Richard Woods @Richard_Autism

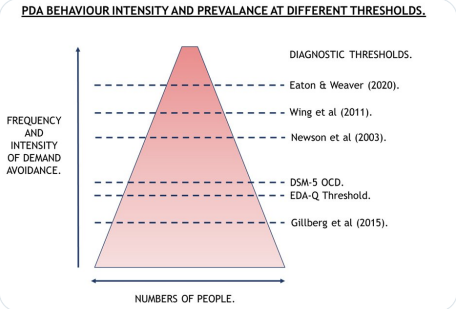
11 May • 64 tweets • Richard_Autism/status/1392255503816871941

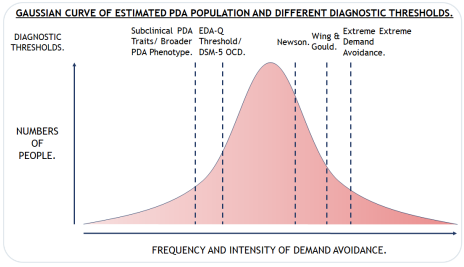
Reflecting how my journey on PDA, has gone from "rebranded autism" in 2017, next a pseudo syndrome resulting from interaction of autism & various comorbids. To it is a common Disorder.

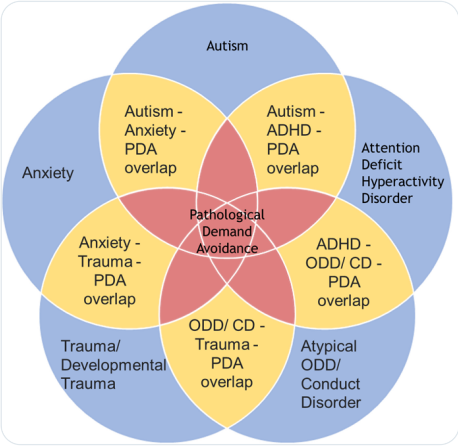
Anyone want to take bets, I will view it as a rare autism subtype (joke)?

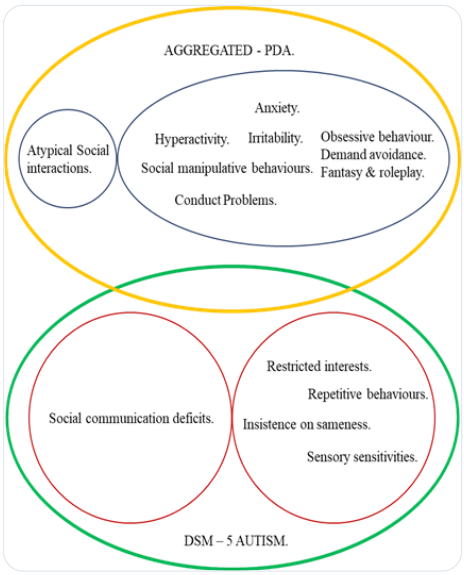
I should point, I can see why people think PDA is rebranded autism/ a pseudo syndrome resulting from interaction of autism and various comorbids.

I can see why people think PDA is a rare autism subtype. I think that outlook is not cogent, nor particularly scientific nor ethical. I can go into detail why I hold that view.







