María I. López-Ibor[1, 2]
Juan J. López-Ibor[1, 2, 3, 4]

What do psychiatrists need to learn? Knowledge, skills and attitudes

[1]Departamento de Psiquiatría
Facultad de Medicina
Universidad Complutense

[2]CIBERSAM (Centro para la Investigación Biomédica en Red en Salud Mental)

[3]Instituto de Psiquiatría y Salud Mental
Hospital Clínico San Carlos

[4]Instituto de Investigación Sanitaria del Hospital Clínico San Carlos (IdISSC), Madrid. Spain

In every culture and through history, religion has always being important, it is considered to play an adaptative role, that may help different societies to satisfied one or some human universal necessities. Therefore, according to psychological point of view, the more common aspect of religion in universality.

Religion and spirituality are very important for some people, it helps them to find life sense, in this aspect and not in other, we can clonclude that religion and spirituality are part of the quality of life. The World Health Organization (WHO) support that spiritual values or spirituality are an important component in quality of life.

Very often religious experience has not been taken into consideration by psychiatrist. It is not surprising that there are very few research studies and publications that help psychiatrist to explore religiosity in their patients. Many data suggest that religion in particular, or sipirituality in general (considered as an intimate and personal experience that not include rituals of any religion) is associated with increased sense of well-being, decreased depressive symptoms and is related with lifestyle behaviors' (enhance positive coping strategies against stressful life events) and provide larger and stronger social networks.

Psychiatrists are trained in interviewing and they are aware of the domains that should be assessed: history of the present illness, diagnostic criteria, family history , formal mental status, social history, ...but even though we know spirituality is sometimes essential for patients, psychiatrist in general find more difficult and intimate to talk about one´s religions or spiritual life than one´s sexual experience.

In this paper we review questionaires that measure religiosity, spiritual well-being, religious coping strategies and beliefs and could help psychiatrist in taking spiritual history.

Spiritual matters and religion should become part of clinical psychiatric assessment, we have to take into consideration cultural beliefs, values that are important for patients and therefore spiritual concerns should be considered as a part of the patient-center medicine.

Therefore psychiatrists need to take into consideration the role of religion and spirituality in the diagnosis, symptoms, dyshabilities and resilience.

Key words: Religion, Spirituality, Clinical interview, Quality of life

¿Qué necesitan aprender los psiquiatras? Conocimientos, habilidades y actitudes

En todas las culturas y a lo largo de la historia la religión ha desempeñado un papel destacado, de lo que se deduce que realiza una función adaptativa, invocada en todas las sociedades para satisfacer una o varias necesidades universales humanas. Por tanto, y desde el punto de vista psicológico el rasgo más destacado de la religión es su universalidad.

La religión y la espiritualidad son importantes para la vida de muchas personas, le dan un sentido a sus vidas, en este sentido y no en otro, se puede considerar que la religión y la espiritualidad son parte de la calidad de vida. La organización mundial de la salud (OMS) reconoce que los valores espirituales o la espiritualidad es un componente de la calidad de vida.

Muy a menudo el fenómeno religioso ha sido considerado muy superficialmente por los psiquiatras. Por eso no es de extrañar que pocas publicaciones existen que ayuden a los psiquiatras a explorar la religiosidad de los pacientes. Muchos estudios científicos que demuestran que la religión en particular o la espiritualidad en general (definida como experiencia individual y personal y que no incluye los ritos y rituales de una determinada religión) se asocia con un mayor bienestar y disminuye los síntomas depresivos pudiendo relacionarse con estilos de vida (mejorar las estrategias de afrontamiento ante situaciones adversas) y proporcionan una de las mayores y más poderosas redes sociales.

A lo largo de su formación como especialistas los psiquiatras son entrenados en la entrevista clínica y en la exploración del estado mental, son conscientes de los aspectos que deben abordar durante la entrevista: el motivo de consulta, los criterios diagnósticos, la historia familiar y social….., pero incluso aunque sabemos que la espiritualidad es a veces muy importante para el paciente, psiquiatras consideramos que es más difícil preguntar a los pacientes sobre sus creencias religiosas que sobre aspectos relacionados con la sexualidad.

