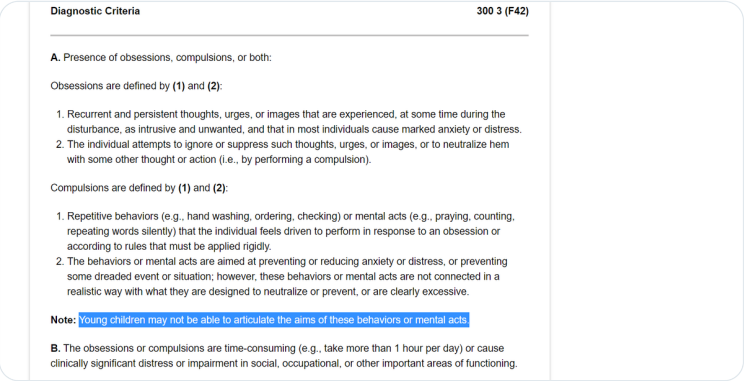
Richard Woods @Richard_Autism

30 Dec • 36 tweets • Richard_Autism/status/1344213719283326976

Oh crikey. Looking briefly at OCD again. Notice this in its DSM criteria:
"Young children may not be able to articulate the aims of these behaviors or mental acts."



Diagnostic Criteria **300 3 (F42)**

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by **(1)** and **(2)**:

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize hem with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by **(1)** and **(2)**:

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

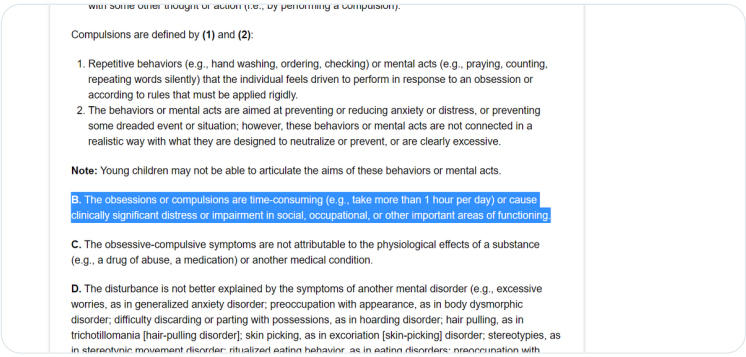
Applying the same logic to PDA debate. If we do not expect non-autistic children to not always be able to understand/ rationalise their behaviours. Why are we expecting autistic CYP to be able to do the same to have a "Rational Demand Avoidance" group?

As I state elsewhere are good reasons to expect many autistic CYP being labelled with "Rational Demand Avoidance" who CAN NOT rationalise their behaviours, their demand avoidance.
https://rationaldemandavoidancecom.files.wordpress.com/2020/08/01-august-2020-cannot-have-rational-demand-avoidance-if-a-person-cannot-rationalise-their-demand-avoidance.pdf

This supports my point that the differences between "Extreme Demand Avoidance" and "Rational Demand Avoidance" are arbitrary.

Going back to OCD DSM criteria:

"B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."



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B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with

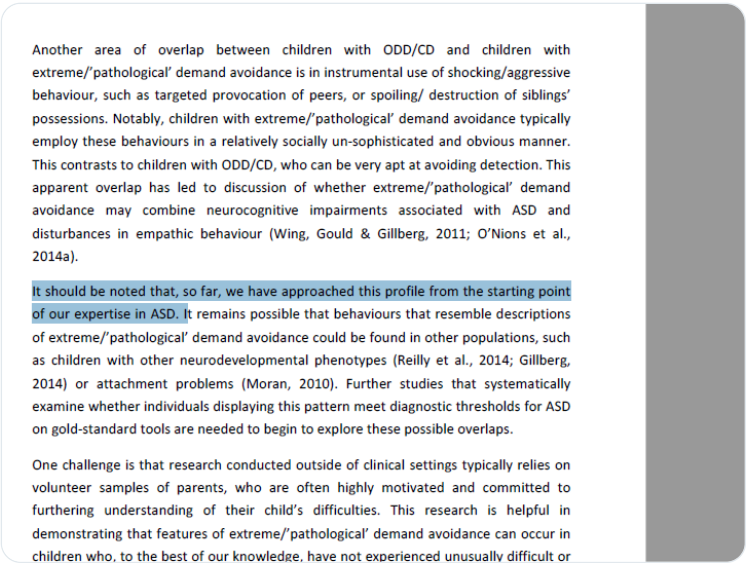
Note the part to causing significant distress or impairment in social, occupational, or other important areas of functioning. If any child is school refusing that would seem to meet definition "important areas of functioning".