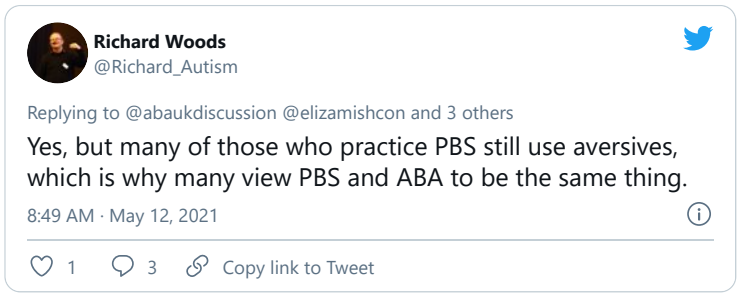


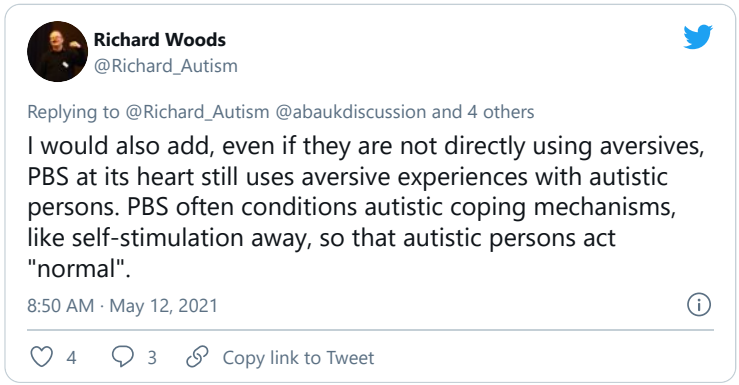
Although, I suspect some would argue it is cognitive dissonance with PDA. I cannot accept the demand that PDA is autism. I am being dogmatic & narrow minded calling

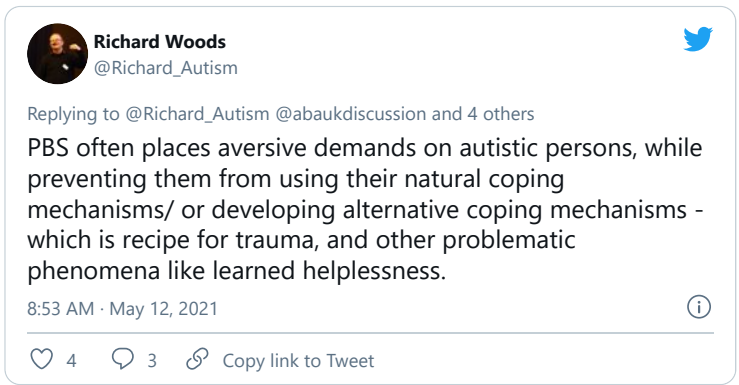
for scientific-method-based approach to PDA, maintaining integrity of autism.

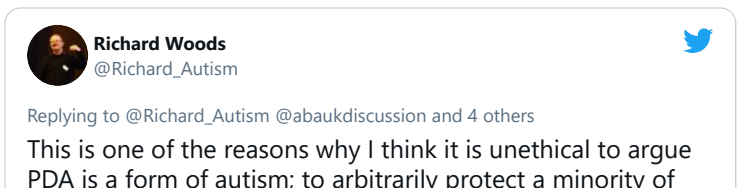
I need to reflect upon this more.

Tangent, but I am making this a generic thread on more reflections on PDA.





