INVITED GUEST EDITOR

BEYOND FACT-CHECKING: BUILDING TRUST WITH FAMILIES IN AN ERA OF HEALTH MISINFORMATION

Developmental and behavioral pediatricians across South Asia are increasingly encountering a challenge that extends beyond diagnosis and treatment: health misinformation and disinformation. Whether discussing autism, ADHD, intellectual disability, learning disorders, medications, therapies, vaccines, or educational supports, clinicians are often faced with families whose understanding has been shaped by social media, messaging apps, online influencers, and commercially motivated sources.

Across the region, information now travels rapidly through WhatsApp groups, Facebook communities, YouTube channels, and family networks. While these platforms can facilitate support and knowledge-sharing, they can also amplify misleading claims. Families may encounter promises of autism "cures," warnings about evidence-based medications, or testimonials promoting expensive and unproven interventions. Such messages often spread faster and farther than nuanced scientific information.

It is tempting to view misinformation as a problem of ignorance or poor judgment. Yet doing so risks overlooking a more important question: Why are some families particularly vulnerable to misinformation in the first place?

Families caring for children with developmental differences often face uncertainty, stigma, long wait times, fragmented services, and limited access to trusted information. Many are searching for answers during periods of fear, grief, or confusion. In such circumstances, misinformation frequently provides something that evidence-based medicine cannot always offer immediately: certainty, hope, simple explanations, and promises of rapid improvement.

Several factors may increase vulnerability to misinformation. These include low health literacy, language barriers, limited access to specialist care, financial hardship, distrust of institutions, previous negative healthcare experiences, social isolation, and cultural beliefs about disability and child development. In many South Asian settings, where developmental services remain unevenly distributed, families may rely heavily on informal networks to fill information gaps. Understanding these vulnerabilities is essential because misinformation is often not the root problem—it is a symptom of unmet informational and emotional needs.

For clinicians, this requires a shift from blame to curiosity.

Recently, I met a family of a child with ADHD who had initially agreed to consider medication. At follow-up, the parents arrived deeply concerned after viewing multiple social media videos claiming that stimulant medications cause permanent brain damage and addiction. Rather than beginning with correction, we explored their fears and discussed where the information had come from. Their primary concern was not medication itself—it was the possibility of harming their child. Once that fear was acknowledged and addressed respectfully, they became more receptive to discussing the evidence. The encounter served as a reminder that most misinformation is rooted in understandable parental concerns.

When a parent reports that autism can be cured through supplements or expresses fears about developmental therapies or medications, direct confrontation may strengthen existing beliefs and damage therapeutic relationships. A more effective approach begins with understanding.

Instead of asking, "Why would you believe that?" consider asking, "Can you tell me more about what you heard?" or "What concerns you most about the treatment we're discussing?" Such questions communicate respect and create space for dialogue. Families are more likely to reconsider inaccurate information when they feel heard rather than judged.

Several practical communication strategies can help:

1. Ask before telling. Explore what families have heard and where the information originated.
2. Validate emotions. Fear, uncertainty, and hope often drive misinformation uptake more than a lack of knowledge.
3. Focus on the underlying concern. Address the worry behind the belief rather than simply correcting the claim.
4. Lead with the truth. Spend more time discussing what we know than what we do not know. Rather than repeatedly restating inaccurate claims, focus on clear, evidence-based messages that families can remember and act upon.
5. Use clear, plain language. Simple explanations and concrete examples are often more effective than lengthy scientific discussions.
6. Recommend trusted resources. Provide culturally relevant and language-appropriate sources before families return to online searches.

Another useful technique is the "truth sandwich": begin with accurate information, briefly acknowledge the misinformation, and then return to the evidence-based message. In practice, clinicians should spend far more time discussing the truth than the myth. For example, rather than spending several minutes explaining why an autism "cure" advertised online does not work, it may be more effective to briefly acknowledge the claim and then focus on what evidence tells us about autism, child development, and interventions that can meaningfully support children and families. This approach helps prevent misinformation from becoming the dominant focus of the conversation and leaves families with accurate information that is easier to remember.

Perhaps most importantly, recognize that trust is often more influential than evidence alone. Families are rarely persuaded by a single conversation. Instead, trust develops through repeated interactions characterized by empathy, transparency, and respect. In developmental pediatrics, where longitudinal relationships are central to care, every encounter represents an opportunity to strengthen that trust.

Misinformation and disinformation are unlikely to disappear. Indeed, advances in artificial intelligence and digital communication may make distinguishing credible information increasingly difficult. However, the solution is not simply to provide more facts. It is to build stronger relationships.

As developmental and behavioral pediatricians, our role extends beyond diagnosing developmental conditions and recommending interventions. We are also interpreters of information, guides through uncertainty, and trusted partners for families navigating complex decisions. By understanding the factors that make families vulnerable to misinformation and responding with curiosity rather than judgment, we can transform potentially adversarial encounters into opportunities for education, partnership, and trust.

In the end, the most effective antidote to misinformation may not be better information alone—it may be a stronger therapeutic relationship.

Best Regards

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