En este trabajo se revisan una serie de cuestionarios que pueden ser utilizados y ayudar a los psiquiatras a explorar la religiosidad, la espiritualidad y si la religión o no juega un papel en las estrategias de afrontamiento del paciente.

Los aspectos religiosos y espirituales de nuestros pacientes deben ser explorados, es necesario que tengamos en cuenta que son valores en ocasiones importantes y que junto con otros deben pasar a formar parte de lo que hoy se denomina medicina basada en el paciente. Por lo tanto los psiquiatras deben de aprender el papel que la religiosidad y la espiritualidad juegan en la aparición y manifestaciones de la enfermedad y en el proceso de afrontar la enfermedad, el sufrimiento y la discapacidad y en la resiliencia en general.

Palabras clave: Religión, Espiritualidad, Entrevista clínica, Calidad de vida

NEEDS OF THE CLINICAL PRACTICE

The practice of psychiatry and general medicine requires a subtle combination of scientific knowledge and ethical considerations that affect values per se and above all those of the patients.

At times, an attempt has been made to add the terms *cultural and spiritual* to the definition of health given in the Founding Charter of the World Health Organization,[1] *State of complete physical, mental and social well-being and not merely the absence of disease or infirmity.* In any event, the cultural element is included in the definition of mental health of the Organization itself that considers it as: *a state of well being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and efficiency and is capable of making a contribution to the community*[2]

On the other hand, the criteria for the diagnosis of a mental disorder, especially in the DSM,[3] include the need of a clinical significance determined by the suffering of the patient and the associated disabilities. The latter is not, in short, anything else but the impact on the quality of life. Thus, it is not surprising that in July 2011, the WHO, in collaboration with the World Bank, published the FIRST GLOBAL REPORT ON DISABILITY[4] it is defined as the capacity of maintaining a relation with the surroundings that make it possible to generate quality of life. In other words, the patient should not be considered as a passive subject who must be freed with scientific and technical means of a suffering and disability that suddenly occur but rather a person with full rights to a full capacity of life. The fact that the World Bank has taken an interest in these aspects[5] since 1993 stresses the importance of health as capital of the society, that is decreased or lost due to the disease, disability and premature death and that has led to the notion that health is not a mere consequence of development, that permits better health care, education level and quality of life but rather, on the contrary, it is the consequence of this greater level of health.

For all these reasons, it could be stated that the disease affects the person and not the mind[6] and even less the brain or that *Psychiatry is the most scientific of the humanities* and the *most* humanistic of the *science*, as expressed by Sir Martin Roth that recalls another famous quote: *Anthropology is the most humanistic of the sciences and the most scientific of the humanities.*[7] Thus, the cultural aspects and those referring to the individual and cultural values are a mainstay of medicine focused on the person and in a practice sensitive to the values and aspects of the human experience in which the values are implicit or explicit, in form of emotions and aspirations. The consideration of what fair and healthy values are corresponds to ethics and the way these are applied to a specific person and special situation corresponds to the moral disciipline.[8] Both disciplines are fundamental in the training of the physician and even more so in the psychiatrist who has to keep in mind the cases in which the competence to evaluate and decide on what is most convenient may be affected. In fact, and in the context of the above-mentioned definitions, mental health consists of a balance between personal, social and cultural values and the goal of the clinical interventions is to be able to reach an understanding of social and cultural values beyond those of the values per se, something essential in the modern societies that are increasingly more multicultural.

On the other hand, well-being is not something that is age, gender or income related (whenever these are above the poverty level), but to the fact of being mature (capable of guiding oneself, of cooperating and of having a sense of transcendence), honesty (wise, capable of waiting and of loving).[9]

Religion and spirituality contribute to shaping the image the patients have on their disease and therefore their attitudes regarding the treatment. Thus, psychiatrists should learn the role played by religiosity and spirituality in the appearance and manifestations of the disease and in the process of coping with the disease, suffering and disability and resilience in general.

HOW TO COPE WITH THE STUDY OF SPIRITUALITY AND RELIGIOSITY.

