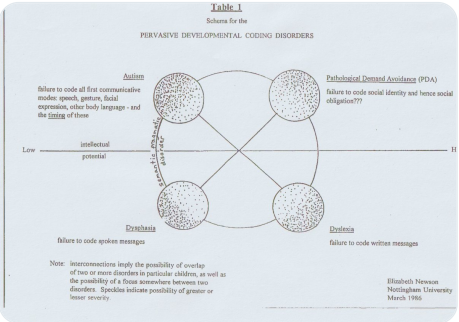
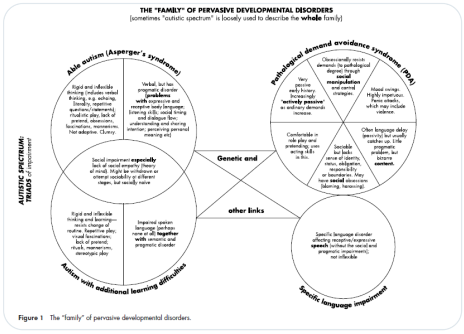
Richard Woods @Richard_Autism
28 Jul 20 • 28 tweets • Richard_Autism/status/1288194679150907392

I have been reflecting on the 2 main family diagrams for PDA, one from 1986 & second from 2003, thinking about how I currently conceptualise PDA and its relation to autism.

First off there are the 2 main diagrams of PDA.
1986 is "Pervasive Developmental Coding Disorders".
2003 is "The Family of Pervasive Developmental Disorders".
I cover issues with these elsewhere:
https://rationaldemandavoidancecom.files.wordpress.com/2020/07/06-july-2020-analysing-historical-nature-of-pda.pdf

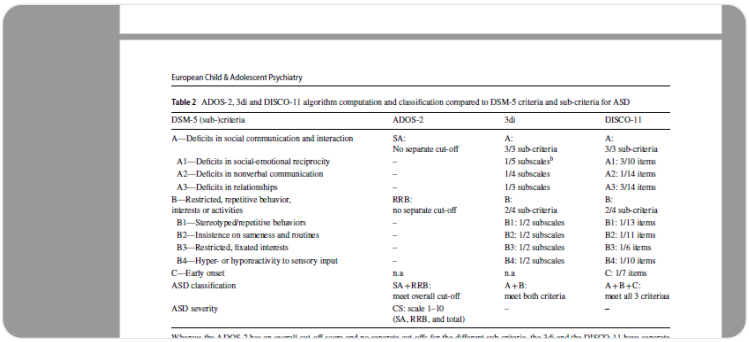




So I need to establish that I using the DSM-5 criteria brief descriptions as noted in Evers et al (2020, p5).

How well are DSM-5 diagnostic criteria for ASD represented in standar…
Five years after the publication of DSM-5 in 2013, three widely used diagnostic instruments have published algorithms designed to represent its (sub-)crite

https://link.springer.com/article/10.1007/s00787-020-01481-z



European Child & Adolescent Psychiatry

Table 2 ADOS-2, 3di and DISCO-11 algorithm computation and classification compared to DSM-5 criteria and sub-criteria for ASD

DSM-5 (sub-)criteria	ADOS-2	3di	DISCO-11
A—Deficits in social communication and interaction	SA: No separate cut-off	A: 3/3 sub-criteria	A: 3/3 sub-criteria
A1—Deficits in social-emotional reciprocity	–	1/5 subscales[b]	A1: 3/10 items
A2—Deficits in nonverbal communication	–	1/4 subscales	A2: 1/14 items
A3—Deficits in relationships	–	1/3 subscales	A3: 3/14 items
B—Restricted, repetitive behavior, interests or activities	RRB: no separate cut-off	B: 2/4 sub-criteria	B: 2/4 sub-criteria
B1—Stereotyped/repetitive behaviors	–	B1: 1/2 subscales	B1: 1/13 items
B2—Insistence on sameness and routines	–	B2: 1/2 subscales	B2: 1/11 items
B3—Restricted, fixated interests	–	B3: 1/2 subscales	B3: 1/6 items
B4—Hyper- or hyporeactivity to sensory input	–	B4: 1/2 subscales	B4: 1/10 items
C—Early onset	n.a	n.a	C: 1/7 items
ASD classification	SA + RRB: meet overall cut-off	A + B: meet both criteria	A + B + C: meet all 3 criterias
ASD severity	CS: scale 1–10 (SA, RRB, and total)	–	–

I am using the aggregated profile:
https://www.researchgate.net/publication/337146735_Demand_avoidance_phenomena_circularity_integrity_and_validity_-_a_commentary_on_the_2018_National_Autistic_Society_PDA_Conference
mainly using wording from Newson et al (2003, p597).

