Essay topic - 'Seeing the whole person beyond the diagnosis'

The Pentimento of the Psyche: Revealing the Masterpiece Beneath the Clinical Overwrite

By Mr Allan Joseph

Introduction: The Ghost in the Paint

I was taught to trust what is visible. First the skin in the anatomy lab, then symptoms in the clinic. Yet it was only in a quiet gallery, far from the hospital's sterile light, that I found a language for what unfolds on the psychiatric ward.

In art restoration, there is a phenomenon known as a pentimento - from the Italian pentirsi, to repent. It describes the ghostly emergence of an earlier image beneath the final layer of a painting: a hand originally raised in blessing but later lowered; a face turned toward the light, then painted over in shadow (Gooch & Tumblin, 2007). As the oil paint ages to become translucent, the artist's original intent bleeds through the revision. Pentimento shows that a masterpiece isn't a single, finished truth, but something that has been changed, reworked, and lived with over time.

On the wards, I watch the 'final layer' being applied every day. I watch the admission process, where a lifetime of complexity is rapidly compressed into the heavy impasto of the clinical overwrite: 50-year-old male. Schizophrenia. Blunted affect. Treatment-resistant. It is a necessary shorthand, a triage of the soul required by a system groaning under demand.

However, standing on the periphery with my notebook and stethoscope, I have begun to see the ghosts. I have learned that the diagnosis is merely the paint we apply to manage the pathology. To 'see the whole person' is the conservator's art: it is the patient discipline of waiting for the pentimenti - the erased lines of the original self - to shine through the heavy pigment of the illness.

The Impasto: The Clinical Overwrite

The diagnostic manual in my pocket - the DSM-5 - is a form of cartography. It helps us navigate the terrifying, chaotic terrain of psychosis and distress with reliability. However, the philosopher Alfred Korzybski famously warned that "the map is not the territory" (Korzybski, 1948). In the heat of a busy placement, where bed pressures are critical and the registrar's pager never stops beeping (AIHW, 2024), I have felt the pull of the map. It is easier to treat 'The Schizophrenic in Bed 4' than it is to encounter the terrified man named Arthur.

I too, early in my placement, also found comfort in the label. The label created distance. Psychosis is a clinical puzzle; a screaming man is a frightening reality. This reductionism creates what medical anthropologist Arthur Kleinman calls the loss of the "illness narrative"(Kleinman, 1988). When we overwrite a patient's life with a diagnosis, we risk reducing their humanity to a list of symptoms. This is the "clinical gaze" in its most reductive form (O'Callaghan, 2022).

I have watched as a patient's passion for poetry was noted as 'hypergraphia', and how a widow's spiritual keening was flattened into 'depressive affect'. The diagnosis acts as a sealant. It is efficient, protecting the clinician from the intensity of the patient's pain, but it is ethically incomplete. The RANZCP Code of Ethics demands we "respect the dignity, humanity, and rights of patients" (RANZCP, 2018). Dignity is not found in the summary; it is found in the subtext. To truly practice medicine, we must look beneath the sealant.

The Underpainting: A Narrative of Recovery
I learned this lesson through 'Arthur' (a pseudonym), a man I met in the psychiatric intensive care unit (PICU). In the morning handover, Arthur was presented as a catalogue of deficits: negative symptoms, avolition, poverty of speech, social withdrawal (American Psychiatric Association, 2022). To the team, he was a medication regimen to be optimised. To me, he was a source of unease.

One afternoon, I sat with him in the courtyard. The silence stretched between us, heavy and uncomfortable.

Then, I noticed his hand.

His fingers were tapping a rhythm against his knee - not the chaotic twitch of akathisia, but a precise, syncopated 5/4 time. It was deliberate. It was disciplined.

"That's a difficult time signature," I ventured.

The 'poverty of speech' fractured. Arthur's head lifted. For a moment, the dullness of the antipsychotics left his eyes. He began to speak not of the government plots that haunted him, but of Ralph Vaughan Williams and the architecture of symphonies. He had been a cellist - a section leader - before the first psychotic break shattered the melody of his life.

