



Identifying psychiatry as a science or an art has been a topic of ongoing discussion for a long time. This paper explores some of the qualities that make psychiatry a science, and an art. It is widely perceived that there is a schism between science and art in psychiatry. However, this perception is questionable and might even be detrimental to the development of psychiatry. This paper suggests a few approaches that may help work towards the unity of art and science in psychiatry for the benefit and continued growth of the profession.

The systematic categorisation of empirical data is a scientific component of psychiatry. Before the 1960s, the field of neuropsychiatry was limited. As a result, psychiatry predominantly relied on the categorisation and examination of symptoms and treatments to tackle psychopathology (Cawley, 1993). This approach led figures like Thomas Szasz to argue that psychiatry is not a science because it relies on symptoms instead of objective tests (Szasz, 2008). However, this view may fail to acknowledge that despite the notable shortcomings of psychiatry's empirical approach, it has still provided time-tested, valuable insights and approaches concerning the psyche (Harland et al., 2004). Like all sciences, it is true that psychiatry entails a degree of uncertainty, admittedly, more so than other fields. (Cawley, 1993) This is due to the complex and shifting nature of its subject. However, this does not exclude the scientific nature of psychiatry.

Recent advances in psychiatry have solidified the identity of psychiatry as being scientific. Advances in neuroscience have provided further insights about the brain, for example, through new methods of brain imaging and genetic sequencing (Rutherford and Hellerstein, 2008). These advances have played a role in supporting and correcting various insights on psychopathology and its treatment. Furthermore, psychiatry has increasingly incorporated the scientific method into its approach. An illustration of this is that randomised control trials are increasingly recognised as a means to validate the effectiveness of psychodynamic therapies (Thoma et al., 2012). Although the presence of science in psychiatry has been disputed until recently, it is becoming increasingly apparent as technology progresses.

The art of psychiatry is most evident in its clinical practice. This was illustrated by a recent study on a small group of psychiatry trainees and their supervisors, who were consultants. The study, by Chur-Hansen et al examined the participants' views on psychiatry as an art or science. A recurring theme emerged in their answers. Most of the participants considered "art" to be in the clinical practice of psychiatry (Chur-Hansen and Parker, 2005). There does indeed seem to be an "art" in effectively relating to and understanding the psyche of the patient. Three axioms, derived from Cawley's six, (Cawley, 1993) are proposed to encapsulate non-scientific but central components in psychiatry:

The individual is unique and simultaneously shares characteristics with other people.

The individual has an inner world and awareness of self that can be reached by empathy.

The style and content of the patient's communication provides essential information about their direct experience and welfare.

These axioms are the basis upon which the art of psychiatry lies.

Despite clinical psychiatry being distinct from the field of humanities, the common ground they share highlights the art in psychiatry. Notably, the three central axioms present in the clinical practice of psychiatry are also pivotal in the humanities. Cawley goes so far as to propose that psychiatry is grounded in the humanities (Cawley, 1993). The artistic quality of clinical practice in psychiatry is emphasised by the common ground it shares with the humanities.

For the purpose of further discussion, it is necessary to distinguish the use of the words "art", "science" and "humanities" within the essay. "Art" refers to the clinical practice of psychiatry as recognised by Chur-Hansen. Notably, this is different from the colloquially and loosely recognised "arts" which will be referred to as the humanities. "Science" refers to insights and practices in psychiatry, gained from endeavour in the natural sciences.

There is a perceived schism between art and science in psychiatry despite their interplay (Knoll IV, 2013). The schism was particularly evident in psychiatry trainees' perceptions about the assessments in their training. In Chur-Hansen's study, trainees identified science as being tested with methods like multiple choice and short answer questions in which there was a right and wrong answer. Conversely, they perceived art as being assessed through methods like essays, which had no definite answers. Instead, it was the quality of their answers that mattered. The schism was also perceptible in the participants' perceptions about the roles of art and science in work. Those interested in the science of psychiatry were thought to enter research, whereas those interested in the art were thought to enter clinical practice (Chur-Hansen and Parker, 2005).

While understandable, the notion of the schism is questionable and possibly detrimental to psychiatry. Chur-Hansen's study noted that qualities often considered to be stereotypically artistic, such as reflection and creativity, are pertinent in scientific parts of psychiatry. Shared qualities like these call into question the validity of a schism between art and science. Art in psychiatry has been aided and strengthened in its insights by scientific advances. Likewise, although science can provide insights into the physical brain, it is not sufficient on its own to explain all phenomena of the psyche (Bloch, 2005, Bolwig 2006). The dangers of overemphasising either art or science are apparent. Reliance on science alone leads to objectification and limited understanding of the patient. On the other hand, over-reliance on art can lead to the development of negative attitudes towards science in psychiatry. These attitudes

may hinder essential components in the development of psychiatry such as research. The perceived schism between art and science proves counterproductive (Harland et al., 2004, Chur-Hansen and Parker 2005).