Pathological demand avoidance syndrome: a necessary distinction wit…
A proposal is made to recognise pathological demand avoidance syndrome (PDA) as a separate entity within the pervasive developmental disorders, instead of being classed under "pervasive developmental…

http://adc.bmj.com/content/88/7/595

Criteria A - Surface Sociability:
A1) Deficits of sense of social identity, pride, or shame.

Criteria B – Anxiety based restricted and repetitive behaviours and interests (RRBIs):
B1) Comfortable in role play and pretending.
B2) Continues to resist and avoid ordinary demands of life.

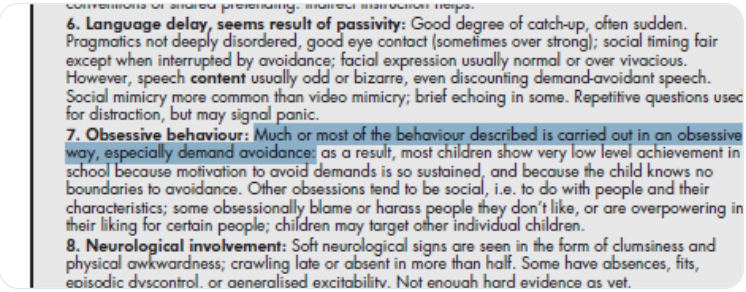
B3) Lability of mood, impulsive, led by need to control.
B4) Obsessive behaviour.
B5) Strategies of avoidance are essentially socially manipulative.

Criteria C – Neurodevelopmental (optional traits):
C1) Language delay, seems result of passivity.
C2) Neurological Involvement.
C3) Passive early history in first year.
C4) Sensory Differences.

This is how I tend to structure PDA diagnostic criteria. I use Newson's wording where possible as I think her clinical descriptions are the least biased ones we have. I think

that most people would accept her ontology for PDA is largely accurate.

Newson in her 2003 article states that most behaviours are obsessive in nature (RRBI). I have placed the comfortable in roll play and pretend in RRBI as it seems linked to disassociation, which is a trauma/ distress response.

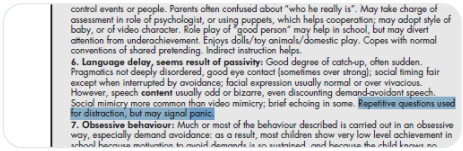


6. Language delay, seems result of passivity: Good degree of catch-up, often sudden. Pragmatics not deeply disordered, good eye contact (sometimes over strong); social timing fair except when interrupted by avoidance; facial expression usually normal or over vivacious. However, speech **content** usually odd or bizarre, even discounting demand-avoidant speech. Social mimicry more common than video mimicry; brief echoing in some. Repetitive questions usec for distraction, but may signal panic.

7. Obsessive behaviour: Much or most of the behaviour described is carried out in an obsessive way, especially demand avoidance: as a result, most children show very low level achievement in school because motivation to avoid demands is so sustained, and because the child knows no boundaries to avoidance. Other obsessions tend to be social, i.e. to do with people and their characteristics; some obsessionally blame or harass people they don't like, or are overpowering in their liking for certain people; children may target other individual children.

8. Neurological involvement: Soft neurological signs are seen in the form of clumsiness and physical awkwardness; crawling late or absent in more than half. Some have absences, fits, episodic dyscontrol, or generalised excitability. Not enough hard evidence as yet.

Newson says that some behaviours are linked to panic or should be viewed as originating from panic. This aspect is supported by research and clinical opinion on high anxiety underpinning most of PDA behaviours.



control events or people. Parents often confused about "who he really is". May take charge of assessment in role of psychologist, or using puppets, which helps cooperation; may adopt style of baby, or of video character. Role play of "good person" may help in school, but may divert attention from underachievement. Enjoys dolls/toy animals/domestic play. Copes with normal conventions of shared pretending. Indirect instruction helps.

