The pitfalls of universalism in child and adolescent psychiatry

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In this issue of the *Journal*, as every month, you will find fascinating pieces of research done on samples of young people coming from clinical departments or from the general population. These samples can belong to very different cultural settings. This month, one paper was based on an international recruitment scheme (European more precisely). Two studies each recruited subjects in Germany, Great Britain, Italy, and one each in Canada, Finland, The Netherlands, China and in an unknown location. In parallel, the readership of *European Child and Adolescent Psychiatry* (ECAP) stems from the whole planet. To what extent are the results presented in these papers transferable to your own cultural background? Most often, authors consider implicitly that their results are potentially universal, but what are the origins of such a postulate and to what extent is it acceptable?

The history of science and medicine obviously leads us to accept the universal nature of diseases and patients. The success of occidental medicine came with the progressive rise of anatomy, microscopy, and physiology. More generally, biology is the cornerstone of modern medicine. But biology like physics has been built on the basis of a postulate of universality: we are all made of the same atoms of carbons, of the same molecules of water; all human beings have DNA within their cells, we have all a heart in our chest and a brain in our skull. We are all the same.

Evidence-based medicine (EBM) follows the same line. Statistics are at the basis of EBM, so that EBM leads sometimes physicians to consider the patient they face as a clone of the average patient for which conclusions are drawn in randomized controlled trials. If all patients are a clone of an average patient, then all patients are identical.

The industrial origin of medications plays also a role. 20 mg of fluoxetine is always the same whatever the country and the local culture (except that fake pills do exist and are

not so rare, unfortunately). People are thus used to consider that treatments, in general, are perfectly reproducible and there is even, sometimes, the temptation to consider psychiatrists themselves as industrial products that are identical and perfectly reproducible.

Modernity took also its part in the promotion of universality. There has been indeed a *Universal Declaration of Human Rights* adopted by the UN in 1948. In this declaration, it is said that “Men are born and remain free and equal in rights”. These words are beautiful, of course, but if all humans are equal then, in a way, they are all identical. There is a universality of the human condition and this universality tends to make us think that human nature is universal too.

People could argue that, on the contrary, at the moment, our societies are promoting differences much more than universalism. Indeed, it appears important nowadays to underline that we all have a gender, a race, sometimes a spirituality or a neuro-specificity. Belonging to such groups seems to be an essential part of our identity. This is true, but the exact opposite interpretation can be considered. Recently, the bank HSBC used the slogan “Difference. The only thing we have in common”. If differences between people become so blatant, then there are no more groups, no more communities: we are all similar except for what makes us unique. In other words, paradoxically, individualism is a universalism.

But now, what about clinical reality? Is not there some kind of universalism in psychiatric practice? Not so often. Consider the efficacy of treatments, even for evidence-based ones, they sometimes work and some other times not. This is, unfortunately, one of medicine’s greatest curses: we never know in advance if what we propose to our patients will treat their problems or not [1]. Of course, DSM disorders are now used worldwide and indeed these disorders seem to be relevant in many different cultural contexts. But, on the other hand, some psychiatric disorders exist only in some very particular cultural contexts: this is the case for koro, a sort of delusional disorder in which an individual has the belief that one’s sex organs are retracting and will disappear. Koro affects mainly people from the Chinese community.

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In child and adolescent psychiatry, physicians do know that there are clusters of importance: being an infant, a child, an adolescent, a girl, a boy. Religions and other cultural specificities can also be important risk or protective factors. Moreover, universality becomes difficult to envisage when we consider the complex pattern of interactions that exists within a family. It is very challenging to define what could be a “universal family” and families are at the center of psychiatric care.

In conclusion, we have to realize that science is not neutral about universalism and societies are not either. Science and societies use universalism for epistemological or political reasons. This is not necessarily a problem; we have just to be aware of it because there is a temptation to consider clinical situations as being universal, which would make obviously life easier for all of us. In these times where migrations become more and more common [2, 3], there is a need for clinicians to be aware of the main cultural specificities of their patients and their patient’s families. Because therapeutic alliance is an essential determinant of good clinical outcomes, we have to struggle every day with some kind of a paradoxical injunction: to base our decision on a universal scientific knowledge and to explain it to patients and their caregivers, while at the same time being able to accept

their personal beliefs that can be very different from ours and from what science says about the world we live in. We have also to struggle with the epistemological tensions that exist between what is universal (molecules), statistical (efficacy), common (culture) and singular (life trajectory), and this is true for our clinic, research, and teaching.

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