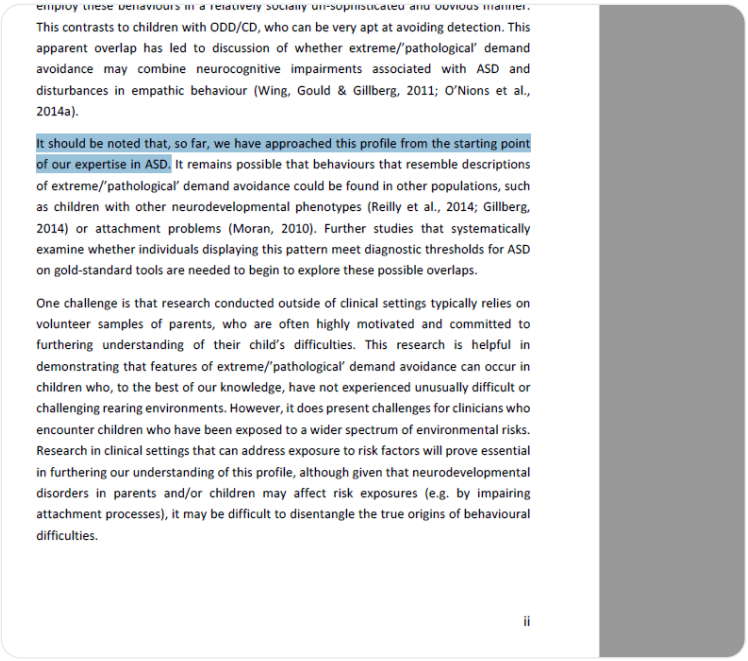




I am also pretty certain, I can explain the weird academic decisions in PDA literature, by assuming that their is an agenda to view PDA as an ASD; probably out of genuine (mistaken) belief PDA is autism.

I am talking about weird things like repeatedly missing/ ignoring non-autistic persons in PDA samples. Likewise, Newson's views on the topic, how she excluded those with autism features from her cohort & NOT basing PDA on the Triad of Impairment etc etc.

It based on the view that it is an axiom that PDA is an ASD, so it is taken as a truth that PDA is autism. We know that there was a research agenda proposed that PDA is an ASD in 2011. That they approached PDA as an ASD.
repository.tavistockandportman.ac.uk/2165/



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 challenging rearing environments. However, it does present challenges for clinicians who encounter children who have been exposed to a wider spectrum of environmental risks. Research in clinical settings that can address exposure to risk factors will prove essential in furthering our understanding of this profile, although given that neurodevelopmental disorders in parents and/or children may affect risk exposures (e.g. by impairing attachment processes), it may be difficult to disentangle the true origins of behavioural difficulties.

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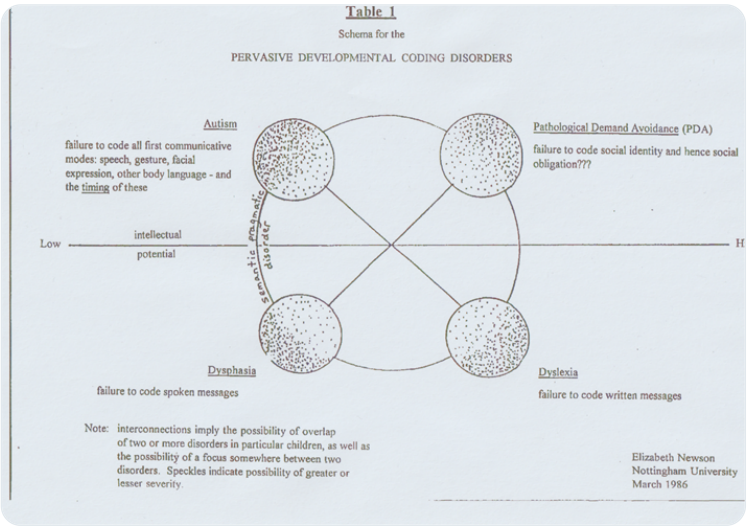
This process is the same one that lead to Newson viewing PDA as having Coding issues, which is when a person struggles to understand/ process certain aspects of communication.

Newson created her own diagnostic grouping called "Pervasive Developmental Coding Disorders" & used it between 1986 - 1996. She created the diagnostic grouping, before she created PDA's behaviour profile in 1988.