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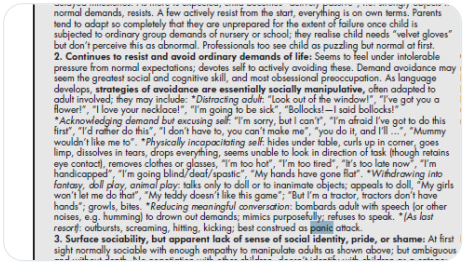


normal demands, resists. A few actively resist from the start, everything is on own terms. Parents tend to adapt so completely that they are unprepared for the extent of failure once child is subjected to ordinary group demands of nursery or school; they realise child needs "velvet gloves" but don't perceive this as abnormal. Professionals too see child as puzzling but normal at first.

2. Continues to resist and avoid ordinary demands of life: Seems to feel under intolerable pressure from normal expectations; devotes self to actively avoiding these. Demand avoidance may seem the greatest social and cognitive skill, and most obsessional preoccupation. As language develops, **strategies of avoidance are essentially socially manipulative,** often adapted to adult involved; they may include: **Distracting adult*: "Look out of the window!", "I've got you a flower!", "I love your necklace!", "I'm going to be sick", "Bollocks!—I said bollocks!" **Acknowledging demand but excusing self*: "I'm sorry, but I can't", "I'm afraid I've got to do this first", "I'd rather do this", "I don't have to, you can't make me", "you do it, and I'll …", "Mummy wouldn't like me to". **Physically incapacitating self*: hides under table, curls up in corner, goes limp, dissolves in tears, drops everything, seems unable to look in direction of task (though retains eye contact), removes clothes or glasses, "I'm too hot", "I'm too tired", "It's too late now", "I'm handicapped", "I'm going blind/deaf/spastic", "My hands have gone flat". **Withdrawing into fantasy, doll play, animal play*: talks only to doll or to inanimate objects; appeals to doll, "My girls won't let me do that", "My teddy doesn't like this game"; "But I'm a tractor, tractors don't have hands"; growls, bites. **Reducing meaningful conversation*: bombards adult with speech (or other noises, e.g. humming) to drown out demands; mimics purposefully; refuses to speak. **As last resort*: outbursts, screaming, hitting, kicking; best construed as panic attack.

3. Surface sociability, but apparent lack of sense of social identity, pride, or shame: At first sight normally sociable with enough empathy to manipulate adults as shown above; but ambiguous

A few diagnostic traits can be viewed as neurodevelopmental in nature. The neurodevelopmental criteria are optional as they are not required for a PDA diagnosis if one follow's NAS's criteria.

Pathological Demand Avoidance: symptoms but not a syndrome

Pathological (or extreme) demand avoidance is a term sometimes applied to complex behaviours in children within—or beyond—autism spectrum disorder. The use of pathological demand avoidance as a diagn…

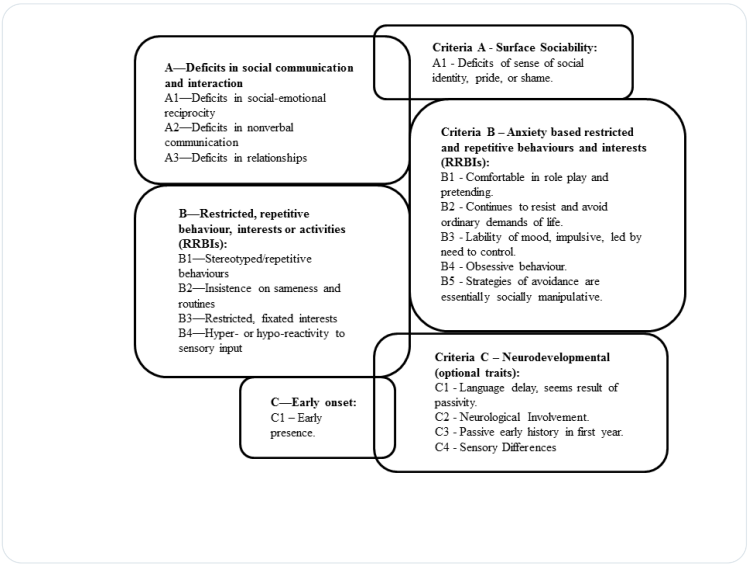
https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(18)30044-0/fulltext

Panel 2: Features of pathological demand avoidance, according to the National Autistic Society, in 2017[5]

- Resists and avoids the ordinary demands of life
- Uses social strategies as part of avoidance, eg, distracting, giving excuses
- Appears sociable, but lacks understanding
- Experiences excessive mood swings and impulsivity
- Appears comfortable in role play and pretence
- Displays obsessive behaviour that is often focused on other people

I think PDA is best explained by being a new type of disorder, Newson's "Pervasive Developmental Coding Disorder"
https://rationaldemandavoidancecom.files.wordpress.com/2020/07/18-july-2020-pda-is-a-pervasive-developmental-coding-disorder-thread.pdf

So what I get is something looking like this. It can be changed for ease of "diagnostic argument". Other's might wish to re-arrange certain diagnostic traits. I think it is an accurate reflection of the literature.