Again supporting the view that "Rational Demand Avoidance" by Help4Psychology, is arbitrary definition, if PDA is viewed akin to OCD, the "Rational Demand Avoidance" group, should be getting PDA diagnsoses.

I am increasingly thinking that a lot people's opinions on PDA are shaped by their background and ideological preferences.

I actively acknowledge my views are informed by seeking scientific-method, inclusive research & practice.

I mean we know that O'Nions and others have been approaching PDA from their understanding of autism:
https://discovery.ucl.ac.uk/id/eprint/1493137/7/O'Nions_Debate_article_accepted_typeset.pdf



Another area of overlap between children with ODD/CD and children with extreme/'pathological' demand avoidance is in instrumental use of shocking/aggressive behaviour, such as targeted provocation of peers, or spoiling/ destruction of siblings' possessions. Notably, children with extreme/'pathological' demand avoidance typically employ these behaviours in a relatively socially un-sophisticated and obvious manner. This contrasts to children with ODD/CD, who can be very apt at avoiding detection. This apparent overlap has led to discussion of whether extreme/'pathological' demand avoidance may combine neurocognitive impairments associated with ASD and disturbances in empathic behaviour (Wing, Gould & Gillberg, 2011; O'Nions et al., 2014a).

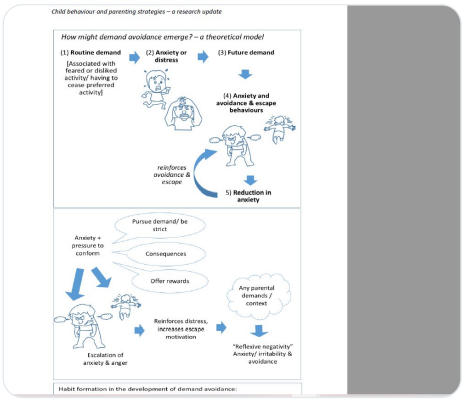
It should be noted that, so far, we have approached this profile from the starting point of our expertise in ASD. It remains possible that behaviours that resemble descriptions of extreme/'pathological' demand avoidance could be found in other populations, such as children with other neurodevelopmental phenotypes (Reilly et al., 2014; Gillberg, 2014) or attachment problems (Moran, 2010). Further studies that systematically examine whether individuals displaying this pattern meet diagnostic thresholds for ASD on gold-standard tools are needed to begin to explore these possible overlaps.

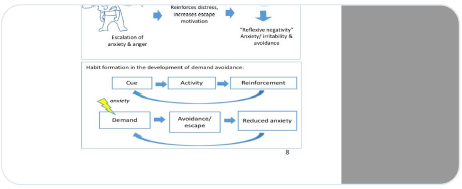
One challenge is that research conducted outside of clinical settings typically relies on volunteer samples of parents, who are often highly motivated and committed to furthering understanding of their child's difficulties. This research is helpful in demonstrating that features of extreme/'pathological' demand avoidance can occur in children who, to the best of our knowledge, have not experienced unusually difficult or

This just raises more questions than answers, as my understanding of autism tells me it is blatantly obvious PDA is not autism. This is point is relevant to the thread.

So O'Nions is proposing a mechanism in PDA for is almost identical to OCD cycle given earlier. More importantly, if one is associating avoidance behaviours to

anxiety/ aversive experience to demands, this different to accepted reasons for RRBIs in autism.

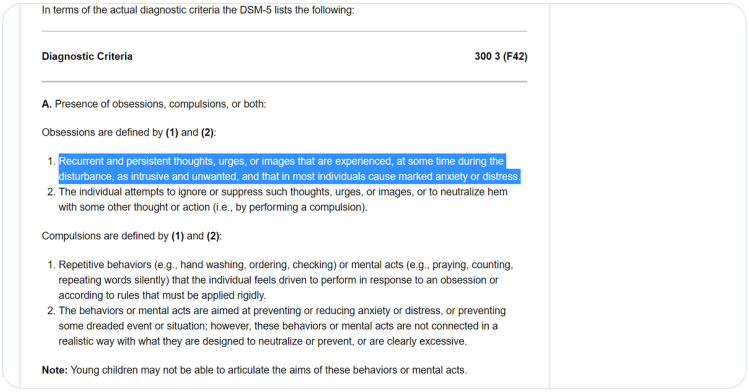




I make often make this point in my demand avoidance behaviours are caused by anxiety, it is not associated to autism, but to comorbids.

