must find out where they should head for. In fact, we are undergoing a period in which we still do not precisely know the basic ingredients of change. What is it that really makes an individual change? We are still at a stage of "trial-and-error," of seeking efficacy and efficiency. The Vikings were wonderful sailors and, as far as we know, they knew nothing about Archimedes' principle. They sailed with boats made of materials that were "empirically" useful. And they didn't do badly, although they probably never thought of making a Viking boat of steel. Ever since we found out that it is not the material but the volume that makes an object float and capable of sailing, a new world in the construction of ships opened up (and what a business was generated, thanks to Archimedes!). In psychological treatments, we lack theorems. Although we live off some of them and, especially, we build on the basis of empiricisms and partial theories. Hence, in psychological therapy, perhaps the new—the really, really new—will come from the hand of the genuine ingredients that promote change. Obviously, this enterprise involves therapists and many psychologists in general. The more we know about the human being, the more we will know about the things that are truly responsible for change.

ACT represents a genuine attempt to bring together theory, research, and applied therapy in the real world. But its ingredients are not new. The use of metaphors, "convincing" by words, and programmed exercises to disarticulate the client's maladaptive "tics" are not new. Nor is interest in the field of acceptance, learning "not to control," "letting things happen" new. The way of structuring the sessions, the interest in systematizing the "insight" work, the combination of action activities and acceptance activities is what makes it a very interesting therapeutic option, especially in borderline personality disorders (or, according to ACT, the Experiential Avoidance Disorder).

With regard to Mindfulness, its recent entrance on the market of psychological therapy places it still under an "assumed value." Meditation, concentration in the present moment, "letting things happen" is not new. However, coming from where it comes from makes it attractive to the professional therapist. It has a good visiting card. And, in fact, it is being investigated in many parts of the national territory and we will soon have results to guide us about its real utility. The most novel aspect: recovering old traditions and strategies and filtering them through the sieve of modernism and research.

Lastly, regarding waking hypnosis, the authors themselves provide the answer to the question of this section, and we quote them literally: "In general, it is very difficult to create something absolutely new. Surely, 'to discover or rediscover' is different from 'inventing

something.' Perhaps this is one of the novel contributions of the Valencia model of waking hypnosis: to rediscover waking hypnosis 70 years after its birth, but providing it with a new perspective, starting out from behavioral-socio-cognitive assumptions of hypnosis".

Effectively, this approach is novel in the general proposal and the particular use of the ways of presenting the technique to the client. And this last point is its principal value: the creativity and originality of the didactic resources and explanations of the technique to the patient, which notably increase the efficiency of hypnosis. The handcrafting of the approach to the patient in the filed of (waking) hypnosis seems to be the most noteworthy aspect. Research will let us know whether or not this adjunct is valuable in diverse disorders with diverse patients (Alarcón & Capafons, 2006, p. 77).

Is the public satisfied?

When it seems that almost everything is said and done in psychotherapy, to come across attempts to remodel, remerge, re-propose one or several parts of the therapist's task is something that the public is always thankful for. But the public is also grateful for the following:

a) Having a well-structured guide to be able to carry out the Acceptance and Commitment Therapy. A guide full of metaphors, well thought-out exercises, and notable creativity. It is also thankful for theoretical roots, and a corpus of systematic and abundant research.

b) Having a formalized approach to focus on the present moment, to open up to experience and to reality, to achieve radical acceptance, to choose the experiences in which to engage, and to promote the "absence" of control, proposed by Mindfulness.

c) Being able to discern the structured and scientific approach to hypnosis from charlatanism and spectacles. To have concise guidelines, with important touches of ingenuity and creativity that provide the client with a useful tool to promote the pleasure of a particular therapy, and that increase its efficiency. A rigorous approach to the field of suggestion always pleases the informed public.

Summing up, there would be "nothing new under the sun" if we considered architecture as just overlapping materials, painting as not much more than the use of colors, and music as only a concatenation of sounds. This way, we would only with great difficulty find anything new. However, new buildings that we could not even imagine before, new paintings that impact us, and music that is a revolution to our ears continue to make their appearance. From this likeness, we can say that there are "new" techniques that should continue to be investigated, refined, and disseminated. And therefore, "we, the public" thank the Doctors Alarcón, Capafons, Luciano, Valdivia, and Vallejo for revealing these techniques to us.

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SOCIAL CHANGES AND POSTMODERN PERSONALITY DISORDERS

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The purpose of this work is to describe the main features of the social changes that took place under postmodernism and the impact of these changes on the development of personality. The paradigmatic patterns of contemporary society and the clinical exaggerations which comprise its disorders are also described. The possible relationship of personality disorders as a context for eating disorders, as the most relevant topography, is analyzed, because eating disorders have become a health problem and a mass media referent in contemporary therapeutic culture. We analyze the social changes that may corrode an individual's character to the point of producing people whose body is the phenomenological basis of their identity, of who they are. The discussion focuses on therapeutic difficulties, and particularly on the not very useful classification and the bitterness against symptoms.
Key words: *eating disorders, culture, personality disorders, theoretical study, postmodernism.*

En el presente trabajo se describen las principales características de los cambios sociales del postmodernismo, así como el impacto de dichos cambios en la formación de la personalidad, describiendo los patrones paradigmáticos de la sociedad actual y las exageraciones clínicas que formarían sus trastornos. Por otro lado, se analiza la posible relación de los trastornos de personalidad como contexto de los trastornos de la conducta alimentaria, como la topografía en auge más relevante y por haberse convertido en un problema de salud y en un referente mediático casi sin precedentes en la cultura terapéutica de nuestro tiempo. Se reparará, por tanto, en los cambios sociales que pueden corroer el carácter hasta crear sujetos en los que el cuerpo sería la base fenomenológica de la identidad del ser que se és. En la discusión, se hará hincapié sobre las dificultades terapéuticas, en especial de la poco útil categorización y ensañamiento contra el síntoma.
Palabras clave: *Trastornos de la conducta alimentaria, cultura, trastornos de la personalidad, estudio teórico, postmodernismo*

The study of personality from a historical or cultural viewpoint is a tradition that goes back to authors from diverse fields of social sciences. Despite the special relevance of this focus for psychology (Fuentes & Quiroga, in press), as personal identity is a key element in the subjective reality, and it maintains a dialectic relation with society (Berger & Luckmann, 1968, p. 214), it has probably not received the consideration it deserves. Intra-psychological emphasis may have cast a shadow on the social context, although no sensible focus would assume the former without taking the latter into account. Be that as it may, in personality psychology, we have advanced little since the classic texts of Freud, Allport, Ericsson, Sullivan, or Adler. In fact, even T. Millon, the most influential contemporary personologist, borrowed the focus point that Gardner Murphy (1956) proposed in his book on personality under the suggestive subtitle of "a biosocial investigation about its origins and structure."

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Currently, both Millon in his first approach to the topic—Theory of Biosocial Learning, in which personality was understood as the behavior pattern resulting from early interaction with biological and socio-family contingencies—and the more recent proposals from radical behaviorism, in which personality is considered a repertory of types of responses selected because of relevant contingencies, and in which language, due to its symbolic nature, regulates behavior—and therefore, the socio-verbal community is the context that explains who an individual is—both underscore culture as the essential variable that explains the emergence of the self (Pérez, 2004, p. 164) or of personality (Luciano, 2002). At this point, a historiography of the SELF becomes inevitable. The concept of SELF is a recent acquisition, and its main defenders were the commercial revolution and the Protestant reformation. The medieval SELF was assimilated into the sociolabor role, where the subject knew who he was according to the class into which he had been born; from the first days of his life, the individual knew where he was, he was totally sure about his secure membership in a group and it was relatively

easy to compare life and oneself, as the social order prevailed over particular individuals (Bruckner, 1996). The commercial revolution led to vertical mobility, the responsibility of rising or falling, the loss of one's membership of the group; the objective ends were no longer obvious, and the focus was on oneself as the agent of one's own destiny. Thus, life horizon depended on itself and the main problem was the struggle to become someone. But, at the same time the individual gained freedom, he lost security, so that any excessive success would bring an "era of perpetual torment" (Bruckner, 1996). The Protestant reformation emphasized the weakening of social ties and the strengthening of individual responsibility, with religious individualism going hand-in-hand with economic individualism (Gardner, 1947, pp. 853-862). So, the modern "self-made man" could make his debut in the Lutheran actualization of the Renaissant homo faber; as indicated by Sennet "The Protestant individual has to mold his history so that the result is valuable and makes sense. The individual becomes ethically responsible for his time in life" (Sennet, 2000, p. 109). Constant work and effort towards his future as the expression of redemption, in which the disciplined use of time and the function of work are proof of the subject's moral value, will mold the Protestant's character, where the search for self-esteem and others' acknowledgement will reinforce individuality.

In the Romantic period, there was an unprecedented expansion in Self vocabulary, which emphasized the essentiality of personality traits: love, passion, soul, spirituality, valor, genius, inspiration, creativity, talent; in short, the existence of a hidden innerness that urged us to act (Gergen, 1991, pp. 43-51). The Romanticism of the 18th and 19th centuries questioned the supremacy of reason, while it distanced itself from functionality, searching for imagination and emotion aimed at others.