I have drawn PDA largely separately from autism. There are 3 areas of overlap. I will explain why I have done this.

First overlap is for communication issues. PDA is meant to not have Theory of Mind deficits & its social communication issues are from a difference source. Yet 20% autistic persons pass false belief tests.
https://www.aettraininghubs.org.uk/wp-content/uploads/2012/08/1_So-what-exactly-is-autism.pdf

competency framework

Department for Education

2.1 Cognition – an impaired theory of mind?

One of the most enduring psychological theories concerning autism has been the assertion that the key universal core 'deficit' found in autistic spectrum conditions is an impaired 'theory of mind' (Baron-Cohen et al. 1985). 'Theory of Mind' refers to the ability to empathise with others and imagine their thoughts and feelings, in order to comprehend and predict the behaviour of others (also called 'mind-reading' and 'mentalising'). Baron-Cohen et al. (1985) found that 80% of autistic children between the ages of 6-16 failed at false belief tasks. These findings were also repeated in subsequent studies using people rather than dolls, such as in the 'Sally-Ann' test (Leslie and Frith, 1988).

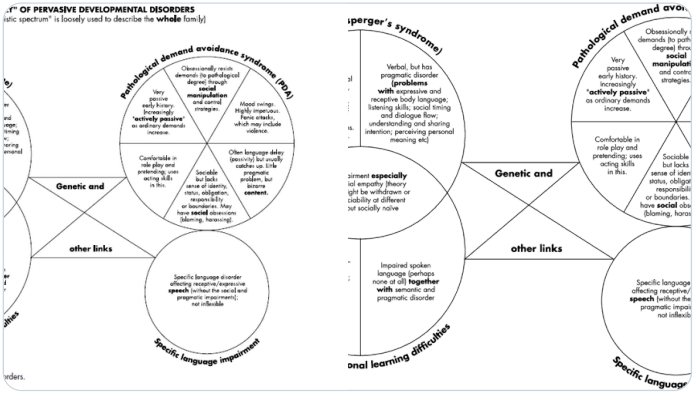
False Belief Task (Kerstin and Martin go for a picnic)

(Illustration based on Sally and Anne False Belief Task in Frith, U., 1989, Autism: Explaining the Enigma)

Richard Woods
@Richard_Autism

Replying to @Richard_Autism @cassie_davies and 2 others

... The surface communication issues for PDA are different to autism, surface sociability and not linked to ToM:
adc.bmj.com/content/88/7/5…
&
discovery.ucl.ac.uk/id/eprint/1005…
&
autismeastmidlands.org.uk/wp-content/upl…



7:02 AM · Jul 26, 2020

See Richard Woods's other Tweets

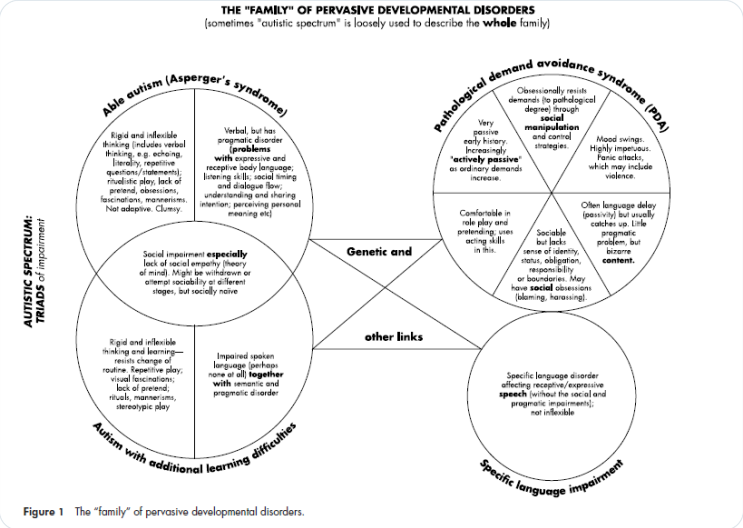
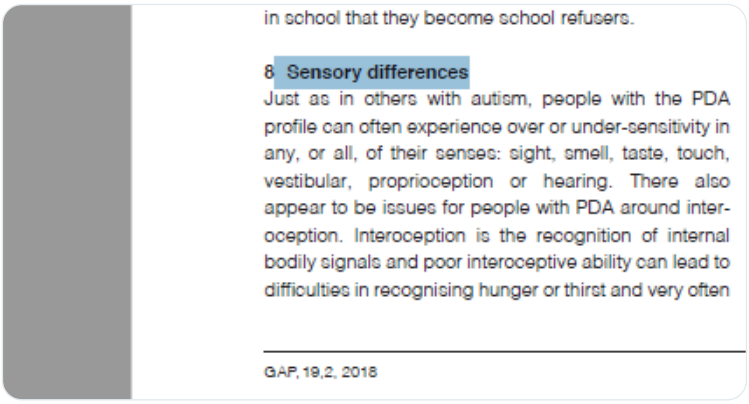


