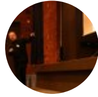
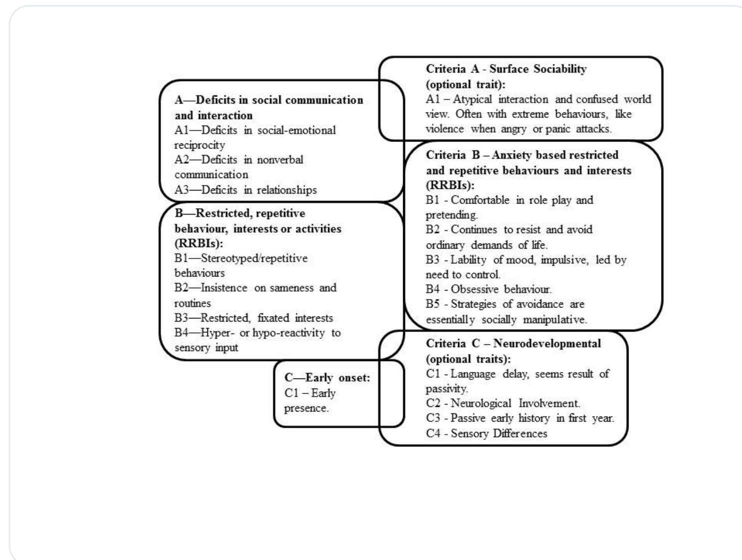


Richard Woods @Richard_Autism

11 Nov • 24 tweets • Richard_Autism/status/1326625277376671745

That moment when you realise, you need to define what you consider to be in all its glory and not.

First one, so this is what I consider PDA traits criteria to be (on the right hand side).



The wording is mainly based on Newson's clinical descriptions, except where Newson's assumptions are wrong. E.g. panic attacks being attributed to Surface Sociability trait.

Main reasons for this, is that if PDA is a common mental disorder, the predicted PDA populations are based off her descriptions which we know to be clinically different to autism & Newson saying PDA is NOT autism.

So logically, I am not saying PDA belongs to any diagnostic grouping, as we do not how PDA fully manifests in all its populations. PDA probably presents differently outside of autism, as most autism co-occurring conditions do.

So, I.e. PDA is not part of the autism spectrum.

If one accepts should be diagnosed, than all persons who its profile are entitled to research, support & diagnosis, irrespective of if they are autistic or not.

Also people can transition into PDA, as this is inline with clinical descriptions of PDA, both Newson and others.

Also inline with modern transactional understandings of PDA, persons should be able to present PDA when sufficiently distressed.

Clinical threshold for a PDA diagnosis. I will accept the one given from Gillberg et al (2015), which is used to make many of predicted PDA populations on. So this is a LOW diagnosis threshold.

"“Classic PDA” was defined as Total PDA score of 5
or more and including the presence of socially manipulative
or shocking behaviour to avoid demands." Gillberg et al (2015, p981). On original PDA DISCO questions.

This is a lower diagnosis threshold than Newson, as she required all her persons with PDA to have socially manipulative demand avoidance, it was not an "OR" to shocking behaviour to avoid demands.

So this means I am throwing out the "Pervasive" and "Developmental" definitions Christie & others use in their PDA interpretations.

I think this is representative of the PDA literature.

That broadly, is my interpretation of PDA.

@threadreaderapp Please can you unroll this in its all splendor?

Thank you in advance.

To clarify, I would move around some PDA features to other PDA traits, so panic attacks should go into the Lability of Mood trait.

@threadreaderapp please can you unroll this one?

I need to point out that it is not a whim discarding "Pervasive" & "Developmental" wordings as underpinning PDA.

For one, there are concerns if PDA is developmentally stable and thus actually is pervasive. We know that PDA has a higer drop-off rate in CYP meeting clinical threshold for a diagnosis compared to autism.
https://acamh.onlinelibrary.wiley.com/doi/abs/10.1111/camh.12368