Towards the end of the 19th and during the 20th century, the Zeitgeist was transformed by the changing socio-economic and political conditions, in which romantic fascination (Gergen, 1991, p. 51) was useless for commercial expansionism and the threat of war. In the Western culture appeared the so-called "modernism" the heir of Enlightenment, in which reason and observation became the basic values, supported by the scientific advances that had produced great discoveries in medicine, industry, and technology. The psychological theories, as elements of the social definition of reality, expanded, increasing their vocabulary to discover the being. On the psychological level, it was essentially different from the romantic level, as the metaphor of the machine, with its nodules, association networks, attitudes and traits susceptible to being measured, became the paradigm. We had gone from the mysterious romantic self to a modern self, recognizable, secure, stable, and reasonable (Gergen, 1991, pp. 73-74).

In the last quarter of the 20th century, w have attended to the end of the modernist transition towards postmodernism, also called "late capitalism" (Sennet, 1998), post-industrial, or multinational (Jameson, 1996, p. 55), post-structuralism or consumerism, depending on the item taken as reference. It could be briefly characterized by its ahistoricity, subjectivism, individualism, the appearance of high-level technologies (Gergen, 1991), consumerism, multiculturalism, victimism, and infantilism (Bruckner, 1996), and a profound modification of the work conditions, in which flexibility, superficiality, and risk will be the signs of identity (Sennet, 2000, orig. 1998) (See Tables 1 and 2).

PART I: SOCIAL CHANGE AND PERSONAL CHANGE

"Personality is the socialized individual " (Durkheim).

We have observed a progressive emphasis of symptoms in the psychological analysis derived from the professional mental health contexts, inversely proportional to the investigation of the subject's history. Thus, we cannot see the forest because of the trees and the Personal History—of the mental health services user—

TABLE 1
ORIGINAL NAMES OF POSTMODERNISM

Late Capitalism
Post-industrial Capitalism
Multinational Capitalism
Post-consumerist Capitalism
Post-structuralist Capitalism

TABLE 2
SIGNS OF IDENTITY OF POSTMODERNISM

Ahistoricism	Multiculturalism
Subjectivism	Victimism
Devaluation of family	Infantilism
Individualism	High-level technologies
Consumerism	Work changes: flexibility, superficiality, and risk

will simply become a Clinical History. There is some parallelism with the current complex situation of psychology in Spain, in which most of the professionals and academics understand it in its applied aspect as an eminently sanitary discipline that goes beyond—without prejudice—clinical psychology. Although the mainly economical criteria or material causes—if I may allude to Marvin Harris—are at the base of this excluding or cutting back on clinical research about symptoms, psychological treatments, still with an acceptable level of efficacy—could be improved if we performed more psychology, if we knew better and in more detail the person who demands these services. But we suggest not beginning the house at the roof and begin by understanding the subject within the macro-social context that gives him meaning. In fact, a whole current of theoreticians and professionals have been successfully developing the relations between the socio-cultural context and personality. Thus, we quote Horney, who discovered certain characteristics of the modern subject, that Lasch subsequently took up, among which is these individuals' special and intense dependence of affection and love, that will increase their susceptibility and fear of being hurt, which will—paradoxically— result in their incapacity to give what they demand (Horney, 1937, p. 91). Such dependence and incapacity to love are seen in the neurotic arrangements of the "self-complaints" (low *self*-esteem, *self*-concept, and *self*-assurance), in the tendency to brag about oneself and about objects—an extreme that we will come back to in a later section, regarding consumerism—,the expression of hostility towards others, and submissive behavior (Horney, 1937, pp. 33-36; p. 102). Ortega mentions this hostility when distinguishing the inactive or self-complacent individualism, in which the narcissist hides his resentment and envy, from the creating individualism in which, according to William James, the subject's value lies in what he does—the merits, achieving the maximum possible of the world's comprehension (Ortega, 1981, p. 158, original 1914). However, it does not seem that contemporary culture uses the search for knowledge to protect itself from anguish but instead the search for affection (Horney, 1937, p. 135), as well as the zeal for power, fame, and possessions, that are used as repertories of a broader class: control over or securing one's position in and gaining society's respect, to give one a greater feeling of security. The need for control involves an enormous amount of impatience, irritability, fear of failure, low frustration tolerance, and incapacity to build reciprocal relations. This subject—in this case, it is the description of the modern neurotic—acts as if he had no history, and he evades the responsibility of taking charge of his own existence, as if it did not behoove him to direct it. In this sense, according to Ortega, if man has no nature but only history, and this is the circumstance to which the subject is subject—in allusion to Pérez's (2003a, pp. 64) formulation—, to be alienated from it would be like an alienation from oneself. Thus, this lack of historicity has developed culturally and has imitated nature and become one of the symptoms that contemporary authors deem prototypical of postmodernism (Jameson, 1996, p. 232); history has lost its meaning as a source of knowledge and personal/social direction. According to Lasch (1999), this display of current ahistoricity should not be considered optimistic, but instead the hopelessness of a society that is incapable of facing the future. The loss of faith in politics, from which the subject has distanced himself after the social activism of the 60s, is presented as the consequence of late capitalism, where politics is carried out from depersonalized virtual multinational companies. This loss of referents for the subject is consolidated in a retreat into oneself, and the paradigm is the narcissistic Self. This author notes a psychological characterization of this narcissism—beyond the superficial and simplistic description of a selfish, self-oriented subject—according to which, the dimensions of the narcissistic personality are inner emptiness, hostility, excessive self-reference, fear of failure and old age, short-lived and deteriorating relations, fear of depending on others, generalized dissatisfaction, self-hate-more than self-love, in the sense of Horney (1937, p. 143)- and idolatrizing famous people who have nothing but a good image (Lasch, 1999, pp. 41-42). (See Table 3.)

With reference to the figures of the communication media, Gergen already commented that the invasion of commercial TV and other social communication formats, where the real or palpable presence of the subjects is unnecessary, has made such figures comprise a significant part of people's personal life, with the celebrities being a common frame of reference (Gergen, 1991, pp. 84-85). Regarding the above-mentioned retreat into one's interior, with the obvious resulting subjectivism and psychologism, we suggest that it has been partially the result of an advance of therapeutic scenarios (Gergen, 1991, p. 34) from which they treat what they are helping to maintain; that is, the valuation of

positive mental health and the search for a continuous psychological state with no discomfort (which seems to be inversely proportional to the quality of modern life), enhanced by the psychological and psychiatric culture so extended in our times (Lasch, 1999, pp. 27-32). Along these lines, Pérez Álvarez has cited examples of social impregnation by the clinical culture, such as the psychoanalytical culture, the self-esteem culture, and psychopharmacological cosmetics (Pérez, 2003, pp. 40-41). We note that this new therapeutic creed—which reinforces psychological self-scrutiny (Lasch, 1999, p. 72) is, among others, one of the results of the improvement of life conditions and the transition or progress of capitalism, that has gone from production—doing—to mere consumption, which has a more global psychological effect on the subject, not only affecting his way of life but also his values, desires, fears, goals, and social relations. The ethics of work as a right and a moral and material responsibility have given way to the concept of work as the freedom to consume, and deriving from this, consumption is true autonomy, although actually, we have gone from family control to the control of the large corporations that operate by publicity (Lasch, 1999, pp. 101-102). Consumer behavior, as one of the great results of the socialization of the Well-being State, could affect the conformation of the Self; to a great extent, the Self would reincarnate in the products consumed; no longer are objects sold, but instead psychological properties (i.e., jeans that are "liberty," cars that are "elegance," creams that are "youth," clothing that lend "personality"). Such objects with subjective properties confirm such a volatile and fleeting Self as the fashions themselves. The rapid obsolescence of consumable objects does not only interest the producers and intermediaries of acquisitive power, but also the consumers themselves, as the value of the objects does not reside in their material properties but in their nurturing psychological function ("having a personality, youth, freedom, security"). As this value is not supported by a consistent personal history but by an immediate and circumstantial action, it loses its vigor or effect after repeated contact with the subject, similar to psychological extinction. Thus, the Self "is no longer the son of its works"—to quote the Cervantes' famous phrase of Quixote—but the result of a marketing project beyond its control. In the postmodern age, there has been an irruption—or invasion—of communication technologies (Gergen, 1991, pp. 76-90), leading to an exponential increase in contact among subjects and the unavoidable knowledge of other selves to admire, denigrate, love, hate, influence, desire, compete with, understand, and fear in the short space of a life. Taking into account that the comparative context has increased vertiginously for the individuals of our times and therefore, the competition (for a good job, fame, a good image, success, power, etc.), along with an increase in the real and virtual possibilities of control, one could conclude that we have the social conditions that increase the likelihood of becoming neurotic in Horney's (1937, p. 155) sense. Such colonization of the Self (Gergen, 1991, p. 100) generates a fragmentation, which together with the enormous increase in our personal dictionary to define our introspective or private states, and ends up by fracturing or dissipating a Self that—to quote Pérez Álvarez— would be more contingent than consistent (Pérez, 2001). The extraordinary increase in contact with other persons facilitates private dialogue about them, their scenarios and situations, so that subjective life has spread out and taken on relevance unthought-of in other eras. Both subjectivism and the social saturation could be defenders of going from a stable Self to one that is extremely circumstanced in its multiple relations. Subjectivism, understood as the break-up with the old modernist Truth, would, then, be another sign of identity of postmodernism; it refers to each person's stance as a criterion of truth (Pérez, 2001). Constructivism is the appropriate focus of the generalized fragmentation of the current age. Truth then depends on the observer's viewpoint and, therefore, what we consider reality is be