The core problem of the approach to spirituality and religiosity is that they form a part of the patient's individual idiosyncrasy and cultural identity and of the values underlying them. The questions on values provoke two, sometimes uncomfortable, responses on attitudes and on the values per se in perspectives regarding important questions of life, of the psychiatrist treating the patient. Thus, the clinician is generally afraid to cause rejection that may distort and interfere with the patient-doctor relationship and, in short, of affecting the result of the intervention of the psychiatrist. In this case, the fear of the patient is doubly stigmatized, first as a mental patient and second as undocumented which, in the eyes of the physician, is carried away along by deceits and superstitions.

Therefore, it is well to remember, although only in a concise way, how the general idiosyncrasy and cultural identity are established in general.

Idiosyncrasy

The word idiosyncrasy comes from ancient Greek, *idiosynkrasía*, 'a peculiar temperament,' 'habit of body,' also called *idios* 'one's own, *syn* 'with and *krasis* 'mixture.' Currently, it is defined as the set of individualizing qualities or traits that are characteristic of a person or group. Therefore, idiosyncrasy and identity are two overlapping concepts.

The Social Identity Theory[10,11] maintains that the social group that one feels they belong to supports the definition of that which the person is, or rather, that the identity per se depends on the identification with a social group and not vica versa. The group identity is not the aggregation of the identities of their group, but rather it is the individual who identifies with it. Once the identification has occurred, two processes are initiated, one of categorization, which distinguishes one group from another, so that all the human groups (this also occurs in the primates) see and are seen explicitly by others as culturally different. In general, this is based on some characteristic that is present (e.g. religion) that ends up stigmatizing the individuals of the "other groups." The second process consists of exaltation of one's own in agreement with which the individuals consider that the characteristics of the members of the group per se are good and desirable, while the characteristics of the members of other groups are bad and undesirable.

This theory explains this so-called evolutive oxymoron of the hominids, and especially of the human being, while simultaneously being capable of greater devotion and solidarity and of greater intraspecific aggressivity. This is the simultaneous presence of an extraordinary intragroup cooperation and tolerance and extraordinary intolerence and intergroup aggressivity.

Identification with the group entails a mechanism for the continuance of the subject in it. For the subject, the advantages are great: *inter-pair* cooperation and defense against foreign groups. Furthermore, the exaltation of one's own becomes a prophecy that fulfills itself. On the other hand, the group considers it to be a threat if one of their members leaves since it destroys the social identification, and the group initiates mechanisms, sometimes extreme, to avoid the heresies and apostasies. Among these, the most powerful was ridicule and ostracism.

The consequence of all of this is that every intervention aimed at modifying the cultural idiosyncrasy and identity, even for a possible benefit to cure the patient, is condemned to failure and entails risks.

The Setting of the Cultural

The word culture has different meanings and too many different concepts are associated to it.

It has been defined as the set of shared attitudes, values, goals and practices that characterizes an organization or group.

In a certain way, culture opposes inheritance because it must be accepted that human phenomena are not exclusively the results of the human genetics.

Declaration of Mexico on Cultural Policies[12] literally state that:

> *Culture may now be said to be the whole complex of distinctive spiritual ritual, material, intellectual and emotional features that characterize a society or social group. It includes not only the arts and letters, but also modes of life, the fundamental rights of the human being, value systems, traditions and beliefs.*
>
> *Culture gives man the ability to reflect upon himself. It is culture that makes us specifically human, rational beings, endowed with a critical judgment and a sense of moral commitment.*

Race, on the contrary, is a biological concept. It refers to the common genetic inheritance. However, it is currently considered as something antiquated, inexact, and above all, that gives rise to abuses. Thus, the Declaration of the UNESCO: The Racial Question (1950)[13]

> *National, religious, geographical, linguistic and cultural groups do not necessarily coincide with racial groups; and the cultural traits of such groups have no demonstrated connection with racial traits.*

Very often, serious errors are made when using the term 'race' in popular language. It would be better to drop the term "race" completely when speaking of human races and speak of "ethnic groups."

Max Weber had defined Ethnic Groups as:[14]

Those human groups that entertain a subjective belief in their common descent because of similarities or physical type or of customs of both or because of memories of colonization and migration, this belief must b important for the propagation of a group; conversely, it does not matter whether or not an objective blood relationship exists.