Figure 1 The "family" of pervasive developmental disorders.

The second area of overlap is for sensory differences. Eaton et al (2018) gave PDA "Sensory Differences":
https://www.ingentaconnect.com/contentone/bild/gap/2018/00000019/00000002/art00003
Most people know that DSM-5 gave autism sensory differences as an RRBI.

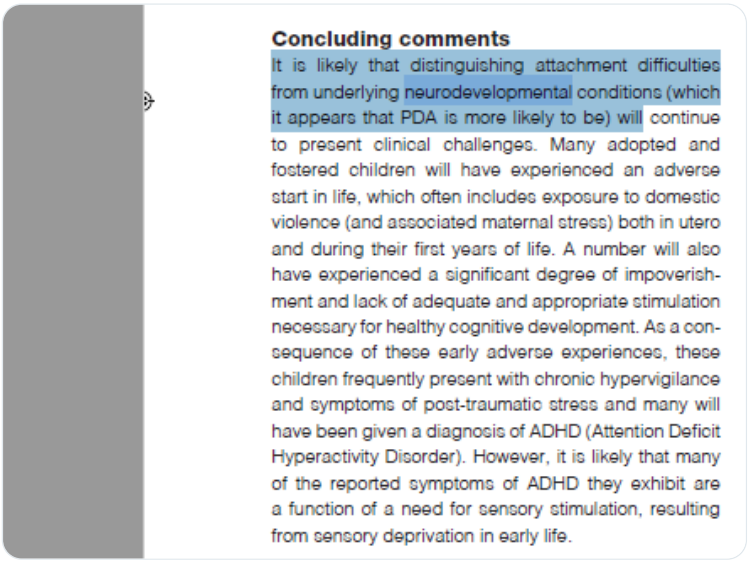

in school that they become school refusers.

8 Sensory differences

Just as in others with autism, people with the PDA profile can often experience over or under-sensitivity in any, or all, of their senses: sight, smell, taste, touch, vestibular, proprioception or hearing. There also appear to be issues for people with PDA around interoception. Interoception is the recognition of internal bodily signals and poor interoceptive ability can lead to difficulties in recognising hunger or thirst and very often

GAP, 19,2, 2018

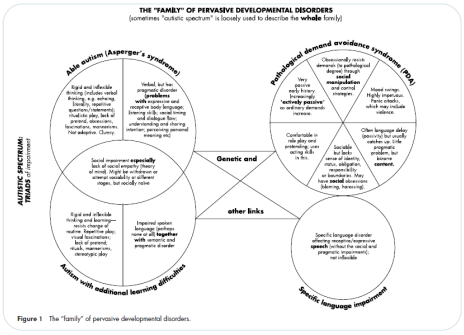
In this PDA criteria I placed Sensory Differences in "Neurodevelopmental" in line with Help4Psychology Research. It is optional as it is not compulsory for a PDA diagnosis.