TABLE 3
CHARACTERISTICS OF THE NARCISSISTIC SELF
Adapted from Horney (1937) and Lasch (1999)

Inner Emptiness
Hostility
Excessive self-reference
Fear of failure and old age
Short-lived and deteriorating relationships
Dependence on affection and love
Fear of dependence
Generalized dissatisfaction
Self-hate
Idolatrizing famous people
Fear of being hurt
Incapacity to love
Drive to brag
Hostility towards others
Submissive behavior
Susceptibility

nothing more than a construction depending on the subject's previous perspective (Gergen, 1991, p. 127, Watzlawick, 1998, p. 11). However, such constructivism, different from the Orteguian one in which man's intervention on reality involved responsibility for the knowledge and the added effort, which is what re-valuates existence (Ortega, 1914/1981, p. 147), excuses the subject from being the agent of knowledge. In contrast, the assumption of a stable self structure is eroded, although whether the mind will continue to exist—either reified or identified with the brain—is not pertinently clarified, or whether we will talk about the mind metaphorically, so we can make the mistake denounced by Nietzsche of confusing the model with the thing it represents and end up being used by the metaphor (Navarro, 1981, p. 426). In any case, there is a predominance of language—not that there wasn't before, if we recall Nietzsche and the analytical philosophical tradition again—as if everything were language, when reality (external and subjective) is constructed in the interaction with the socio-verbal community, like Vigotsky stated (although we have missed any reference to him in the constructivist texts consulted). So, with no relation, there would be no language to conceptualize the self's emotions, thoughts, or intentions (Gergen, 1991, p. 204) and "the autobiography becomes a socio-biography" (Gergen, 1991, p. 211). Regarding the identity of the self, postmodernism participates in the plurality of selves and of a self in continuous process, more than in the persistent modern sameness. Lawson mentioned the crisis of realism and objectivism, targeting reflectiveness: "The postmodern situation is in crisis, a crisis of our truths, our values, the beliefs we hold dearest. A crisis that owes its origin, its need, and its strength to reflectiveness […] understood as self-reflection or self-awareness" (Gergen, 1991, p. 177). It could be noted that the excess of anxious reflectiveness—more than criticism—as an essential characteristic of the modern and postmodern subject, is understood as a failure rather than a virtue. This failure can be seen in many individuals' current incapacity to take charge of everyday tasks such as feeding, raising, educating their children, etc. With regard to this aspect, certain social changes, such as women's incorporation into the working world or the creation of the therapeutic State, along with the excessive psychologism seen, for example, in the increased anxiety in the psychological scrutiny of youngsters, has relieved the family of its responsibilities in favor or social organizations and institutions (Horney, 1937, pp. 70-71; Lasch, 1999, p. 286). In any case, the excess of self-focused attention has been observed to be at the root of most psychological disorders (Morrison, 2003), as it can be detrimental to a person's functioning, "getting in the way of life problems to end up having priority over them" (Pérez, 2003, p. 26, p. 88). In fact, hyper-reflectiveness about certain psychological events is observed as a condition related even to such devastating disorders as schizophrenia (Sass, 2003). If this is so, the subject constructs himself in this social scheme, where personal identity is difficult to maintain stably in such a contradictory social chorus; it is not surprising that the formation of the Self could frequently turn schizoid (fractured or divided self, according to Laing's description), borderline (many selves with unstable, blurry, and extreme presentations) or narcissist in the above-mentioned sense.

On another level, the changes in work cannot be disregarded. These changes in work conditions, that were described very accurately by Sennet (2000), have brought about changes in character, understood as the ethical value we attribute to our desires and our relations with others. This author underscored that industrial capitalism had given way to a new regime, whose characteristics would be the reinvention of bureaucracy, flexible production, and concentration without centralization. In short, the changing demands of the external world would not only modify consumable products, but also the business organizations (Sennet, 2000, p. 53). As a consequence, the lack of attachment to such products and the tolerance of fragmentation, which are the patterns of useful and comfortable behavior for the dominant classes, but which could corrode the workers on the lower steps of the flexible production regime (Sennet, 2000, p. 64-65). The business organization has become decentralized, a sort of subcontracts, where the final product is the result of various business islets, but it has not brought higher levels of equality of workers' responsibility, but instead has gone from the old pyramid of bureaucratic hierarchy to a reticular structure (Sennet, 2000, p. 56-58). On the other hand, the function—the profession—has been disrupted in many productive areas; computerizing the machinery, which has led to aseptic and comfortable work environments, has distanced the worker from the product in such a way that his work identity is weak (Sennet, 2000, p. 73). The ease of flexible work produces the

paradox of indifferent, unattached, and uncritical subjects; in short, individuals with little commitment to work because of their scarce comprehension of their profession. Flexibility and ease are conditions that prevent intellectual stimulation; the only challenge for the subject is to assume risk. However, dealing with risk creates ironic and ahistorical characters, because the maxim is to take advantage of the moment and be on the move constantly, without trusting plans for the future. The other option is to avoid such uncertainty by working for the State and so, we see how most of the university youth plan their future as civil servants, moving away from the apprehension caused by risk and perhaps away from work options that would be more stimulating for their personal and intellectual development, but also more difficult to achieve in a regime in which there is an oversupply of higher titles and at the same time, there is decreased demand for them (Sennet, 2000, pp. 92-93).

Other relevant characteristics of the contemporary subject are his infantilism and victimization, two pathologies of contemporary society (Bruckner,1996) in which, on the one hand, we observe a generalized anesthesia of the conscience so that there is a buffered effect of the consequences of one's acts and an avid demand of no effort—the adult imitates the child—whereas on the other, everyone sees himself from the stance of a victim whose executioner could be the superego, the neighboring town, the lack of vital space, the rich, the infidels of this or that God, and everyone demands favorable treatment that, legitimized by their complaints, lead them to use any means to achieve their ends. In fact, both phenomena are observed in the current way of coping with old age. Contemporary fear of old age and death (Lasch, 1999, pp. 253-263) have become profoundly intolerable, not only because in the old person we see the loss of professional status or higher incidence of illness; but also because the transformation of the value of wisdom provided by age into the value of depending almost exclusively on social reinforcement (for example, image), or of being up-to-date in technological change, the loss of the historical sense of life—with no path to the future—together with the changes produced in the family (such as the loss of the generational fabric) and the pathologization of old age (as something to cure or to treat) are factors to which the contemporary subject usually responds with panic. He attempts to alleviate this panic by not thinking about old age—which will logically bring him more of the same—or trying to put off old age, which will lead to more frustration because, although exaggerated biotechnological optimism invites us to believe in it, to prolong life expectation is not the same as avoiding old age (Fukuyama, 2002, pp. 101-123). Sennet states that the changes in work conditions have to do with the importance granted to youth; in late or current, flexible capitalism, older workers lack the necessary energy to adapt to the demands of rapid business changes, and they are more skeptical about risk. In contrast, experience is not a value on the rise and the working life has been reduced to one half (Sennet, 2000, pp. 97-101). In any case, to live in a society in which old age has become a problem instead of an unavoidable fact of life, leads to psychological changes in the subject, such as constant anxiety about the passing of time and an early downfall because of the loss of one of the most reinforcing social values. We want to be children and we are the victims of age, so we try to have a youthful image—to seem young. Precisely, the image is considered the main stimular vehicle of communication (Lasch, 1999, p.71), given the consumerist whirlpool of visual stimuli, with an increase in the number of hours we dedicate to watching TV, movies, publicity, video games, Internet, DVDs, written press to "see" rather than to read, exponential increase in TV channels, fleeting fashions, and quick cycles, increase of music that we "hear" on TV. In short, it seems that only what we see exists. Such a hypertrophy of the image is one of the factors that makes the experience of the Self continue to rely on the image of one's own body. It is not just that a certain esthetic model is culturally predominant and individuals try to achieve it, but—from the preceding analysis—that the social changes promote profound changes in personality and they direct behavior—in a subject/society dialectic—to achieve the adaptation to prevailing social conditions, although such adaptation may have an excessive price. Even so, it seems that the narcissistic personality is a good way of holding off the anxiety and tensions of modern life (Lasch, 1999, p.74) and "becoming schizoid" the best response to certain contexts (Pérez, 2003b).

It is therefore not surprising that, in an iconographic society, image disorders have become predominant. On the one hand, we cannot escape the similarity between the prototypical image of modernist transition art, whose expressions are minimalism, sobriety, languidness, nakedness in buildings and the disappearance of the differences between the exterior and the interior (Jameson, 1996, p. 128), and the psychopathology of

anorexics, in whom personal identity is confused with body. The fragmentation of the self can very well extrapolated to the fragmentation of corporeity, in part due to the redundant iconographic techniques from modernness to our days, where, as noted by Martínez Benlloch (2001, p.104 y 122-123), the body has been micro-fragmented, endlessly revealing the parts more than the whole, offering the subject/spectator—in an extraordinarily compulsive manner—orifices, breasts, low-cut pants that reveal the hip-bone and panties, transparencies, clothing that clings to bottoms, mini-bikinis, hair, lips, abdomens, and cheek-bones to the extent of granting such areas their own meaning and value, in other words, pieces to desire, love, hate, and, therefore, susceptible of being controlled and improved. Inflation of the image cult is not a contemporary phenomenon. In classic Greece, this cult was patrimony of the men, and its expression was the Athenian gymnasium and anthropocentric sculpture (Sennet, 1997, pp. 47-51). The naked body of the Athenian dignified his condition of citizen and was a sign both of his good health and of his degree of civilization and culture (Sennet, 1997, p. 35), insofar as now it is a symptom of youth, self-control, well-being, discipline, attractiveness, happiness, and self-assurance. Both in Sparta and later in Rome, the function of the body cult was related to the achievement of strength to wage and win wars, whereas its current function is to control the likelihood of being successful (partner, work, friendship, youth) in the struggle to be someone special. In olden times, modeling one's body was only within reach of certain social classes (noblemen, citizens, soldiers) whereas nowadays, it has become universal—thanks to the communication technologies—and democratically distributed—thanks to socioeconomic equality—both its valuation and people's capacity to dedicate a good part of their life to it—perhaps free from the load of sustaining life itself.