The word ethnicity derives from the classical Greek *ethnos*, 'town,' 'nation' and designates the persons considered to share a common ancestry that share a distinctive culture. It is a word loaded with stigma. In English, during the XIV to XIX centuries, it was synonymous of pagan, unbeliever, and with the sense of stranger and also, coinciding with the European expansion, as immigrant or native. Therefore, ethnic is the opposite of nation, it is the extra-group versus the intra-group and comes to mean a group of persons whose members identify each other through a common inheritance, often consisting in a common language, common culture (frequently sharing the same religion) and an ideology that stresses ancestry or common intermarriages.[15] Thus, the members of an ethnic group are conscious of belonging to the same group and their identity is also marked by the recognition by others as a different group.

In Europe, there are 87 different "European populations" although neither France nor Switzerland admits any ethics group in their own populations. In the United States, seven are considered: European, Afro-Americans, Asiatics, Latin (recently called Hispanics or of Spanish origin) and (Indians)-Native Americans.

Society and Culture[16]

The word society refers to a group of persons while culture designates the pan-human capacity and the totality of non-genetic human phenomena.

Societies are often clearly limited. The cultural features are frequently mobile and the cultural limits as such may be porous, permeable and plural. Because conflicts after the Cold War were more frequent and violent due to cultural differences more than ideological ones, the concept arose of Clash of Civilizations.[17] While during the Cold War, the conflicts arose between Western Capitalist Countries and the Eastern Communist block, it is currently more likely that this would occur between the most important civilizations of the world.

Eight civilizations are recognized within this context:[18] Western, Latin American, Islamic, Occidental, Latino Americana, Islamic, Sinica (China), Hindu, Orthodox, Japanese and African. It must be stressed that this contemporary cultural classification clashes with the classical notion on sovereign states. However, Max Weber[19] already considered that the ethnical groups were artificial social constructs, based on the subjective belief of a *Gemeinschaft* (community) that was shared and as we have indicated above, the belief in a shared *Gemeinschaft* did not create the group, but rather was a consequence of the attempts to monopolize power and status.

MEASURE OF SPIRITUALITY AND RELIGIOSITY

The mode and intensity of how religiosity and spirituality contribute to quality of life are still not clear, although in patients with cancer, spirituality contributes to better psychosocial adjustment.[20]

In spite of the difficulties, well-being can be measured. To do so it is necessary to evaluate the presence of positive emotions, the personality structure in regards to maturity and integration, satisfaction with one's own life (there is a significant correlation between religiosity and spirituality on the one hand and psychosocial well-being on the other[21,22] and with the presence of certain virtues (value, justice, moderation, honor, wisdom, love and hope).[23, 24]

In the following, we will explain the most useful instruments for the teaching and examination of spirituality and religiosity in the clinical practice. The first six have been analyzed and proposed by Koenig:[25]

Kuhn's Spiritual Inventory. This is a spiritual inventory that investigates seven areas: meaning or purpose, beliefs and faith, love, pardon, prayers, meditation and mass attendance, among 35 questions of the style:

- What things do you believe in or have faith in?
- Has your illness influenced your faith?
- How do you exercise faith in your life?
- How has your faith influenced your behavior during this illness?
- What role does your faith play in regaining your health?

Matthews' Spiritual History. This is a tool to be applied during the first interview. It is made up of three fundamental questions:

- Up to what point is religion or spirituality important to you?
- Up to what point do your religious or spiritual beliefs influence the way you look at your medical problems and the way you think about your health?

- Would you like me to address your religious or spiritual beliefs and practices with you?

Recently, the author has reduced the questions to two:

- Do your religious or spiritual beliefs influence the way you look at your medical problems?
- What can I do to support your faith, religious believes or religious commitments?

FICA Spiritual Assessment Tool, of Christina Puchalski, is made up of five questions that are remembered by the English initials of the area they study: **F**aith, **I**mportance, **C**hurch, **A**pply, **A**ddress.

- **F (**faith**)** - What is your religious tradition?
- **I** (importance) - How important is your faith to you?
- **C** (church) - What is your church or community of faith?
- **A** (Apply) - How do your religious and spiritual beliefs apply to your health?
- **A** (Address) - How may we address you spiritual needs?

