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Close

Controversial Therapies: Why Do Some Unproven Therapies Become Popular?

To be **controversial** a therapy must have something about it that attracts supporters. I have tried over the years to identify those ingredients that permit some ideas to have a significant number of believers in spite of limited research-based evidence of being meaningful and effective.

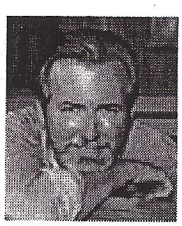
1. **Intuitively appealing**. "Our preference for intuitively appealing explanations of any complex phenomenon might lead them to appear to be simpler and hence, intuitively appealing . . ." (Michel, G.F.) In other words, we are attracted by simple answers to hard questions.
2. **Anecdotal record of success**. Success is anecdotal (personal success stories) and not research based. There are many influences that must be recognized before you can attribute a particular outcome to a specific cause. For instance, parents and the child become vested in being rewarded for their effort or expenditure (you get what you pay for). I call one variation of this phenomenon "private school syndrome." The private school may even offer inferior services and opportunities as compared to the public school, however, since the parent had to pay or fight for it, it is assumed to be better. This "ownership" promotes the perception of value and effectiveness. The "placebo effect" of sugar pills, and the "Hawthorne effect" (the tendency to work harder when experiencing a sense of participation in something new or special) are common examples of variables that influence outcomes unrelated to the therapy that seeks to take the credit.
3. **Guru factor**. The proponent of the therapy is knowledgeable, charismatic, and knows your child. He or she offers to assume the parent's burden, clear up the parent's confusion, and assure the parents that they will never have to look back and experience guilt for what could have been.
4. **No unexplained failures**. The failure of the therapy to achieve expected outcomes is often explained in terms of:
   A. The parent misunderstanding the goal of the therapy,
   B. The therapy providing the groundwork for future (not immediate) growth,
   C. The parent not believing or following through sufficiently for the program to be successful, or
   D. The **child** being lazy and unmotivated.

   In other words, failure is attributed to influences external to the therapy itself.
5. **The lack of research-based support is due to professional jealousy**. The therapy is said to be so good it threatens a profession, entrenched ideas and theories, and challenges the life's work of many respected leaders in the field. The proponents of the therapy claim to "think out of the box" and since they "challenge the status quo" they are rejected by a mainstream that is shackled by old ideas and rigid paradigms. Anyone who stands alone claiming to be better than the group should have a Surgeon General's warning taped to his back.

6. **All forward progress is related to the therapy.** Maturization, exposure to other educational opportunities, the suggestive effect of a placebo and the Hawthorne effect are all variables that often result in significant progress unrelated to the therapy.

Most of the foregoing comments can be explained in terms of well meaning and charismatic individuals or ideas that fall victim to the **self-serving bias** inherent in human nature. **Self-serving bias** is perhaps the most powerful and certainly the most researched of all attributional biases. **Self-serving bias** is the tendency of people to attribute successes to internal personal strengths and abilities and failures to external factors beyond their control.

There is also the need and vulnerability of the parent to consider. When the search for answers becomes desperate, the possible becomes plausible, and the plausible becomes credible. After 15 minutes of discussion the experienced clinician can often describe characteristics about a child that the parent has not even disclosed. The parent often sits back in awe of the accuracy of the picture that the clinician has drawn and says, "You know my child." The assumption, the hope, and the need is for the clinician to also know what to do to help the child. Unfortunately, the answers are often conclusions based on the unique personal experience of the clinician rather than a reflection of a research-based consensus of opinion across disciplines. For instance, in an attempt to find help for a child a difficult child with no friends, parents would probably relate equally well to the concept of "Hyperlexia," "Right Hemisphere Dysfunction," "Semantic Pragmatically Learning Disability," "Nonverbal Right Hemisphere Learning Disability," "Social Communications Spectrum Disorder," "Social Perception Disability," "Nonverbal Perceptual Organization Output Disability," "Left Hemi Syndrome," "Right Parietal Lobe Classification," "Nonverbal Social Learning Difficulties," or "Social Emotional Learning Disability." Dr. Crook, who wrote *Solving the Puzzle of Your Hard to Raise Child,* blames pollution, antibiotics, and yeast! A parent with such a child may even resonate to the concept of Asperger Syndrome or early onset Bipolar Disorder. The point is that any one of these labels has the potential of initially garnering the support and commitment of a caring and desperate parent. It is important to become an educated consumer of information that appears logical and charismatic. Just because someone recognizes your child it doesn't mean that he knows your child. In other words, just because someone knows the question, it doesn't mean that he knows the answer.



About the Contributors

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Other Resources

Websites

National Resource Center on AD/HD
Complementary and Alternative Medicine [for AD/HD]
http://www.help4adhd.org/en/treatment/complementary/WWK6