Coming back to the present, it is considered that a large quantity of individuals from postmodern society, described as having schizoid, borderline, and narcissist personality styles, do not display behaviors related to improving their self-concept and body image from the viewpoint of well-being and consistency of the self, but instead from the anguish they feel when faced with the enormous demands of contemporary social environment, the self's perplexity, and their sense of emptiness in a life project that has no past and no future, only a present that must be "alleviated" in order to get by. It is a way of carpe diem whose values are to avoid anticipated pain—not pain that is realistic and contingent on life—from rejection, failure, assuming the responsibility of taking charge of one's life and insistently curing the narcissistic wound of being someone in the world—by the way, a world where the Self is becoming fragmented.

PART II. POSTMODERN PERSONALITY AND IMAGE DISORDERS

Despite the withdrawn nature that personality and its disorders have in the academic and professional world, given that both the categorical definitions and the dimensions lack univocal acceptance in the scientific community, their clinical significance cannot be disregarded—either as an introduction or as Axis II context (Fuentes & Quiroga, in press). Thus, the above-mentioned social characteristics are the contingencies that conform us, and the responses selected by the environment have a high likelihood of becoming excessive to the point of becoming neurotic responses like those described by Horney in 1937 and by Lasch in 1999 (Table 3) and therefore, of significantly affecting the subjects and their social environment. Personality disorders can be defined by the subject's situation in and with the social context, that is, how they relate to the context, either because of their fear of loss (dependent), submission because of fear of rejection (avoidant), need for attention and gratification (histrionic), being objects of its power (antisocial), need for affection and intense reactions to imagined loss (borderline), fear of dependence (narcissist), fear of being hurt (paranoid), giving up when faced with social demands (depressive), affective detachment from others (schizoid), extreme compliance with rules (obsessive-compulsive), criticism of others (negativist), etc.

In a postmodern context, concern for one's image has been the rule and not the exception; from the empty self, self-hate, incapacity to love, hostility, fear of failure, idolatry of corporal totems, and excessive need to control, it is not surprising that people become neurotic. A person's self-image and image one presents to others is currently so supported by corporality that it could easily lead to the attempt to control—through diet and other similar behaviors—to change oneself and become someone else. Searching for another body to stop being an unacceptable and insecure Self and to achieve a valuable identity has become the existential project of many human beings. This ontological insecurity described

by Laing in schizophrenics, will be commented upon (Laing, 1964, pp. 35-38); adolescence as a critical period (García & Pérez, 2003) is probably be the period when the severest psychological disorders occur most frequently, as it is the crucial time of development of the person who struggles between recognition and sensitivity to criticism, in the midst of conflicting social roles, and with a postmodern environment that inserts unachievable values. In this way, it can produce insecure and hostile people. Thus, the perfect little girls usually preferred by parents will make an enormous effort to be the best adolescents. Brilliant—and exhausting—academic achievement, closely following ideal esthetic models, and avoiding failure are a priori functionally useful behaviors for their life project, although, as stated by Ortega, "some people reach full self-expansion by taking second place and the zeal to get first place annihilates all their virtue" (Ortega, 1914/1981, p. 36). Thus, eating disorders (EA) have become a severe health problem for westernized societies, where food abounds and personal attraction is closely linked to thinness, especially in women. The high economic status is particularly sensitive to this problem, although in the last few years, there has been a clear shift towards other social classes and an extension of the problem to developing cultures; even some countries far removed culturally from our social environment have begun to note an incidence of EA similar to that of our own social environment. Prevalence rates similar to the Spanish one have been observed in the Iranian population (Nobekht & Dezhkam, cited in Ruiz Lázaro, 2004) and a higher frequency of eating behavior alterations was observed in non-immigrant Iranian women than in Iranian women residing in North America (Abdohalli & Mann, 2001). In Fiji, where the obese body was prevalent and valued, a similar change has been observed—coinciding with the entrance of Anglo-American TV in 1995 (Martínez, 2001, pp. 116-117). On the other hand, the more westernized Latin American countries—for example, Argentina, that also has deep individualist, subjectivist, and psychologist roots— have the highest prevalence rates of EA of Latin (Ruiz Lázaro, 2004). In order to analyze this problem from the cultural viewpoint defended herein, in solidarity with the proposal that García and Pérez (2003) made concerning schizophrenia, a genealogy of documented eating disorders should be made that would begin with the cases listed under the section of Saint Anorexia, not so much because they didn't exist before, but because no previous descriptions of the subject's personality was found and that is a central criterion of the present work. From Saint Liberata until Catherine of Sienna (Toro, 1996, pp. 17-19), certain cultural and functional aspects have been observed that are similar to those of our present day anorexics; on the one hand, the valuation of fasting—in those cases, as a rite of moral perfection, a sign of disincarnated love or to attain the ideal image of a fainting Christ—and, on the other, the function of fasting as an avoidance behavior in marriages of convenience (but not convenient for the women) or as a liberation from body passions or sexual demands. Of the famous fasts, for example, Sissi and Lord Byron, mentioned by Toro (1996, pp. 79-81), we emphasize precisely the fame of the characters—with the reinforcement this involves and the resulting fear of losing one's famous image—and the comfortable way of life that would excuse them from practical tasks and the daily requirements of life—resulting in an excess of free time to dedicate to themselves—, the contact with models of a perfect life, either because of sainthood or narcissism—which involves a demand to remain faithful to such perfection—and a dramatic existence, where the role is confused with the person, where the character can either be pleasant or unpleasant to the person who plays the part. The similarity with the conditions of anorexic persons of our times is noted, although the idiosyncrasy of the socio-cultural niche (religious or noble) makes the dialectic relation in the configuration of the Self substantially different and both the life project and the construction of the identity of the saintly anorexics is very different from that of the youngsters who currently fill our classrooms. The analysis should be completed—although here it is only indicated—with a reflection on the participation of other explanatory variables that, without prejudice of the cultural level practiced here, could shed some light on such a ubiquitous phenomenon. At other levels, we know that eating behavior suffers alterations in other psychopathological disorders (for example, depression, anxiety, psychosis) and these could be antecedents of anorexia nervosa in many cases—on the other hand, disorders from which the saintly anorexics would not be excused and much less the celebrities shown. Inanition rapidly triggers obsessiveness and rigidity, and it decreases the delusional threshold, a relevant aspect in many mystical and revelation experiences. Readers are reminded of the divine engagement ring of Catherine of Sienna, made of Christ's foreskin, which nobody saw but

TABLE 4
REFERENCES ABOUT PERSONALITY AND ETHICS

Pillay (1977)	Low self-esteem
Garfinkel (1982)	Bulimia nervosa: impulsiveness, emotional lability, and extroversion. Restrictive anorexia nervosa: Introversion
Bell (2002)	Borderline Personality Disorder
Kleinfield (1994)	Restrictive anorexia nervosa: larger repertory of avoidance behaviors
Bulik (1995)	Dependent personality
Braun, Sunday y Halmi (1994)	Co-existence of personality disorders and affective disorders
Dowson, 1989; Hertzog, 1992a; Skodol, 1993; Waller, 1993; Wonderlinch, 1994; Murukami, 2002	Borderline Disorder
Grilo, 1996; Murukami, 2002	Avoidance Disorder
Johnson y Wonderlich, 1992; Casper, 1990; Anderluh, 2003	Avoidant-dependent and Obsessive-compulsive Personality
Herzog, 1992b; Johnson y Woonderlich, 1992; Levin y Hyler, 1986; Skodol, 1993; Díaz-Marsá, 2000a y b	Compulsive-purging anorexia nervosa and bulimia nervosa: Borderline and histrionic personality disorders
Herzog, 1992; Johnson y Wonderlich, 1992; Wonderlich, 1994; Gillberg, 1995	Restrictive anorexia nervosa: Obsessive-compulsive personality
Kennedy, McVey, y Katz (1990)	Restrictive anorexia nervosa: Schizoid and schzotypal personality Bulimia nervosa: Borderline personality
Sexton, 1998; Rämstan, 1999; Graell, 1999; Rosevinge, 2000	Restrictive anorexia nervosa: schizoid personality Compulsive anorexia and bulimia nervosa: Histrionic and borderline personality

she exalted after a revelation; and Saint Teresa's celestial visits that led her to wish for death because of the exalted life that awaited her. Not eating was reinforced by the experience of ecstasy and communion. Cachexia also leads to an increase in analgesia to pain—understood as a global experience—so that the prolonged lack of appetite can be a compensating function both in depressive states and in vital traumatic situations—or example, humiliation, submission, or maltreatment—so that once the restriction pattern is installed, it leads to a loss of weight whose psychological consequences also maintain the behavior. There are, then, many reasons both to not eat and to continue not eating. Currently, the increase in the quality of life and time to "talk to oneself," social pressures (of success and beauty), raising the demands of perfection—given the arbitrariness of such records—the fragmentation of the Self and of the body, the modification of the family structure and functions, among other factors, have become increasingly more universal. There are more conditions to produce people with dysfunctional behaviors related to body, food, and life. These personalities have habitually been seen in clinical work with such patients, noting certain common characteristics of behavior, in addition to pathognomonic eating behavior, for example: perfectionism, rigidity, detachment or extreme emotional instability, social avoidance, sexual inhibition or promiscuity, anhedonia, alexithymia, extreme family dependence, avoidance of the therapeutic relation, manipulation, lying, lack of fantasy and personal identity problems. From a historical perspective, the description of personality in patients with eating problems comes from Janet, who referred to hysterical anorexia, with loss of appetite, hyperactivity, and histrionic traits, and to obsessive anorexia, which keeps the appetite, plus scrupulousness, and obsessive-compulsive traits. Garner (1989) noted that personality factors can play an important role in the pathogenesis or, at least, in the symptomatic expression of eating disorders, and there are a large number of studies that have investigated the typical personality theme in these disorders, of which Table 4 offers a summary.