Maugans' SPIRITual History, that studies six areas, also identified by their initials in English, each one of which is studied by several questions:

Spiritual belief system

- Do you have a formal religious affiliation?
- Say the name or describe its system of spiritual beliefs.

Personality spirituality

- Describe the beliefs and practices of your religion that you personally accept.
- Describe those beliefs and way of practicing that you do not accept or follow.
- That you accept or believe (beliefs or specific practices). What does the spirituality or religion mean for you?
- What is the importance of your spirituality/religion in your daily life?

Integration with a religious community

- Do you belong to any religious or spiritual groups or communities?
- What is your post or role?
- What importance does this group have for you? Is it a source of support? In what ways is it?
- Does the group of community provide support to deal with your health problems?

Ritualized practices and restrictions

- What type of specific practice do you carry out as part of your religious or spiritual life (e.g. prayer, medication?)
- Is there any type of lifestyle practices or activities that your religion forbids? Do you abide by them?
- What meaning do these practices and restrictions have for you?
- Is there any specific element of the medical care that is forbidden due to religious or spiritual reasons?

Implications for medical care

- Are there aspects of your religion or spirituality that you would like me to keep in mind while I am treating you?
- Would you like to consider with me the implications of the religion and spirituality in health in general? Is there any type of knowledge that you could consider would strengthen our patient-doctor relationship?
- Do you believe that there are any barriers between us due to religious or spiritual reasons?

End-stage events planning

- When we plan for your medical care near the end of life, what impact will your religious faith have in your decisions?

The HOPE Questionnaire covers four areas, once more, identified by their initials in English: **H**ope, **O**rganized religion, **P**ersonal spirituality and practices and **E**ffects on medical care and end-of-life issues.

H - Sources of hope, meaning, comfort, strength, peace, love and connection

- What are your sources of feeling hope, strength, comfort and at peace?
- What do you cling to at difficult times?
- What supports you to be able to continue on?

O – Organized religion

- Do you form a part of any religious or spiritual community?
- Does it help you? How?
- Which aspects of your religion are helpful to you and which are not?

P - Personal spirituality and practices

- Do you have any spiritual beliefs independent of your religion?
- What aspects of your spirituality or religious practice are of most personal utility?

- E - Effects on medical care and end-of-life issues. Has the fact of having becoming ill helped you to

stimulate your spirituality?

- Is there anything that, as your doctor, I can do for you to help you access the resources that have usually helped you?
- Are there any practices or restrictions I should know about in providing you your medical care?

ACP Spiritual History. The *American College of Physicians* and the *American Society of Internal Medicine* named a consensus panel which, considering the previous questionnaires, proposed four simple questions for patients with a serious disease:[26]

- Is religious faith or spirituality important for you in your current disease?
- Has your religious faith been important in other moments in your life?
- Do you have anyone to speak with about religious questions?
- Would you like to consider these religious questions with someone?

ROS Religious orientation scale[27]

This is a scale developed by Allport and Ross in 1967 to measure intrinsic aspects (e.g. are my religious beliefs that which really guide all my life) and extrinsic to the religious orientation such as, for example, "Is the church is the best place to have good social relations?

Spiritual well-being scale (SWBS) of McDonald[28]

This is a scale that measures two important aspects. Firth, the sensation of religious well-being (e.g. I believe that God loves me) and second, the sensation of existential well-being (I think that life is a positive experience).

Index of core spiritual experiences (INSPIRIT)[29]

This scale measures spiritual experiences and the search for meaning of life and positive attitudes and behaviors in regards to life and care of health.

McGill Quality of life Questionnaire (MQOL)[30]

This is a multidimensional scale that measures the quality of life, presence of physical and psychological symptoms, capacity of finding meaning in life, achieving objectives and having the capacity of control.

Systems of beliefs inventory (SBI-15) of Holand.[31]

This scale was developed to measure beliefs and religious practices in the patient population. It measures emotional (hope), cognitive (existence of God), behavioral (meditation, players) and social (support between persons of similar beliefs) aspects. However, it does not measure existential aspects related with satisfaction felts and purpose of life.