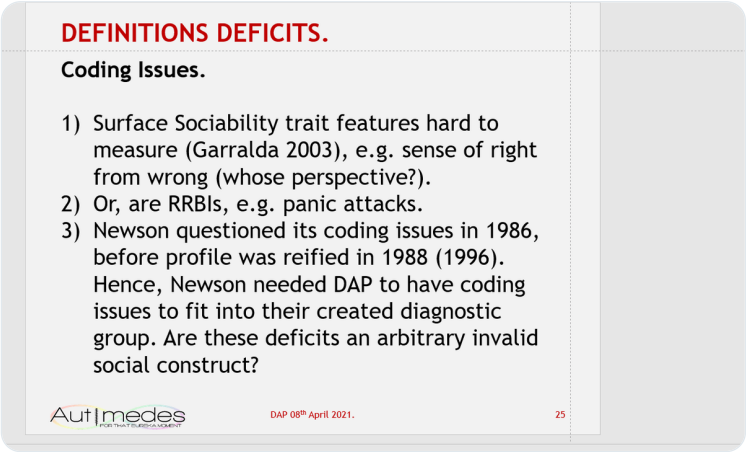
We know that Newson was questioning what Coding issues PDA had in 1986, see the diagram below. Newson needed PDA to have Coding issues to fit into her newly created diagnostic grouping.



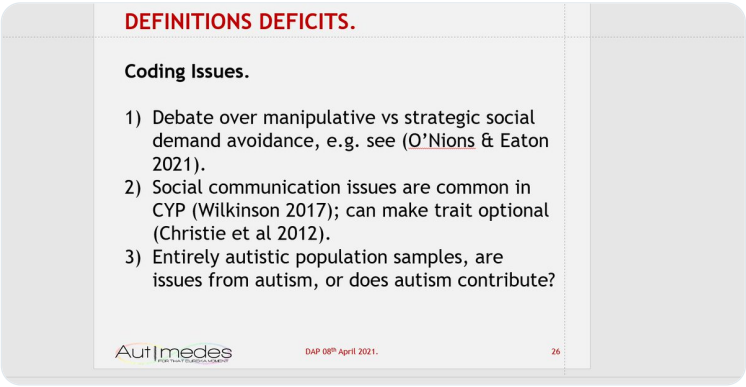
Newson was aware she was reifying PDA when she created her behaviour profile in 1988.

Newson's decision to assume PDA was a Pervasive Developmental Coding Disorder, explains why her behaviour profile has one social communication issues trait of: "Surface sociability, but lack of sense of identity, pride, or shame."

We also know that specific trait is highly problematic. Much of its features are either RRBIs in nature, i.e. not social communication issues. Or, do not reliably measure its proposed deficits in social identity/ pride/ shame.

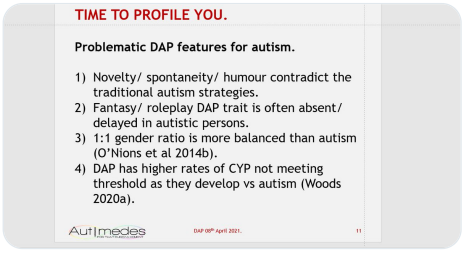


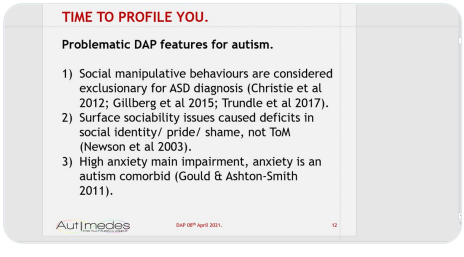
We also know that PDA is not meant to have Theory of Mind deficits and this is supported by Bishop (2018). There are many good reasons to be skeptical of viewing PDA as having Coding issues.

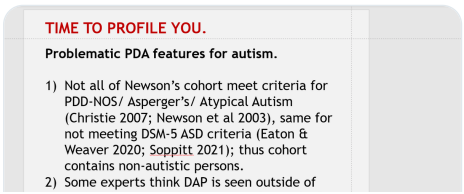


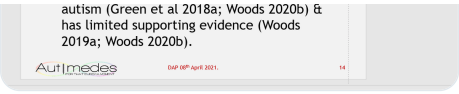
So, what do I think is happening with weird academic decisions in PDA literature, around viewing PDA as an ASD. Is the same processes, is that such decisions are derived from the need that to have PDA as an ASD.