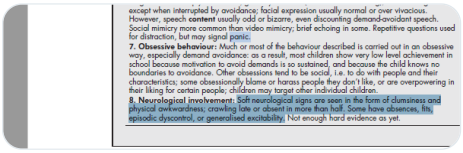

Concluding comments

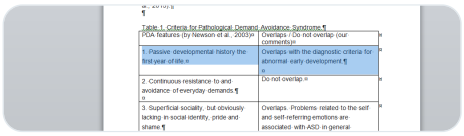
It is likely that distinguishing attachment difficulties from underlying neurodevelopmental conditions (which it appears that PDA is more likely to be) will continue to present clinical challenges. Many adopted and fostered children will have experienced an adverse start in life, which often includes exposure to domestic violence (and associated maternal stress) both in utero and during their first years of life. A number will also have experienced a significant degree of impoverishment and lack of adequate and appropriate stimulation necessary for healthy cognitive development. As a consequence of these early adverse experiences, these children frequently present with chronic hypervigilance and symptoms of post-traumatic stress and many will have been given a diagnosis of ADHD (Attention Deficit Hyperactivity Disorder). However, it is likely that many of the reported symptoms of ADHD they exhibit are a function of a need for sensory stimulation, resulting from sensory deprivation in early life.

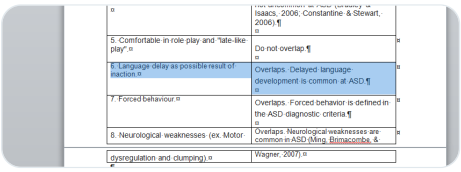
The third & last area of overlap is on the early history aspects of the diagnostic criteria and neurodevelopmental criteria. This is as features of these criteria are not specific to either construct.

Autism has "clumsy" on it and Newson notes clumsy aspect in "Neurological Involvement". Also commented on in Norwegian Systematic review by @OrmStian. Language delay was differential marker between Classic autism & Asperger's Syndrome.

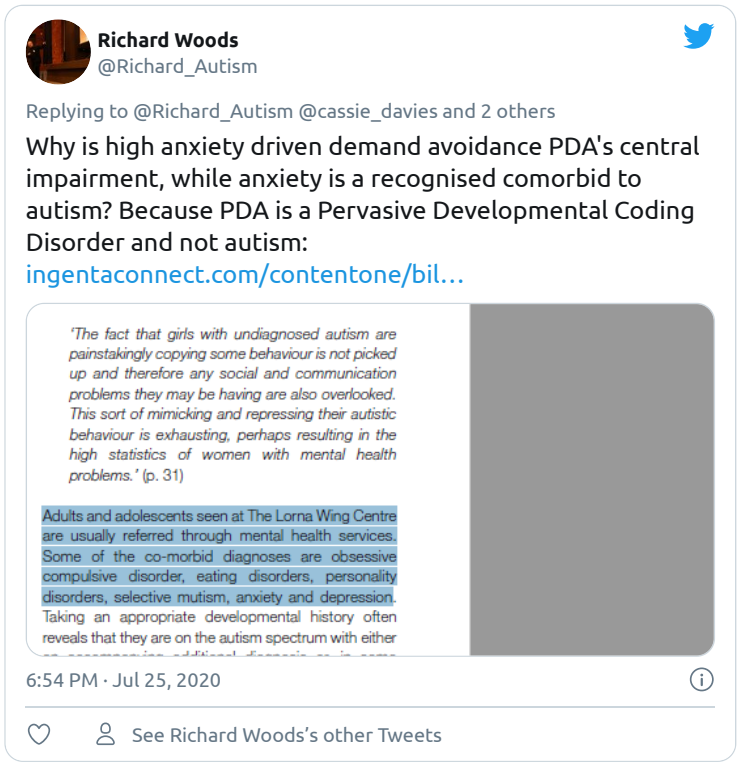








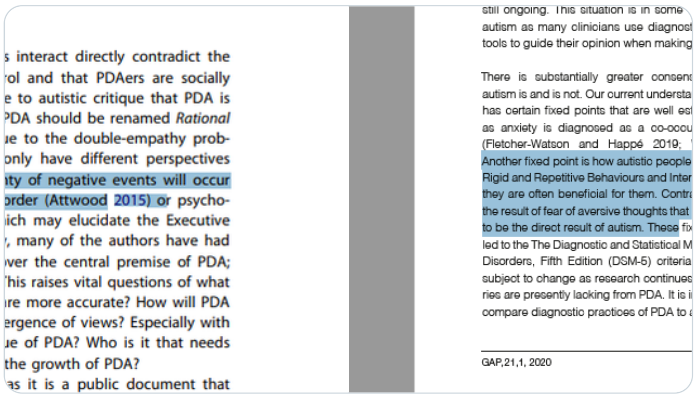
I very deliberately kept the RRBI's separate for autism & PDA. PDA's RRBIs are attributed to anxiety, which is acknowledged to not be an autism comorbid & differential marker to constructs like OCD/ GAD etc.