Brief RCOPE[32]

This scale measures coping strategies (positive and negative). Among the positive strategies, the search for spiritual support, pardon, purification, is found. Among the negative ones, fear of being punished, the devil, punishment stand out. It is a scale which, due to its characteristics, is not appropriate for use in non-Christian persons.

The Spiritual Transformation Scale[33] is made up of 40 items, in the style of:

- Spirituality has become more important to me.
- The way I look at reality has become more spiritual.
- Due to spiritual changes, I have gone through a process of changing my priorities.
- Now, I more frequently have feelings of gratitude.
- Now, I pray more often for others.
- I always look for a spiritual purpose of life.
- My faith is shaking and I am not as sure of what I believe.
- Spirituality now seems less important to me.

WHAT MUST BE TAUGHT AND HOW: CONCLUSIONS

In the first place, knowledge, that is, being able to understand the spiritual or religious factors that affect the course and treatment of psychiatric disorders: psychopathology (especially of depression, substance abuse), recognizing the risk factors and the protective factors and evidence (for example, as the spiritual beliefs decrees drug abuse, anxiety and depression).[34]

In the second place, it is attempted to acquire skills such as feeling comfortable when religious and spiritual subjects must be dealt with.[35]

In the third place, it is necessary to develop attitudes such as empathy and an approach without prejudices, and this is what has been called religious or spiritual contertransference.

This psychiatrist should deal with the general parameters of religiosity and spiritualities and those that affect the culture of the patient. To do so, it is necessary to study the behavioral aspects of the religious rituals and to be aware that religion and spirituality are two components of faith of one person.

The Guidelines for the Psychiatric Evaluation of Adults of the American Association of Psychiatry,[36, 37] make explicit reference to the questions that we have been mentioning in the following way:

This psychiatric evaluation ought to be performed in a manner that is sensitive to the patient's individuality, identifying issues of development, culture, ethnicity, gender, sexual orientation, familial/genetic patterns, religious and spiritual beliefs, which may influence the patient's symptoms and behaviors.

A good psychiatric interview forms a part of what is currently called "medicine based on the person." The patient should be considered as an individual with a series of attributes, skills, problems, experiences, but also as a member of a group, that is, in that which also affects their family and social and cultural aspects.

During the interview, in the first place, the symptoms of the patient should be identified. However, it should also be identified how these symptoms interfere in their activities of their daily life. It must be considered that the complaint of the patient is also a symptom and deficiency. For example, if the patient complains that he/she forgets the dates, it may also be a symptom of dementia and also interfere in their daily activities.

During the interview, questions should be made to try to reach a diagnosis, establish a prognosis and the treatment, but not only this. It is also necessary to include in the picture and attempt to identify how these symptoms in this specific person interfere with their daily activities and in the role they occupy in society, in their family, and in work.

The psychiatric evaluation should be sensitive to the individuality of the patients, identifying that in regards to development, culture, ethnicity, gender, sexual orientation, styles of religious practice either inherited or acquired, spiritual beliefs, social class and the circumstances of the physical setting and social environment that may affect their symptoms or behavior.

Among the special requirements for the training of residents in psychiatry of the *Accreditation Council on Graduate Medical Education, ACGME*[38] of the USA, mention is made of the knowledge of the religious and spiritual factors that influence physical and psychological diseases.

Religiosity and spirituality have a great impact on psychotherapy. In fact, psychoanalysis has always been considered to be incompatible with a spiritualist vision of the human nature, although there are some exceptions such as the case of Oskar Pfister, a Lutheran minister, theologist and psychologist, who became interested in psychoanalysis and maintained a close friendship and mutual admiration with Freud. Pfister made the following comment: "*By itself, psychoanalysis is not more religious than irreligious. It is an impartial instrument that can be used by pastors or laymen, as long as they only use it for the service of freeing suffering beings.*"

In the teaching of psychotherapy, it is necessary to learn to detect when religious subjects are relevant or when they may be useful without ever violating the barriers between psychotherapist and the patient and paying attention to the contratrnasference. There are times when these questions may have a repercussion on the technique to be chosen.

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