This was the pentimento.

Beneath the clinical label of avolition lay a crushing grief for a lost identity. As Charon (2006) argues, narrative medicine requires us to "recognise, absorb, interpret, and be moved." I was moved.

Seeing Arthur as a musician changed the architecture of his care. It aligned with the RANZCP's Recovery-oriented practice, which centers on "supporting people to define their own goals" (RANZCP, 2019). For Arthur, recovery wasn't defined by the clinical goal of total silence (hallucination cessation), but by the personal goal of returning to music. We found him a radio. The diagnosis explained his pathology, but the pentimento explained his soul.

Provenance: Culture as the Canvas

In art, "provenance" refers to the stewardship of a work. As I navigate my placements, I am painfully aware that seeing the whole person requires understanding their cultural provenance - a history often erased by the white coat. This is acutely visible when treating Aboriginal and Torres Strait Islander peoples, where the "clinical overwrite" of Western psychiatry can inadvertently replicate the violence of colonisation.

If we view an Indigenous patient solely through the aperture of a DSM criterion, we risk pathologising a cultural reality that we might not fully understand. We may mistake a spiritual connection to Country for delusion, or mislabel the rational sequelae of intergenerational trauma and Adverse Childhood Experiences (ACEs) as a personality disorder (Sara & Lappin, 2017).

The RANZCP Position Statement on Aboriginal and Torres Strait Islander mental health teaches that "psychiatrists need to be aware of the impact of history, culture and racism" (RANZCP, 2020). We must align our gaze with the concept of Social and Emotional Wellbeing

(SEWB), which recognises that health is not just the absence of disease, but the connection to land, kin, and ancestry (Gee et al. 2014, p. 55).

Similarly, for the asylum seekers I have met, the trauma of displacement acts as a "massive group trauma" (RANZCP, 2021). In acting as a healer, we must listen to the stories of land, of displacement, and of loss that exist beneath the presenting symptoms.

The Restoration: The Student as Witness

If the patient is the canvas and the diagnosis is the frame, what is the role are we stepping into? The system pressures us to be industrial technicians, tasked with rapid turnover in a landscape of "grossly overburdened" resources (Hayter et al., 2024). The Medicare Benefits Schedule (MBS) incentivises the quick procedure over the long conversation (MBS Review Taskforce, 2020). But the psychiatrists I admire, the ones who truly heal, operate like master art conservators.

A conservator does not destroy the painting to remove the damage. They do not scrape the canvas raw to eliminate the cracks. They work painstakingly to stabilise the structure, to clean away the grime of neglect, and to integrate the damage into the image (Frank, 2005). They acknowledge that the painting has been changed, and work to preserve the original composition whilst honouring its history.

Even as a student, I'm learning that this work asks for advocacy - protecting time for care and empathy in a system that often rushes people. It necessitates a shift from a paternalistic 'illness model' to a collaborative 'wellness model' (Leamy et al., 2011), where the patient is the lead artist of their own restoration. As emphasised by the World Health Organisation's Quality Rights initiative, we must move away from coercion and toward supported decision-making (WHO, 2019). This means learning to also work in partnership with families and carers, who may hold the memory of a patient's 'original lines' when the patient themselves is no longer able to do so.

Conclusion: The Gallery of the Human Spirit

The diagnosis is an essential tool - it provides the scaffolding for our work, the billing code for the hospital, and the language for pharmacology. But I have learned, through Arthur and others, that it is not the sum of the person. To see the whole person is to look for the pentimenti - the traces of the cellist beneath the silence, the history of the land beneath the trauma.

As I look toward my future in this field, I aspire to be a clinician who has the patience to sit with the canvas, waiting for the light to catch the oil just right, until the ghost of the original self shines through. Only then, when we have seen the masterpiece beneath the overwrite, can the true work of healing begin.

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