Most of the studies confirm the high prevalence of personality disorders that are congruent with the description of the most common personality styles in postmodern society. According to the studies, they are the following: schizoids, borderlines, and narcissists. In subjects with ED, an avoidance pattern is confirmed, which could be integrated in the Experiential Avoidance

Disorder, expounded by Hayes (1999, pp. 58-69), in which the restrictive topography may be associated with the schizoid personality, whereas the bulimic would be associated with borderline and narcissistic personalities. As a last note, we propose a likeness among the negative symptoms observed in schizophrenia, of which the schizoid personality could be its formal stage (Pérez, 2003b) and the symptoms of coldness, emotional detachment, autism, and fracture of the self in patients with restrictive anorexia (whose most prevalent personality is usually also schizoid). That is, both of them share the culture niche that would give them non-syntonic form and the abnormal experience of themselves. So, the construction of the personal identity with a pronounced absence of social contact prevents them from learning how to know, perceive, interpret, and anticipate feelings and affects, and this social cognition deficit is probably more disorganizing and has more impact on many patients' general functioning because of what it shares with the loss of common sense (that is, communality, or having to do with the world).

DISCUSSION

Although there is extensive evidence that EDs are something more than eating disorders and that there are profound alterations of the personality in most of the subjects with such dis orders, it does not seem that these findings are being incorporated into the focus of treatment; insofar as it is a culturally produced behavior pattern, it is not susceptible of being approached exclusively from a medical perspective, because to conceptualize Anorexia Nervosa as an illness is neither pertinent nor operative (Duro, 2003) and probably this is the cause of the facts documented —although not as much as one would wish—in the clinic: drop-outs, continuous relapses, incorrigible resistances, very extensive psychological treatments, mediocre therapeutic response and/or unclearly defined therapeutic elements (McIntosh, 2005), the lack of explicit pharmacological treatments and the immobilization of the family due to the stigmatizing of "being an illness." However, we are not attempting to deny the psychopathology of EDs, but rather to go back to it, something not very common in the contemporary clinical community (Pérez, 2003a). Thus, one of the most habitual errors when focusing the treatment with these patients—and let us not forget other psychological disorders—may be the precipitation with which techniques are implemented without the patient previously having expressed commitment to change and the concrete direction of the change, as well as raging against the symptom. Leaving aside the therapist's theoretical school, the premature use of techniques has often had the purpose of relieving the therapist's anxiety rather than doing something effective for the patient. Perhaps that is why the third wave of behavioral or cognitive-behavioral therapies (Hayes, 2004, pp. 5), in which the subject's history, family and social context and acceptance—first, the therapist's and subsequently, the patient's—of the existential value of the behavior problem in the patient's way of being in the world allow one to take a different philosophical stance, seems to have been adopted by an increasing number of clinicians, mainly to focus the treatment of patients who are particularly refractory against current interventions.

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METAPHORS IN COGNITIVE-BEHAVIOURAL PSYCHOLOGY

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Metaphors, more closely associated with literature than with science, have not been totally introduced into the more scientific forms of psychology (the cognitive-behavioural school of thought). Although they are under-employed in this type of psychology, we find them comfortably installed in other psychological perspectives (psychoanalytic, humanist, and constructivist). In recent years, probably due to the convergence of different lines of thought, the doors of cognitive-behavioural psychology have opened up to metaphors. In this article, we analyse the way this has come about, how metaphors are employed within cognitive-behavioural therapies, and what advantages this provides.
Key words: *Metaphor, metaphoric thinking, cognitive-behavioural psychology.*

Las metáforas, asociadas más a la literatura que a la ciencia, todavía son poco utilizadas en la psicología más científica (la corriente cognitivo-conductual). Aunque infrautilizadas en esta psicología, sí que nos las podemos encontrar cómodamente instaladas en otras perspectivas psicológicas (psicoanalítica, humanista y constructivista). En los últimos años, probablemente por la convergencia entre las distintas corrientes de pensamiento, las puertas de la psicología cognitivo-conductual se han abierto en mayor medida para las metáforas. En este artículo, se analiza cómo se ha llevado a cabo esta apertura, cómo se emplean dentro de las terapias cognitivo-conductuales y qué ventajas presenta su utilización.
Palabras clave: *Metáforas, pensamiento metafórico, psicología cognitivo-conductual.*

We humans have the tendency to generalize, label, and think in black-and-white in order to organize reality. This kind of simplification has probably led us to refer to logic-formal thought versus creative thought or to science versus art, as if they were completely differentiated entities. We have even assigned a physiological basis to this distinction: the right hemisphere for creative aspects and the left one as the support of rational aspects.

Within this duality, it is clear where we have put metaphors: in creative thought or art. When we talk about metaphors, one of the first associations that reaches our brain is literature and we obviously would never associate metaphors with science. "Metaphors" and "science" are two concepts that seem rather contradictory to us. Can that be why the psychologists who are closer to the more scientific orientations within psychology (behaviourists and cognitivists), in our zeal to dissociate from psychology anything that does not sound scientific, have not incorporated within our techniques the use of metaphors to the same extent as other tendencies?

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The purpose of the present article is three-fold, and it will attempt to describe:

- The incorporation of metaphors into the cognitive-behavioural orientation.
- The use of metaphors within cognitive-behavioural therapies.
- The advantages of using metaphors.

AN EXAMPLE

Before leaping into the definition of the term "metaphor," let us look at an example. There are infinite examples of metaphors because, actually, they have always been used since the ones we find in the Gospel until those that are present in children's literature (the ugly duckling, the ant and the grasshopper, etc.). The example chosen is a widely used metaphor in the acceptance and commitment therapy (Wilson & Luciano, 2002). That is, it is a "therapeutic" metaphor.

> "Two women were sharing an office, working at their respective computers. While one of them was writing, some messages began to appear on her computer-screen. Messages that said "you will never solve your problem," "you are useless," "people disapprove of you." When she read these messages, she began to believe them and to suffer terribly. They seemed so true!!! Then she tried to

delete them from the screen but could not. So, she went on working. Once in a while, they reappeared but as she knew she could not delete them, she didn't try and went on working. Despite the messages that appeared once in a while and made her suffer, the woman enjoyed herself and felt good because her work was coming out just the way she wanted it to.

The same thing began to happen to the other woman. The same messages as those of her colleague began to appear: "you will never solve your problem," "you are useless"…Then, she tried to delete them, but she could not. She suffered very much because she was absolutely sure that the messages were true. Moreover, she suffered because she could not delete them. So, she stopped working and began to think about what she could do to delete the messages. She was sure that if she could not delete them, she could not go on working. So she began to try one method after another, but to no avail. The messages were still there. She looked angrily at her colleague because she saw her working and she even seemed to be enjoying her work. She thought her colleague could work because she did not receive the same messages as her. So, she went on trying to delete them. Her suffering increased: she had increasingly more negative messages, all her attempts to delete them failed, and, to top it, she made no headway on her work. She got stuck in that situation."

In this metaphor, the messages represent automatic negative thoughts and the behaviour of the second woman, avoidance behaviour. However, we shall not stop here to squeeze the therapeutic juice from this metaphor (which exists). We only described it in order to exemplify the concept.

DEFINITION

Ever since the times of the Greek philosophers, people have thought about metaphors in the attempt to define them. Aristotle defined the metaphor as a series of words in which a comparison is made between two or more entities that are literally different (Lyddon, Clay, & Sparks, 2001). He went beyond that, stating that the capacity of generating metaphors revealed the power of the mind over the possibility of things (Sims, 2003).

According to Siler (Cfr. Azzollini, & González, 1997), metaphor and analogy can be homologated under the general category of metaphoration, which is defined as follows:

Metaphoration: 1) an object, image, idea, or process that is compared with something else. 2) All types of metaphor, which include allusions, allegories, analogies, symbols, and troponyms or figures of speech, which may involve all the physical and psychological senses.

Copi suggested that the metaphor is an analogical inference and, as such, comes from the similarity of two or more things in one or more aspects to conclude the similarity of those things in some other aspect (cfr. Azzollini & González, 1997).