Richard Woods

Child Adolesc Ment Health 2020; *(*): **–**

a). Characterising the behaviours around DAP
ars to be highly subjective (Woods, 2019b).
her sources of likely bias that undermine the valid-
this research have not been accounted for. These of
are from the studies' participants, DAP carers.
y, DAP carers are a vulnerable group and often
ience high anxiety levels (Woods, 2019a, 2019b);
s not discussed in Stuart et al. (2019). Completing
uestions (Stuart et al., 2019) could lead to question
e among participants. Secondly, the carers com-
d all 4 questionnaires used in Study 1, providing a
non rater bias. Thirdly, it is recognised that the
in interest into DAP since before 2010 can lead to
ns to be 'on the lookout' for features of DAP
ons et al., 2016). This interest is plausibly driven by
l media campaigning by DAP carers. The sample
ourced through the PDA Society, and their partici-
n in this research, one would assume, indicates
support for the construct. It is also reasonable to
ne that the participants are knowledgeable on DAP.
fore, this is a credible source of confirmation bias.
e central message of Stuart et al.'s results is that IU
salient driving factor behind many behaviours in
Specifically, leading to: control behaviours with-
ng into fantasy and role-play; and behaviour char-
sed as meltdowns. I would argue that these results
directly support a different theory around autism,
tropism (for more information see Woods, 2019a),
uggest other mediators of behaviour, with IU and
ty being a final common pathway. Monotropism

for clinical practice. The EDA-Q has 2 thresholds, with the lower one for those aged 12 and above (O'Nions et al, 2014). Wider literature suggests between 44% and 89% of participants do not meet the caseness for DAP into adulthood (Woods, 2019b), and this is significantly higher than found in autism (Iemmi, Knapp, & Ragan, 2017), indicating DAP is not a form of autism. There are attempts to control the numbers of DAPers identified, partly by diagnosing it over a 2-year time period (Summerhill & Collett, 2018). A diagnosis approach over a 2-year time period risks biasing the DAP profile as this is likely to result in the most severe cases being diagnosed, with individuals with 'milder' presentations no-longer meeting the clinical threshold for DAP at an older age. The Stuart et al. (2019) paper tentatively supports the notion that there is little scientific justification for this aspect of the assessment pathway.

Stuart and colleagues' two studies provide a description of a proposed interaction between IU, anxiety and DAP. DAP is not a research priority of the autistic population (Woods, 2017). The clinical need for the DAP construct is contested (Woods, 2019b), and the implications of conducting potentially unnecessary research on a vulnerable group, like DAP carers, should receive higher attention in the research literature and likewise, respecting the wishes of autistic persons. Their results would benefit from replication using research methods that do not inherently reify DAP. If DAP is to be accepted, its diagnostic and screening tools need good quality research to produce comprehensive and valid measurements for DAP.

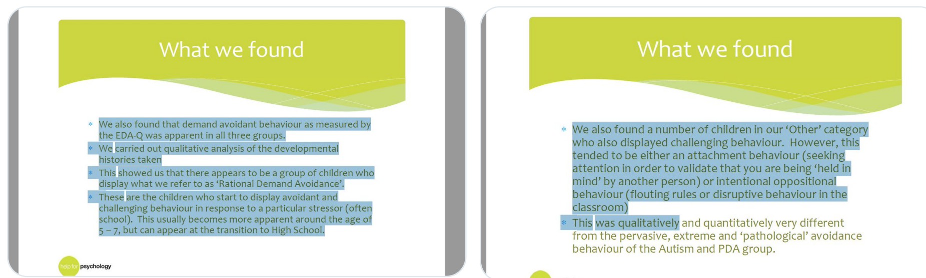
Second point, I have already covered that clinicians, mainly Wing, Newson, Gould &

Gillberg have said people can transition into PDA. I provide where they say this elsewhere.

I would also point out that certain clinical populations probably require persons to display PDA after infancy. Especially as most disorders are diagnosed in teenage years, Off the top of my head the average age of a dx is 14.

Next point is that persons developing into PDA, so it is not necessarily developmental is data from the EDA-Q. The tool is known for detecting PDA outside of autism, so called "false-positives" because the person is not autistic...

If one accepts that PDA is seen outside of autism, then many of these "false positives" are going to correct positive identifications. I also include "Rational Demand Avoidance" group as PDA.
https://network.autism.org.uk/sites/default/files/ckfinder/files/Differential%20diagnosis%20between%20PDA%20and%20attachment%20disorder%20-%20Dr%20Judy%20Eaton.pdf



If one accepts many of these "false positives" are actually PDA, then it no longer is necessarily "Pervasive".

It is scientific to reject outdated assumptions when presented with new information, such as EDA-Q commonly detecting PDA outside of autism.

The important thing about this EDA-Q data, is that the EDA-Q is currently only validated to detect PDA in autistic CYP. It will likely detect PDA more commonly outside of autism when validated on predicted populations.

Which just highlights the absurdity of basing PDA diagnoses on "Pervasive" and "Developmental" descriptors.

@threadreaderapp Please could you unroll this?

Thank you in advance.

• • •