@Richard_Autism

Replying to @Richard_Autism @cassie_davies and 2 others

A differential marker between autism & other conditions with RRBI's is the source of RRBI. If source is from fear/ anxiety/ aversion it tends to attributed as non-autism in nature:
researchgate.net/publication/33…
&
tandfonline.com/doi/full/10.10…



s interact directly contradict the
ol and that PDAers are socially
e to autistic critique that PDA is
DA should be renamed *Rational*
ue to the double-empathy prob-
only have different perspectives
ity of negative events will occur
order (Attwood 2015) or psycho-
ich may elucidate the Executive
, many of the authors have had
ver the central premise of PDA;
This raises vital questions of what
re more accurate? How will PDA
ergence of views? Especially with
ue of PDA? Who is it that needs
the growth of PDA?
as it is a public document that

still ongoing. This situation is in some
autism as many clinicians use diagnost
tools to guide their opinion when making

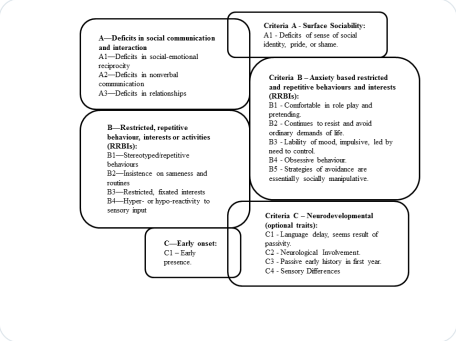
There is substantially greater consens
autism is and is not. Our current understa
has certain fixed points that are well est
as anxiety is diagnosed as a co-occu
(Fletcher-Watson and Happé 2019;
Another fixed point is how autistic people
Rigid and Repetitive Behaviours and Inter
they are often beneficial for them. Contr
the result of fear of aversive thoughts that
to be the direct result of autism. These fix
led to the The Diagnostic and Statistical M
Disorders, Fifth Edition (DSM-5) criteria
subject to change as research continues
ries are presently lacking from PDA. It is i
compare diagnostic practices of PDA to a

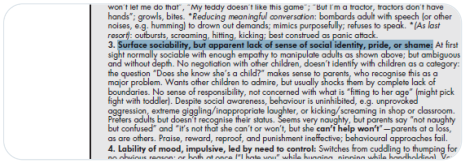
GAP.21,1, 2020

6:36 AM · Jul 26, 2020

See Richard Woods's other Tweets

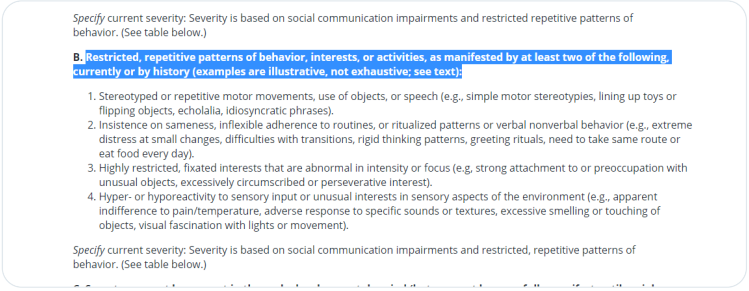
I guess last thing to point out, the wording for A1 for PDA is different in the criteria I list above, the one in the image is accurate & taken from Newson et al 2003 article.





won't let me do that', 'My teddy doesn't like this game'; 'But I'm a tractor, tractors don't have hands'; growls, bites. *Reducing meaningful conversation*: bombards adult with speech (or other noises, e.g. humming) to drown out demands; mimics purposefully; refuses to speak. *(As last resort)*: outbursts, screaming, hitting, kicking; best construed as panic attack.
3. **Surface sociability, but apparent lack of sense of social identity, pride, or shame:** At first sight normally sociable with enough empathy to manipulate adults as shown above; but ambiguous and without depth. No negotiation with other children, doesn't identify with children as a category: the question "Does she know she's a child?" makes sense to parents, who recognise this as a major problem. Wants other children to admire, but usually shocks them by complete lack of boundaries. No sense of responsibility, not concerned with what is "fitting to her age" (might pick fight with toddler). Despite social awareness, behaviour is uninhibited, e.g. unprovoked aggression, extreme giggling/inappropriate laughter, or kicking/screaming in shop or classroom. Prefers adults but doesn't recognise their status. Seems very naughty, but parents say "not naughty but confused" and "it's not that she can't or won't, but she **can't help won't**"—parents at a loss, as are others. Praise, reward, reproof, and punishment ineffective; behavioural approaches fail.
4. Lability of mood, impulsive, led by need to control: Switches from cuddling to thumping for