Although we could establish distinctions among concepts such as metaphors, parabolas, allegories, etc., in this work, the term metaphor will be used in a broad, generic way. We will focus on the key aspect of the concept; that is, in the transfer of a meaning (Mosterín, 2003). In modern Greek, the vehicle that transports passengers from the airplane to the airport terminal is called "the metaphor." This bus can constitute the metaphor of how we understand the term "metaphor": a transfer of meaning.

METAPHORS WITHIN THE ORIENTATIONS OF PSYCHOLOGICAL THOUGHT

The metaphor matches psychoanalytic thought perfectly. Freud stated that thought expressed in images was closer to the unconscious than thought expressed in words (Kopp & Jay, 1998). In fact, psychoanalysis places more emphasis on the interpretation of metaphoric language (jokes, symbols….) than of literal language.

Another of the orientations of thinking within which the metaphor is more comfortable is constructivism. According to this stance, reality is not independent of the observer (McNamee & Gergen, 1996; Ibañez, 2001). That is, each person has his or her own reality and, therefore, no realities are more real than others. Reality is confused with the glasses of who looks through them. Therefore, the metaphors we all use to define the world are our way of filtering reality or, in other words, they make up our own reality.

Constructivists do not differentiate literal language from metaphors because, according to them, we do not perceive reality objectively but instead, we construct it, and therefore, what we normally call literal language as well as metaphors are both the same kind of construction. Experimental studies support this idea, concluding that metaphoric language does not require a special processing in comparison with literal language. In an investigation carried out by Gallego (1996), they verified

that metaphoric and literal utterances were understood with the same facility and speed. In this sense, Lakoff and Johnson (1980) have shown that our conceptual systems are built to function metaphorically.

Humanists are also comfortable with the use of metaphors. They are probably so comfortable with the use of metaphors because, more than any other psychological tendency, their orientation is based on literature. We should take also into account that, as the humanists have never attempted to identify themselves with science, this has made it easier for them to use metaphors, which are charged with being not very scientific tools. Telling stories or metaphors is an extensively used resource in their therapeutic techniques. A clear example of this is found in the books of the famous Jorge Bucay (Bucay, 2002, 2003).

In contrast to the previous tendencies, in general, the more traditional cognitivist stance has ignored metaphors. Cognitivism's essential idea is based on the existence of an "objective" or "logical" way of seeing reality and, when not seen through these lenses, the person is considered to be distorting reality (thus, the famous lists of erroneous or distorted thoughts). The therapist should identify the bias of the client's interpretations and, through logic-rational analysis, change them. In other words, this kind of therapies is based ion logic positivism, which enhances the empirical search for the truth that distorted thoughts obscure. This type of viewpoint favours the use of "rational" or "literal" language in therapy instead of the metaphor.

Nor has the more basic aspect of classic cognitivist psychology been characterized by research of metaphoric thought. It is strange to observe how cognitive psychology, so rooted in the metaphor of the computer, is aware that it uses this metaphor as a way to analyze human behaviour and, nevertheless, it does not transfer the use of metaphors as a way of seeing reality in our daily life. It is as though the cognitivists accepted the use of metaphors as a method of scientific study but not as a way in which humans analyze the world.

It goes without saying that the most classic behaviourism, mainly based on the principles of Pavlovian, Skinnerian, covert, and vicarious conditioning has not left much room for the study and therapeutic employment of metaphors. As noted ironically by Sims (2002), although some behaviourists have openly attacked metaphors, they do not hesitate to use metaphors from cartography, engineering, or computer sciences to describe human functioning.

METAPHORS IN COGNITIVE-BEHAVIOURAL PSYCHOLOGY

The cognitive-behavioural viewpoint is undergoing a new stage in which, little by little, metaphors are finding a place.

As analyzed by Yela (1996), the different stances within psychology are merging. A clear example of this is seen in the fact that the constructivist ideas are gaining ground within the cognitive field. Even Albert Ellis (1993), the maximum exponent of cognitive therapies, underscores the need to incorporate practices and theories of a more constructivist and humanist nature. This wind of change in the more radical stances brings with it the use of metaphors (Kopp & Jay, 1998; Lyddon, Clay, & Sparks, 2001; Meichenbaum, 1993; Otto, 2000). Now, instead of changing distorted thoughts by means of logic-rational methods, many therapists start out from the basis that there is no rational way to see reality but instead, some metaphors that are more useful than others in certain cases, so they try to change or work with the client's metaphors, which he uses like the lenses of his reality. A clear example of this is found in Salkovskis' (1999) article, in which he uses metaphors in the cognitive-behavioural treatment of obsessive-compulsive disorders as a way of helping the patient to reappraise her obsessive thoughts. One of the metaphors consists of comparing these thoughts to blackmailers (no matter how much you give them, they never have enough).

When considering more behavioural tendencies, differentiating them from the cognitive ones, we can see that they have also become more flexible, that is, they have opened up their windows to let in the breeze of metaphors. A good example is seen in the therapy of acceptance and commitment (see the excellent handbook of Wilson & Luciano, 2002). This therapy is based on behaviourism that is supported by the principles of functional contextualism and experimentation in language (the relational frames theory). In this therapy, clients are helped to distance themselves from the context that surrounds the problematic situations in which they find themselves. The goal is for clients to abandon the struggle against their thoughts and to focus on their behaviour to achieve their values. In fact, the metaphor described at the beginning of this article, which was taken from this therapy, illustrates this idea very well. I will not go more deeply into the description of this therapy, I only want to underscore that the metaphor is one of its basic tools.

It is well-known that metaphors and stories have always been an important instrument in child psychology from the different psychological perspectives. Therefore, we can also consider child psychology as a doorway for metaphors (Gardner Cfr. Capafons, Alarcón, & Hemmings, 1999).

Not to mention hypnosis at this point would be an unforgivable oversight. Once hypnosis managed to enter the cognitive-behavioural arena (not without many obstacles because of the mysterious aura that has always surrounded it), it has become a new gateway for metaphors to come in. Let us recall that most suggestions that are used in hypnosis are completely metaphoric (Capafons, 2001; Hilgard & Hilgard, 1990; Kingsbury, 1994). Erickson is, no doubt, the most representative example of the use of metaphoric language in hypnosis (Erickson & Rossi, 1979; Zeig & Rennick, 1991). Erickson used metaphors as analogies of the patient's problems. Through Erickson, metaphors became a main axis of Neurolinguistic Programming (O'Connor & Seymour, 1992). Metaphors have become a tool that can be employed with the client when he is in various states: hypnotized, relaxed (many of the visualizations used are pure metaphors), or simply when he is in a normal state of alertness.

METAPHORS IN THERAPY

The metaphors used in therapy can be classified in two large groups: A) metaphors expounded by the therapist and B) metaphors we identify in the client's narration.

A) The metaphors used by the therapist can be the therapist's original metaphors or they can be extracted from other sources (Burns, 2003). In fact, life itself is an endless source of metaphors. Experienced therapists have a file full of metaphors under their arm, and they also use their creativity to invent suitable metaphors during therapy. The following is an example of a prefabricated metaphor we can use in the treatment of a depressive client (Otto, 2000):

"Imagine a gargoyle on your shoulder: as gargoyles are made of stone, this depression gargoyle is weighing you down and making it hard for you to move to perform any kind of activity. Moreover, it is constantly whispering in your ear. The messages are negative, humiliating, they blame you for everything. If you feel bad, the gargoyle will tell you firmly that you will always feel that way. And the worst thing about it is that you believe everything it whispers to you. In the next few weeks, you should learn to identify these messages and become aware that they come from the gargoyle."

B) To work with the metaphors found in the client's narration, Sims (2003) proposes a series of steps to follow:

1. - Listen to the metaphor. In many cases, psychotherapists listen directly to the meaning of the client's words, but not to the words themselves, which is where the metaphor is found. Therefore, the first step should be to train ourselves to listen to these words that make up the metaphor.
2. - Validate the metaphor. This step consists of "marking" the metaphor for the client, as something that would be interesting to investigate.
3. - Expand the metaphor. At this time, the client is invited to offer the associations produced by the metaphor (the emotions and images it provokes).
4. - Play with the possibilities. Here, the client is asked what the metaphor means. The more meanings that emerge, the more ways of behaving there will be. In both expanding and playing with the possibilities of the metaphor, we must struggle against the endemic habit of assigning them an interpretation, that is, our own interpretation.
5. - Marking and selecting. Once the various possibilities have been seen, we try to choose the one that is the most adapted to treatment goal.
6. - Connecting to the future. Talk to the client about the future by means of the metaphor.

These six steps are based on a premise that is very well described by Watzlawick:

"The message not only conveys information, it also communicates something about communication itself. Therefore, it has meta-communicative relevance and it creates a second-order reality about which we can attempt a subsequent communication "(Watzlawick, 2001, p. 198).

We may think that is not easy to find metaphors in the patient's discourse. However, the narratives are usually full of metaphors. In their analysis of 20 narratives of psychiatric clients, Mallinson, Kielhofner, and Mattingly (1996) concluded that it was customary for patients to include metaphors in their stories to give them meaning.

WHY ARE METAPHORS USEFUL?

We live in a culture that, from the crib, shows us how to think in a logic-rational way, at home, at school, at work. In fact, "you are not being logical" has become an insult. Therefore, when we have a problem, we attempt to address it as "rationally" as possible. Although emotions and unconscious processes affect our decisions (read the excellent article by Simón, 1997), we try to—or we think that we do—deal with everything rationally. When someone comes to the therapist's office, not only the client, but everyone around her has bombarded her with "logic-rational" advice, which has obviously not been useful because, otherwise, she would not have consulted the psychologist. Can we make progress if we go on using the same logic-rational strategies in therapy that the client has used till then?