Part of OCD category A DSM-5 criteria.
"Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress."

Now I accept would argue there maybe clinical differences between obsessions in PDA & demands. Demands in PDA are often caused from the environment, not necessarily internal.



In terms of the actual diagnostic criteria the DSM-5 lists the following:

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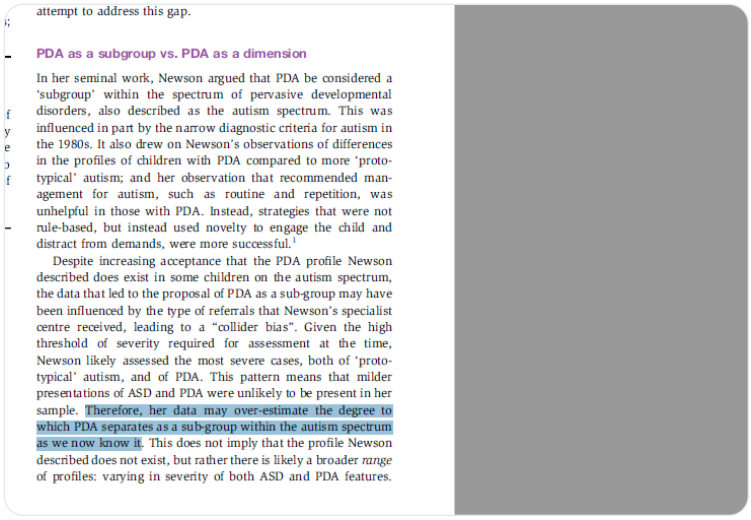
Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

What I am getting to here, effects of the obsession are distressing to the person, mainly causes anxiety in both OCD & PDA. Again both aversive experiences are relieved through a compulsive act, for PDA, avoidance. Avoidance can be a compulsive act for OCD.

I am not impressed with referring to PDA as a subgroup. This is playing the facts, Newson was clear she thought PDA was a syndrome, as it represented a clustering of symptoms.
https://linkinghub.elsevier.com/retrieve/pii/S1751722220301566



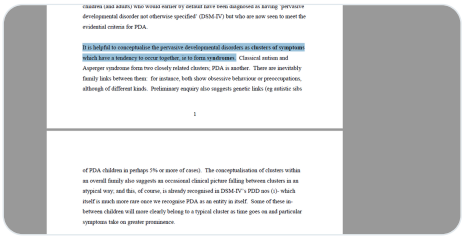
attempt to address this gap.

PDA as a subgroup vs. PDA as a dimension

In her seminal work, Newson argued that PDA be considered a 'subgroup' within the spectrum of pervasive developmental disorders, also described as the autism spectrum. This was influenced in part by the narrow diagnostic criteria for autism in the 1980s. It also drew on Newson's observations of differences in the profiles of children with PDA compared to more 'proto-typical' autism; and her observation that recommended management for autism, such as routine and repetition, was unhelpful in those with PDA. Instead, strategies that were not rule-based, but instead used novelty to engage the child and distract from demands, were more successful.[1]

Despite increasing acceptance that the PDA profile Newson described does exist in some children on the autism spectrum, the data that led to the proposal of PDA as a sub-group may have been influenced by the type of referrals that Newson's specialist centre received, leading to a "collider bias". Given the high threshold of severity required for assessment at the time, Newson likely assessed the most severe cases, both of 'proto-typical' autism, and of PDA. This pattern means that milder presentations of ASD and PDA were unlikely to be present in her sample. Therefore, her data may over-estimate the degree to which PDA separates as a sub-group within the autism spectrum as we now know it. This does not imply that the profile Newson described does not exist, but rather there is likely a broader *range* of profiles: varying in severity of both ASD and PDA features.

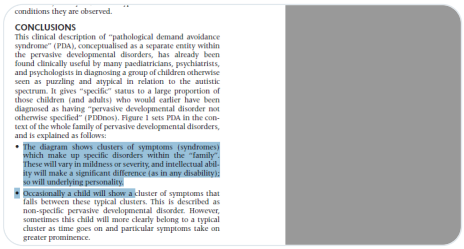
https://adc.bmj.com/content/archdischild/88/7/595.full.pdf?with-ds=yes



developmental disorder not otherwise specified' (DSM-IV) but who are now seen to meet the evidential criteria for PDA.