There has been a strong move to increase the use of humanities in psychiatry in order to prevent science from dominating psychiatry (Bloch, 2005, Ferguson 2006, Rutherford and Hellerstein 2008, Halpern and Lewis 2013). It is believed that a stronger focus on humanities will strengthen the art of psychiatry through the common ground that psychiatry shares with the humanities (Harland et al., 2004, Bolwig 2006, Sukhanova 2013). This is envisioned to benefit both the patient and the psychiatrist (Rutherford and Hellerstein, 2008, Hankir and Zaman 2013).

However, an increased focus on the humanities may not be sufficient to dissipate the schism between art and science in psychiatry. Although the approach may have potential benefit, the way forward may be more effectively found in approaches that marry science and art in psychiatry. Firstly, increased dialogue and collaboration between proponents of science and art in psychiatry may be essential in dispelling the perceived schism. Promoting dialogue that highlights the interplay of art and science in psychiatry could serve to make psychiatrists more aware of the interaction within their profession. Dialogue between senior, respected psychiatrists in particular may be effective because of their ability to pass on new ideas to junior members of the profession. Increased collaboration between opposing proponents of science and art in psychiatry could also actively dispel the notion of the schism in present and future psychiatrists.

Secondly, it may also be helpful to place a strong focus on interactive assessments that incorporate both art and science. Chur-Hansen's study suggests that methods of assessment can unwittingly effect trainee perceptions of the schism. However, it was noted that clinical examinations were considered to assess both science and art (Chur-Hansen and Parker, 2005). Clinical examinations involved trainees interacting with a patient under observed conditions. The trainees then explained the reasoning behind their decisions regarding diagnosis and management. A continued emphasis on clinical examination may assist future psychiatrists to associate science together with art in their professions. As a caveat, it is suggested that the introduction of any change in focus be gradual in order to reduce logistical challenges. Gradual implementation also creates opportunities for continued evaluation of the strategy's success.

In conclusion, psychiatry has proven to encapsulate the qualities of both an art and a science. Its scientific qualities are evident in its systematic approach and increasing emphasis on science. Art in psychiatry is most evident in clinical practice and the common ground psychiatry shares with the humanities. There has been identification of a perceived schism between the artistic and scientific components of psychiatry. In reality, the schism is questionable and possibly detrimental to the advancement of the field. Promotion of dialogue and collaboration between proponents of science and

art may help address this misconception presently and in the future. Furthermore, maintaining a strong emphasis on clinical examination as a major assessment tool could promote the association of art with science for future psychiatric professionals. Although there will always be logistical difficulties, in implementing change these approaches have potential to provide positive long-term impact on the field of psychiatry.

Bibliography

Bloch, S. (2005). "The art of psychiatry." *World Psychiatry* 4(3): 130-134.

Bolwig, T. G. (2006). "Psychiatry and the humanities." *Acta Psychiatrica Scandinavica* 114(6): 381-383.

Cawley, R. H. (1993). "Psychiatry is more than a science." *British Journal of Psychiatry* 162: 154-160.

Chur-Hansen, A. and D. Parker (2005). "Is psychiatry an art or a science? The views of psychiatrists and trainees." *Australas Psychiatry* 13(4): 415-418.

Ferguson, H. (2006). "Finding the art of medicine." *Australian Doctor*: 49.

Halpern, J. and B. Lewis (2013). Humanities: Part 1: introduction: why does psychiatry need the humanities? *Psychiatric Times*. 30: 39.

Hankir, A. and R. Zaman (2013). "Jung's archetype, 'The Wounded Healer', mental illness in the medical profession and the role of the health humanities in psychiatry." *BMJ Case Reports*.

Harland, R., G. Owen and M. Broome (2004). "Humanity and biology in psychiatry." *British Journal of Psychiatry* 184: 363.

Knoll IV, J. L. (2013). "The Humanities and Psychiatry: The Rebirth of Mind." *Psychiatric Times* 30(4): 12-12.

Rutherford, B. R. and D. J. Hellerstein (2008). "Divergent fates of the medical humanities in psychiatry and internal medicine: should psychiatry be rehumanized?" *Academic Psychiatry* 32(3): 206-213.

Sukhanova, E. (2013). "Psychiatry and Art." Retrieved 8 September, 2015, from <http://www.psychiatristimes.com/articles/psychiatry-and-art>.

Szasz, T. S. (2008). *Psychiatry: The Science of Lies*, Syracuse University Press.

Thoma, N. C., D. McKay, A. J. Gerber, B. L. Milrod, A. R. Edwards and J. H. Kocsis (2012). "A quality-based review of randomized controlled trials of cognitive-behavioral therapy for depression: an assessment and metaregression." *The American Journal of Psychiatry* 169(1): 22-30.