This paper describes a resident’s experience with his first Puerto Rican patient who practiced spiritualism, also elaborating on the major problems encountered, in so far as training for psychiatric residents is concerned. Furthermore, an attempt is made to analyze the role that residency training programs should play in preparing the student psychiatrists to assume a more sophisticated role when confronted with such patients, who are so common in the urban ghettos of the United States.

INTRODUCTION

It is generally assumed that university-based psychiatric training programs prepare trainees to do appropriate diagnostic formulations about the patients they encounter. The residents are, for the most part, confident that their supervisors can make the correct diagnostic formulations even if they, as psychiatrists-in-training, are not quite able to do so. With specific reference to the Puerto Rican patients who practice spiritualism, the authors of this paper maintain that psychiatric residents are often at a toss; and they may indeed find that the ideas coming from their supervisors are on occasion unfortunately not very helpful.

Psychiatric residents should reasonably understand the major forces that shape the lives of their patients. No one is surprised that there is so much talk at this time about improving the preparation of the psychiatric residents, so that they be better prepared to understand all kinds of patients, particularly those coming from a minority background. Despite the steady increase in migration of Hispanic peoples to the United States, regrettably little has been done in psychiatric training to explore the patients’ culture and its influences on mental health and the practice of psychiatry in

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Cultural Factors in Training

depth. In this connection, Weidman (1975) argues that the label of culture brokerage is applicable whenever there is a need to recognize the existence of separate cultural and subcultural systems. Psychiatric residency programs have much to learn from the concept of cultural brokerage, particularly if these programs are part of the mental health services to a population, such as the South Bronx community, which clearly belongs to a different cultural system. This area is inhabited mainly by first- and second-generation Puerto Ricans many of whom practice spiritualism, and their behavior in relation to faith healing often appears to outsiders as manifestations of mental illness.

A CLINICAL CASE

On September 9, 1974, police officers and relatives brought a 29-year-old Puerto Rican female to the hospital's general emergency room because of her bizarre and dangerous behavior. She had apparently set her apartment on fire a few days earlier. Her two children were unharmed. While there had been no previous psychiatric hospitalization, she had been seen by a psychiatrist off and on during the preceding year. The relatives claimed that she had lost weight during the preceding month. At examination the emergency room psychiatrist found the patient to be conscious, incoherent, confused, with bizarre behavior and inappropriate affect; she was also engaged in strange ritualistic-like movements. Depressed in mood, her judgment and insight were clearly impaired, and she was believed to be overtly psychotic. Owing to her present condition and the reports that earlier she was violent and agitated, 50 mg of chlorpromazine (thorazine) were administered intramuscularly, and subsequently she was admitted to the inpatient psychiatric unit of the hospital. In the ward, more detailed interviews of relatives revealed that two days prior to admission, the patient had put her two children outside the apartment and had then proceeded to set fire to her clothes in the bathtub. Neighbors called the fire department and the blaze was extinguished before any serious damage was done. Observers said the patient appeared normal then, although somewhat nervous. On the following day, the patient locked herself in her apartment and would not open the door to anyone. She was heard running up and down in the apartment. The police took the patient to another hospital for psychiatric evaluation, which resulted in her being released. Early on the day of admission, the relatives again went to visit the patient to make sure that both the children and she were well. The patient refused to open the door, and so they called the police again. When the door was opened, the patient was sitting on the floor talking to herself and apparently moving quickly from one subject to another. The toilet bowl had overflowed since the patient had put garbage into it, and the apartment was inundated. Through this interview it was also determined that the patient had complained to an outpatient psychiatrist during the preceding year about serious difficulties with her boyfriend. The clinic psychiatrist had viewed her as anxious and depressed at one time or another and prescribed diazepan