It is helpful to conceptualise the pervasive developmental disorders as clusters of symptoms which have a tendency to occur together, or to form syndromes. Classical autism and Asperger syndrome form two closely related clusters, PDA is another. There are inevitably family links between them: for instance, both show obsessive behaviour or preoccupations, although of different kinds. Preliminary enquiry also suggests genetic links (eg autistic sibs

of PDA children in perhaps 5% or more of cases). The conceptualisation of clusters within an overall family also suggests an occasional clinical picture falling between clusters in an atypical way, and this, of course, is already recognised in DSM-IV's PDD nos (),- which itself is much more rare once we recognise PDA as an entity in itself. Some of these in-between children will more clearly belong to a typical cluster as time goes on and particular symptoms take on greater prominence.



conditions they are observed.

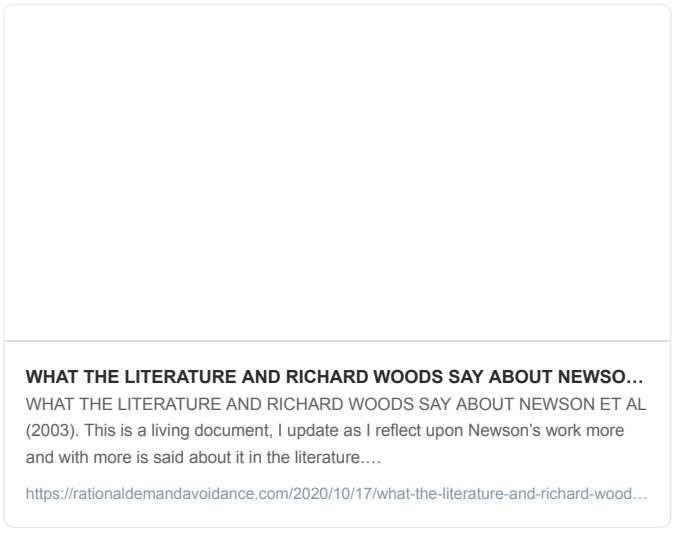
CONCLUSIONS

This clinical description of "pathological demand avoidance syndrome" (PDA), conceptualised as a separate entity within the pervasive developmental disorders, has already been found clinically useful by many paediatricians, psychiatrists, and psychologists in diagnosing a group of children otherwise seen as puzzling and atypical in relation to the autistic spectrum. It gives "specific" status to a large proportion of those children (and adults) who would earlier have been diagnosed as having "pervasive developmental disorder not otherwise specified" (PDDnos). Figure 1 sets PDA in the context of the whole family of pervasive developmental disorders, and is explained as follows:

- The diagram shows clusters of symptoms (syndromes) which make up specific disorders within the "family". These will vary in mildness or severity, and intellectual ability will make a significant difference (as in any disability); so will underlying personality.
- Occasionally a child will show a cluster of symptoms that falls between these typical clusters. This is described as non-specific pervasive developmental disorder. However, sometimes this child will more clearly belong to a typical cluster as time goes on and particular symptoms take on greater prominence.

Something has been nagging about this passage of text:
"Therefore, her data may over-estimate the degree to
which PDA separates as a sub-group within the autism spectrum as we now know it."
(O'Nions & Eaton, 2020, p1)

This sentence is within a section trying to explain PDA as subgroup of autism. As part of a paragraph trying to establish their is a collider bias within Newson's work. I establish elsewhere, this suggestion is nonsense, & not applicable.



WHAT THE LITERATURE AND RICHARD WOODS SAY ABOUT NEWSO…

WHAT THE LITERATURE AND RICHARD WOODS SAY ABOUT NEWSON ET AL (2003). This is a living document, I update as I reflect upon Newson's work more and with more is said about it in the literature.…

https://rationaldemandavoidance.com/2020/10/17/what-the-literature-and-richard-wood…

What has been nagging me about the previous quoted sentence, it just feels like an attempt to explain away the differences between PDA and autism, without critically

engaging with PDA. Without considering that PDA might not be autism.