One cannot assume and treat PDA as an ASD, if one acknowledges their are non-autistic persons with PDA in various research samples. Likewise, PDA is not based on triad of impairment. Or, not caused by autism. Etc etc.









I unsure of how much of this academic "silliness" is deliberate or not. We know generally, PDA is an ASD supporters do not engage with critique & do not reference divergent literature. Similarly, generally aggressively lobbying for PDA to be viewed as an ASD.

The decision to view PDA as an ASD, does seem to be deliberate though. That there are substantial conflicts of interests present in how it is being portrayed and pursued.

One big difference between me and "PDA is an ASD" supporters, generally, is that I am open I have a conflict of interest in advocating for PDA to be viewed as a common Disorder & it should be practiced as such.

I am still reflecting on the initial tweets in this thread. How much of my views are driven by cognitive dissonance or not? Am I being narrow minded/ dogmatic? Am I being unreasonable or not?

I am being dogmatic calling for good quality ethics and practiced around PDA, i.e. scientific-method and inclusive based approach to PDA. I only see that insistence as a positive thing. Quality of ethics & research are often mutually interacting.

I, like all autism stakeholders, should be striving to raise the poor quality standards, of much autism research, policy and practice (which PDA is unfortunately being associated with autism).

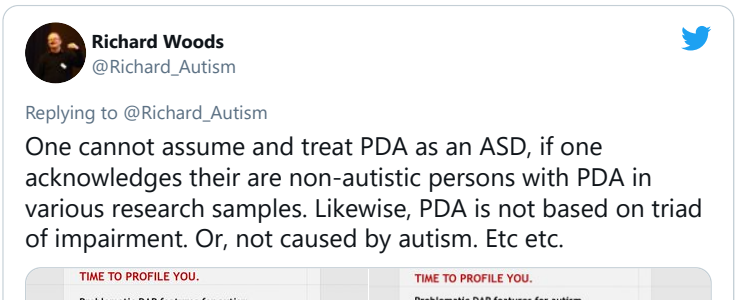
Generally, I think I am being incredibly open minded on PDA. Also highly creative in my approach and rationale about it. I am open to exploring logic, to see where it leads to.

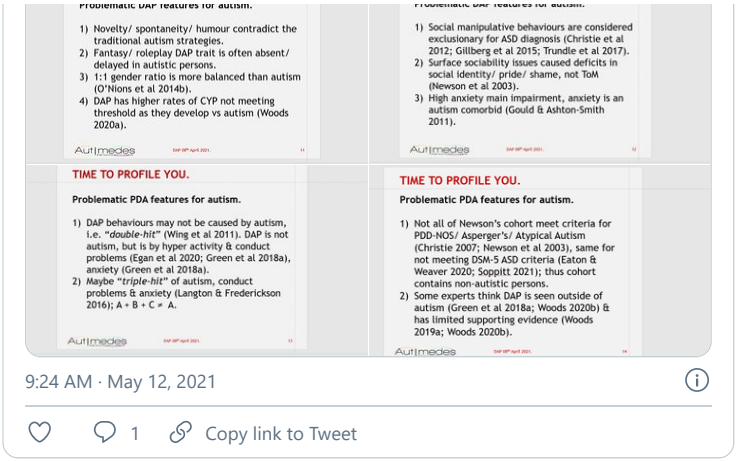
I am still reflecting on. if my rationale on me being open minded etc is strong and robust. I am also wondering if I am just pointless doubting myself. Sometimes it is beneficial to question oneself and ones own biases and assumptions.

To me, this is all part of being a responsible researcher, to critically engage with things and to reflect on things.

I am autistic, a highly intelligent person, who is obsessed with PDA. I naturally reflect about it by default, like making a cup of tea etc.

To underline the point in this tweet, if one is critically reflecting on PDA, noticing MANY/ ALL the reasons PDA is NOT autism; logical thing to do is assume PDA is NOT autism. Which is what happened to me about 18 months ago.