Metaphors can be a good way to start therapy. In any form of therapy, the first step is usually to explain to the patient what the therapy will consist of. Psychological techniques are usually new for the patient, so one way of understanding them is to compare them to something he already knows. This is establishing a metaphor. A good example of this use of the metaphor is found in the article of Capafons, Alarcón, and Hemmings (1999), where they use a metaphor to explain the use of hypnosis (a technique against which there is much prejudice) with very good results.

The use of metaphors is another way of considering the problem, a new way of doing it for the client (Berlin, Olson, Cano, & Engel, 1991; Lyddon, Clay, & Sparks, 2001; Otto, 2000). And it is clear that if the old strategies were no good, the new ones should be welcome. With metaphors, imagination and creativity are suddenly promoted. As noted by Azzollini and González (1997), during the problem-solving process, analogic-metaphoric comprehension can either be a solution, the start of a path toward a solution, or it can substantially change the focus of the problem. In short, metaphors can be heuristic trampolines.

If we require the client's imagination and creativity, his role suddenly becomes more active. The client's mobilization is always the first goal, and sometimes the only goal, in the majority of therapies. Active participation promotes it.

Metaphors present other advantages. One of them is that they are easy to remember. The literature on the recall of verbal information concludes that the material is better recalled if it is organized and interesting, it provokes not-too-intense emotions, and it uses sensory anchors (Otto, 2000). As seen, all these characteristics are found in metaphors. People usually like metaphors: we only have to observe most of the annexes that are sent in e-mails with all kinds of metaphors. Undoubtedly, people like them and they are also easy to remember. Advertisers also know how easy it is to remember metaphors; just look at the amount of ads that use them.

Another advantage is that metaphors do not provoke resistance (Lyddon, Clay & Sparks, 2001; Otto, 2000). If the therapist suggests the correct way for the client to behave, it is likely that there will be some resistance. However, if he tells him a fable about it, there will probably be no resistance.

The efficacy of metaphors is also that they allow the client to externalize the problem and to analyze it from a greater distance (Otto, 2000).

Likewise, metaphors allow contact with and expression of emotions (Lyddon, Clay, & Sparks, 2001). It's as though they allow the expansion of the emotional conscience because one does not stick exclusively to literal experience. Let me to tell you about an experience that illustrates this idea. It occurred during a therapy I carried out with a client during an investigation of chronic pain. The patient was a woman who had suffered from a pain for several years, without any pathological anxiety or depression. The first day of therapy, I only asked her some questions about her life and she responded clearly, without much emotion, as she described her life in positive terms; even the physical pain was well integrated. The second day, we practised relaxation and, while she was relaxing, I explained the metaphor of the garden (Wilson & Luciano, 2002). Briefly, in this metaphor, life is compared to a garden, and the plants are the important themes of one's life (family, friends, work….). When I finished describing the metaphor, I asked her: "What does your garden look like?" The client started to cry, saying that she could see some cacti and she explained that one of them was her brother-in-law (many years ago, he had violated her, getting into her bed). Although this is a very subjective and personal perception (in fact, like all of them), I very much doubt that the client would have told me about this circumstance if I had not explained the metaphor. In fact, throughout the sessions, I verified that her emotional facet emerged more easily when we used metaphors than when we spoke about her life more

literally. My perception with this patient and with other people is that, when one speaks metaphorically, emotions emerge more easily.

SOME REFLECTIONS

Till now, we have talked about the advantages of metaphors, but I cannot conclude without also commenting on some of their disadvantages. The following quotation could be a good aphorism about this:

> "Metaphors create vision, but they also distort.
> They have potential, but also limitations.
> By creating ways of seeing, they also create ways of not seeing."
>
> *Morgan (cfr. Young, 2002)*

Reisfield (2004) speaks very clearly about the limitations of metaphors. In his article, he describes their extensive use in the field of oncology. Metaphors are frequently used to describe cancer, usually war metaphors, although other types as well. According to Reisfield, metaphors help explain the illness but they may often cause misunderstandings and may even provoke negative emotions if the patient does not like the metaphor employed.

While assuming the limitations of metaphors, we have seen the innumerable advantages of their use. With this article, we wished to underscore these advantages because we consider that metaphors can become important tools for cognitive-behavioural psychologists. Tools that can complement the ones we already have. Therefore, I believe we should teach metaphors as therapeutic instruments in our classrooms and promote their applied use.

In addition to urging the teaching and application of metaphors, I believe that we should promote the research of metaphors. There are many interesting questions to answer:

- What is the basis to differentiate literal language from metaphoric language?
- Are metaphors special linguistic resources or, in contrast, is all language essentially metaphoric?
- To what extent do the metaphors that impregnate our lives affect our coping strategies?

In short, we should open our minds so that metaphors can come in.

The mind is like a parachute. It only works if it is open (Robert Dewar).

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REPLY TO PROFESSOR BUELA-CASAL: RESEARCH BELONGS TO EVERYBODY

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Readers' criticism is an important element of scientific research review. In this article, necessary explanations are provided to Buela-Casal's (2006) reply. Some of the shortcomings and limitations found in the study's approach, sample selection, the questionnaire used, and the conclusions drawn are explained. Finally, we agree that opinion studies on the image of Psychology as a health profession carried out by Professor Buela-Casal and his colleagues were not about whether Psychology should be regulated as a health profession.
Key words: *Peer review, criticism, opinion studies, psychology*

La crítica de los lectores es un importante elemento dentro de la revisión de las investigaciones científicas. En este texto se hacen las necesarias aclaraciones a la réplica de Buela-Casal (2006). Se explican algunos de los problemas y limitaciones encontradas en el planteamiento, en la selección de las muestras, en la idoneidad del cuestionario utilizado y en las conclusiones extraídas de los estudios de opinión. Finalmente, se acuerda que los estudios de opinión sobre la imagen de la Psicología como profesión sanitaria realizados por el profesor Buela-Casal y sus colegas no trataban de si la Psicología debe regularse como profesión sanitaria.
Palabras clave: *Revisión por pares, crítica, estudios de opinión, psicología*

The editors of scientific journals have reached an agreement: Post-publication criticism is a necessary complement to pre-publication review to correct errors and limitations in research (International Committee of Medical Journal Editors, 2003). Letters to the editor, the most common presentation form of readers' criticism, facilitate free expression, help conform judgement, and reflect the intellectual vigour of the community concerned (Horton, 2002). Unfortunately, this practice is underdeveloped and infra-valuated by clinicians, academics, professors, and many journals (Bhopal & Tonks, 1994); in our environment, alarmingly so. A large part of the psychology journals in Spain do not ever publish readers' criticisms. Even in those like *Papeles del Psicólogo*, with a mean diffusion of over 45.000 issues and a determined interest in readers' participation, these sections are too often left empty. It is everyone's responsibility of to change this. Therefore, I consider it practically my duty to respond to Professor Buela-Casal (2006) and his heated comments.

We should not risk having the readers, forcibly unaccustomed to these texts, assume that the reply of the famous full professor of a prestigious university follows the style rules that he so "earnestly" advises me to read. The attempt to discredit the discordant voice instead of a calm and humble defence of one's work, the thundering repetition instead an expositive clarity, elemental advice instead of a lucid reflection should not be left as a model for the novel investigator.

I will try not to deflect the reader's attention with references to formal aspects, as that is not the customary content of a post-publication review. Nor will I linger on the justification of the formal aspects of my text (González-Blanch, 2006), which I believe any trained reader can discern; not even on those that the professor emphasizes as "important errors" (Buela-Casal, 2006). In these cases, in behalf of elegance and rigor, one runs the risk of not being very elegant and rigorous. I shall limit my comments, then, to clearing up the "erroneous arguments, incorrect interpretations, and some logical contradictions," according to Buela-Casal (2006).

Concerning the observations I made about the samples of students and registered psychologists, suffice to say that to doubt their representativeness does not mean one has to cancel the investigation, it is sufficient to acknowledge and take this limitation into account in the conclusions. It is common practice in quality works to assume that perfection does not exist, and, therefore, by definition, neither does it exist in sample selection. I still do not understand which part of the procedure (phone contact,

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mailing questionnaires, the instructions given by the teachers, passing the questionnaires out among the students…) is not applicable to the students in the associate centres of the Open University (UNED). Not to include students from the Open University, the most numerous (half of the new registrations) and with a student body of particular characteristics, cannot be dismissed as if it were just one more university among the many universities where Psychology is taught. But neither did I expect the investigators to fly to the associate centre of Malabo to hand out their questionnaires: although they may have a different perception of health there….

That almost 90% of the registered psychologists who were initially contacted did not reply may not mean that they deliberately decided not to participate, but it does not seem a negligible percentage. In short, once again, the statement that the sample was "sufficiently representative" could be qualified, and I did just that. Unfortunately, despite the recruiting effort, a sample of 1.206 registered psychologists may not be "sufficiently representative," contrary to Buela-Casal's (2006) statements.