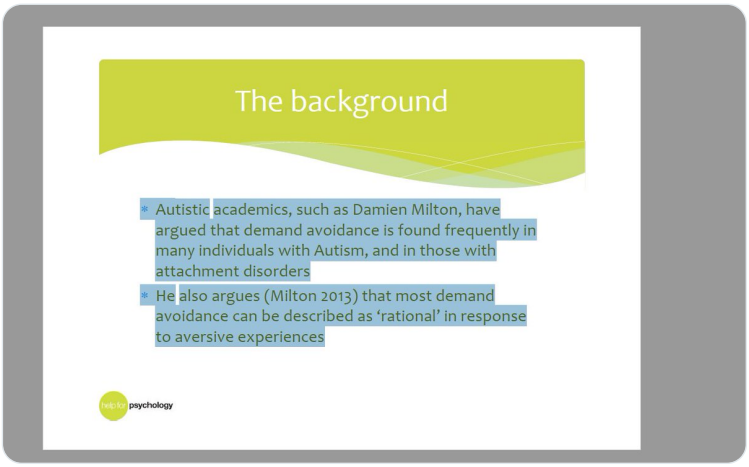
Following sentence.
"This does not imply that the profile Newson described does not exist, but rather there is likely a broader range of profiles: varying in severity of both ASD and PDA features." (O'Nions & Eaton, 2020, p1).

I support the aspect that there is likely to a broader range of profiles, varying in PDA features. There will be some overlap of autism features, that is because autistic features exist within a continuum within the human population.

This then begs the question why they are trying to separate PDA out from "Rational Demand Avoidance" definitions?

Help4Psychology definitions

It is also claims making by Eaton and Weaver for their being a "Rational Demand Avoidance" group, as at Judy Eaton is aware of autistic scholarship on Rational Demand Avoidance, which is not referenced.
https://www.autism.org.uk/what-we-do/professional-development/past-conferences/pda-conference-2018



Looking at their justification for "Rational Demand Avoidance" it does seem to be partly inspired by @milton_damian & my work.

O'Nions & Weaver describe PDA behaviours as being having specific causes, often from school.

Eaton & Weaver also describe PDA as having different developmental aspects to Rational Demand Avoidance.

My issue here is, that many PDA experts & literature say PDA is not developmental in nature; contradicting their approach of diagnosing PDA in those who have developmental features. Those with "Rational Demand Avoidance" would not receive a PDA dx.

The point here is that Help4Pscyhology are unlikely to look for similarities in their "Rational Demand Avoidance" and their PDA, when they do not dx PDA in said persons.

"Rational Demand Avoidance" seems to be defined as a PDA-like autistic group, but it is not PDA. Almost, a PDA-NOS; Pathological Demand Avoidance- Not Otherwise Specified. So people not meeting their PDA threshold.

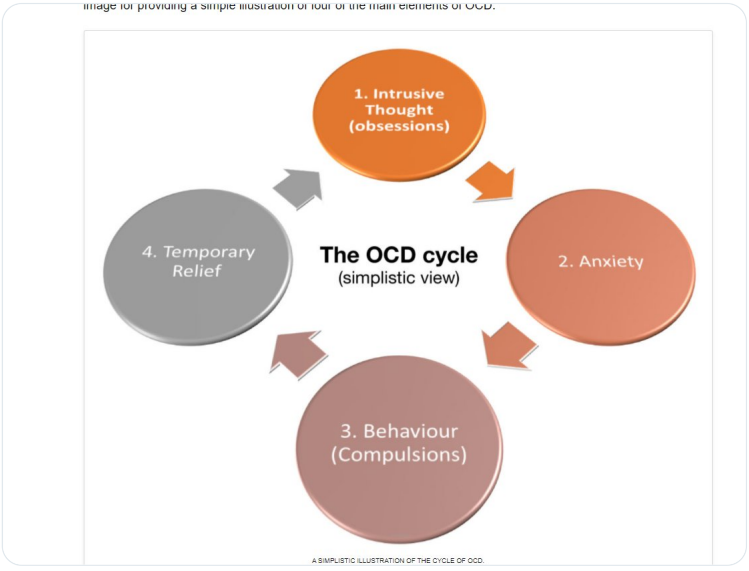
Which feeds back into my point about why are they trying to separate out different PDA profiles?

Maybe it is a case of splitters will be splitters? They will divide PDA, like they are trying to divide autism?

Fundamentally, if core PDA features present at lower frequencies, but still produce same relationships (especially predictive relationships), RDA, would still be PDA (Help4Psychology definitions).

Demand avoidance in "Rational Demand Avoidance" should still follow same process:
Demand
Anxiety (rational or not).
Avoidance.
Temporary Relief.

Even Help4Psychology "Rational Demand Avoidance" would appear to be fundamentally the same as their PDA, on its defining OCD-Like aspect.



@threadreaderapp Please can you unroll?

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