One should note important clinical differences in this conceptualisation of PDA. For one PDA has less social communication issues than autism (1 vs 3). Has 5 compulsory RRBIs, while autism is minimum of 2 or more.https://www.autismspeaks.org/autism-diagnosis-criteria-dsm-5#:~:text=Restricted%2C%20repetitive%20behaviors&text=Great%20distress%2Fdifficulty%20changing%20focus%20or%20action.&text=Marked%20deficits%20in%20verbal%20and,to%20social%20overtures%20from%20others.



Specify current severity: Severity is based on social communication impairments and restricted repetitive patterns of behavior. (See table below.)

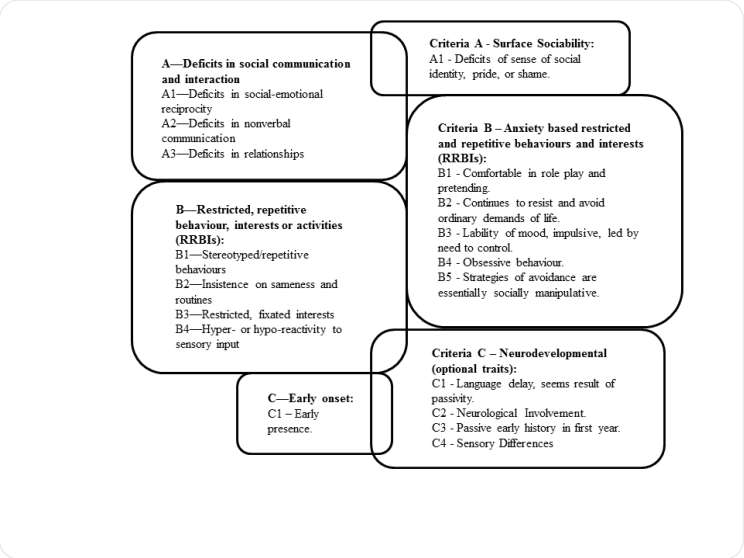
B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

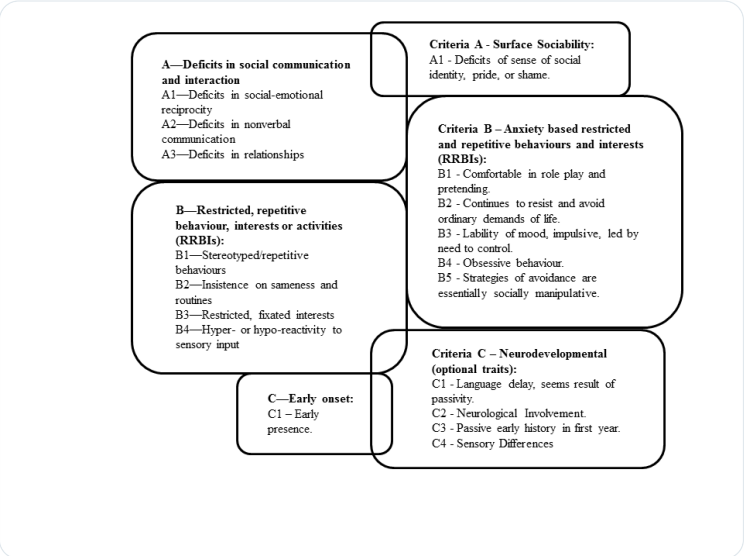
Specify current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior. (See table below.)

I have left out specifiers because: 1) Research should reveal these in good time. 2) I am not a clinician, I do not want to go beyond what I am comfortable suggesting.

Strength of this image is that it contains the PDA diagnostic criteria on it and allows easy comparison to autism. I will probably use it/ variations of it my work going forward.



@PDASociety @DrJudes03 @milton_damian @cassie_davies @autism @Allison66746425 @Jenn__Layton @Shona_Mu @IgHawthorne @FidgetyF_cker @sallycatPDA @MAbsoud @AnnMemmott @Andylowarousal @paullib1972 @HappeLab @GillbergCentre You might be interested in this thread.



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