As explained above, if a study has a sample of questionable representativeness does not completely invalidate its results, and I regret that misunderstanding if I caused it. For example, I could underline that of the registered psychologists who were particularly motivated to respond to a questionnaire with direct questions about the health aspects of Psychology, less than 25% thought that any psychologist could diagnose and treat "emotional and mental problems that affect health," in contrast to 96% who considered that clinical psychologists were capacitated (González-Blanch, 2006). And, assuming the limitations of the sample, I admit that other conclusions are equally legitimate.

Certainly, the results of the factor analysis of the Opinion of Psychology as a Health Profession Questionnaire [Cuestionario de Opinión sobre la Psicología como Profesión Sanitaria (COPPS)] classify general Psychology and Clinical Psychology into different dimensions. This is more striking if we take into account that "we can with difficulty withdraw the clinical sub-discipline" from general Psychology; that was all I said, and all I meant to say. Even those of us who have recently insisted on the need to separate professional profiles can come to acknowledge that it is not easy to think of the psychologist's task without at the same time thinking of the clinical psychologist. But, despite all this, the results of the opinion studies show that, when asked about the health functions, teachers, registered psychologists , and students distinguish between those of the speciality and of the licentiate: between what is recognized by law as health and what is not. I considered, perhaps mistakenly, that this observation was pertinent, given the goal of the professor's studies.

With regard to the COPPS subscale concerning the affinity between psychological and medical sub-disciplines, I consider the professor's distinction between knowledge and opinion fair, but to ask about sub-disciplines without being sure that the surveyed individuals are familiar with them is to expose oneself to considering any affinity appropriate, even the merely cacophonic ones. It was not my intention to be "insolent" when enquiring about the surveyed individuals' knowledge of, for example, immunology and psycho-neuroimmunology; it would suffice to admit my ignorance in either of them for my opinion about the affinity of these sub-disciplines to be, in some sense, devaluated. This was the case for the rest of the pairs that were probed. What would let us establish what Buela-Casal (2006) unenthusiastically calls "a considerable affinity" among disciplines? I didn't know and I asked.

I maintained, and I maintain, that the questionnaires administered to the Spanish population encourage the confusion between the psychologist's work and the clinical psychologist's work because they only ask about the former. I completed the reasoning recalling that the lay population identifies the psychologist with the clinical psychologist by quoting Fowler and Farberman (1998). I was not, therefore, interpreting, in contrast to what the astonished professor states, what the surveyed individuals thought when answering questions such as "is the psychologist qualified to treat emotional and mental problems that affect health?" or "Do you believe that the psychologist is a professional who should be present in all hospitals?" As stated, I was not interpreting; I was relating it to previous studies and to common sense, suggesting that the surveyed individuals, not having had the chance to distinguish between psychologists, answered the questions with the image in mind of their best exemplar within the category of psychologist: the clinician. Perhaps thus perpetuating the confusion of professional roles. In this way, I called attention to the fact that it is risky to assume that the general population's opinion was that, apart from the clinical speciality, the psychologist, in his/her diverse specialities, is considered (and regulated

as) a health professional. Our Association, co-financer of the research, did not hesitate to use these data to reinforce its anti-LOPS argument, alluding to them in an onerous ad of the national press. But I shall not linger here. Any critical reader can assume that "writing up the results of the studies in the best possible descriptive way" (Buela-Casal, 2006) does not guarantee methodological pureness, nor does it attenuate the conflict of interests, nor does it allow the researcher to shirk social responsibility.

Lastly, it is a relief, amidst so much disagreement, to be able to coincide with Buela-Casal (2006) in that the opinion studies published by his team are not about whether Psychology should be regulated as a health profession, which, in short, is what originated the great polemic of the last few years (González-Blanch & Álvarez, 2004; González-Blanch, 2005). There is a big step between the relation of Psychology and health and its regulation as a health profession and, as Buela-Casal (2006) writes: "[…] no doubt, one must perform a very biased reading to conclude that the works published [the series of opinion studies on the image of psychology as a health profession] are about that [whether they should be regulated as health professionals]." If, by the title of my article, I may have given the impression that the professor and his collaborators' studies attempt to address this issue, I herewith rectify.

When all is said and done, not long ago, I wrote that we would have to "[…] acknowledge the work already performed, from the viewpoint of self-criticism and the best spirit" and I concluded in a way I would rather not remember….

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REPLY TO GONZÁLEZ-BLANCH (2006B): REPLY TO PROFESSOR BUELA-CASAL: RESEARCH BELONGS TO EVERYBODY

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The article is a reply to Gonzalez-Blanch's comments published in the present issue. Once again, the author has trouble following the scientific publication norms and as a result, the text is difficult to understand. The present article shows that the objections González-Blanch raises are mainly due to his lack of knowledge of some of the basic principles of research in psychology.
Key words: *Opinion studies on Psychology, Psychology as a health profession.*

En este articulo se da réplica a la respuesta de González-Blanch (2006), publicada en este mismo número. Una vez más este autor tiene dificultades para seguir las normas de publicación de artículos, lo cual dificulta la comprensión del texto. Se demuestra como la mayor parte de las objeciones que plantea se deben a su desconocimiento de varios principios básicos de la investigación en Psicología.
Palabras clave: *Estudios de opinión sobre Psicología, Psicología como profesión sanitaria.*

It seems necessary to begin by clarifying something that a priori should not take up space in a scientific publication and it is that the publication rules are compulsory for any kind of article published in a scientific journal. And the title of González-Blanch's (2006b) article is a poor example insofar as it neither corresponds with the content nor with the article to which it attempts to respond. Therefore, I once again advise him to study the texts already mentioned in Buela-Casal (2006) because he continues to prove that he is not familiar with the publication rules.

Reflection is essential in research and in the writing up of scientific articles, and when reflection is scarce or nonexistent, people write things that, when you read them, may even turn out to be funny. This is the case of González-Blanch (2006b) when he writes that "It is everyone's responsibility of to change this," in reference to the appropriateness that the 45.000 readers of *Papeles del Psicólogo* should participate by sending their criticisms of the published works. Suppose that only one out of every hundred follow this advice: that would mean that, for each issue published, the journal would receive 450 letters. If the letters had a maximum space of one page, that would be 450 pages. For the good of the journal, let us hope that not one out of every thousand will follow his advice, because even then, there would be 45 pages per issue.

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González-Blanch (2006b), in reference to his observations about the samples, says, "…to doubt their representativeness does not mean one has to cancel the investigation …," in effect, this is true, but not because of what this author believes; it is true because of a simple question of logic: to doubt its representativeness does not imply that a sample is not representative, because the error may lie in the "doubt," as we consider may be the case here. It is part of the basic training in the Licentiate of Psychology to know what conditions must be fulfilled so that a sample is representative and, among them, one of them has to do with the size of the population and the level of confidence the investigator wishes to reach. In any basic book of Mathematical Psychology, one can consult the formula to calculate the size of the sample as a function of the population and for each level of confidence. Therefore, we think that González-Blanch (2006b) would do well to apply the formula to the studies whose methodology he is criticizing (Buela-Casal, Bretón-López et al., 2005; Sierra et al., 2005), arriving at the surprising and absurd conclusion, if he maintains his argument, that a sample of one million Spaniards is not representative with regard to the number of the population of Spaniards. In short, in order to calculate the representativeness of a sample in research, a formula was used and not mere opinion criteria like those proposed by González-Blanch (2006a, 2006b).

On the other hand, González-Blanch (2006b) says: "I still do not understand which part of the procedure […] is

not applicable to the students in the associate centres of the Open University (UNED)." The attentive reading of a basic handbook of designs in Psychology research will allow him to understand it. This author seems to be mixing up our studies, and even the studies of other authors because he refers to procedures like "the instructions given by the teachers," where one does not know what he is talking about, because we used nothing of the sort. But I insist, if he reads a basic research handbook, I think this author will understand why the procedure used in the study of Sierra et al., (2005) is not applicable to the students from the Open University [UNED].

It is important to know that González-Blanch (2006b) realizes that it is not the same to ask about people's opinions as to ask about their knowledge, but one should not forget that he wrote that several hundred Psychology professors may not be familiar with the Psychology specialities, as can be seen in González-Blanch (2006a). And insofar as a considerable affinity is established between the disciplines, this becomes clear if one examines the scores of the studies of Buela-Casal, Bretón-López, et al. (2005); Buela-Casal, Gil Roales-Nieto, et al. (2005); Sierra et al. (2005), and these are not mere cacophonic affinities. And, by the way, perhaps it could also be interpreted that the members of the University Coordination council have approved, on the basis of cacophonic affinities, that Psychology should change from the group of Health and Juridical Sciences to the group of Experimental and Health Sciences, which is in accordance with Buela-Casal's (2005) reflections.

Lastly, with regard to González-Blanch's (2006b) interpretations of the responses of the sample from the general population (Buela-Casal, Teva, et al., 2005), they are already explained in Buela-Casal (2006), and such interpretations are no more than his own personal opinion with no other basis, and therefore, further argumentation is pointless.

I would not like to conclude without emphasising that at least Buela-Casal's (2006) reply was useful so that González-Blanch (2006b) could reconsider some of his "erroneous arguments, incorrect interpretations, and some logical contradictions," which is patent in several of his expressions: "I regret that misunderstanding if I caused it…." "I considered, perhaps mistakenly, that this observation was pertinent …," "I consider the professor's distinction between knowledge and opinions fair," "It was not my intention to be 'insolent'" "I didn't know and I asked…," "If […] I may have given the impression that the professor and his collaborators' studies attempt to address this issue, I herewith rectify." Well, at least that's something.

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