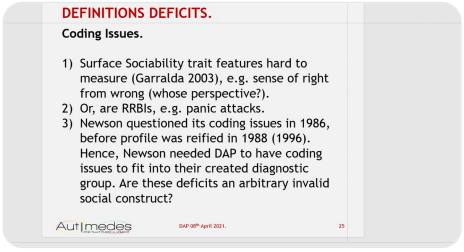


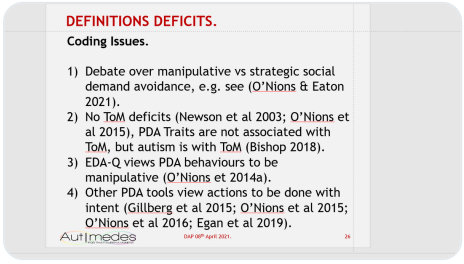
The point is, that it becomes absurd to view PDA is an ASD, when there are like two dozen/ plus reasons PDA is not an ASD. There are substantial more reasons to NOT view PDA as an ASD, when compared to 18 months ago.

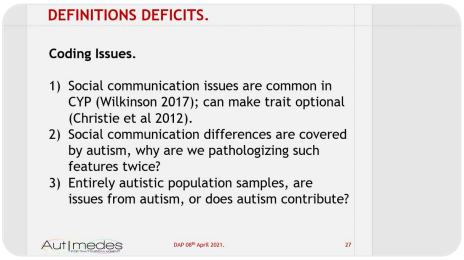
From my understanding there is a strong case PDA is not autism; which is essentially why I hold that position.

I have put more reasons in the slides why it is problematic viewing PDA as having Coding issues. Now across three slides.

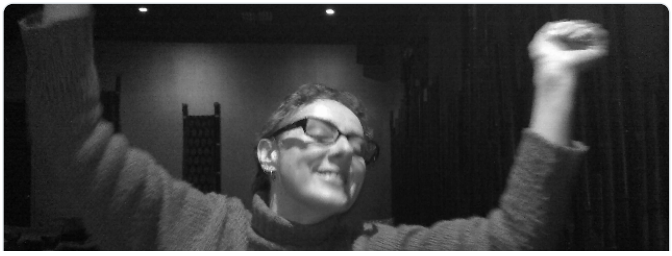
Tangent, I thinking of using widescreen slides in the future, so may well be on less slides in the future.







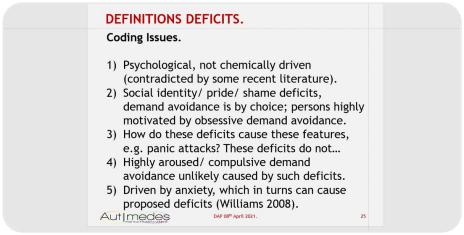
I have been reflecting on the problems with proposed coding issues in PDA. Blog post by Donna Williams is important, as it explains rationale behind proposed deficits in social identity/ pride/ shame. I have updated the slides again.

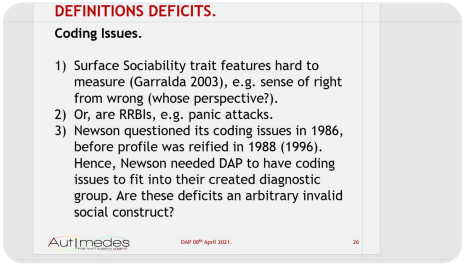


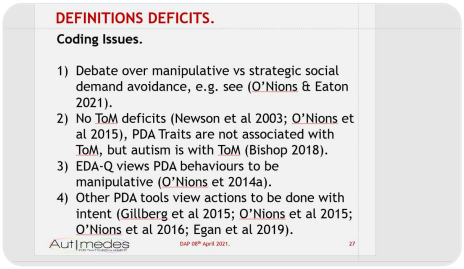
Exposure Anxiety versus Pathological Demand Avoidance.

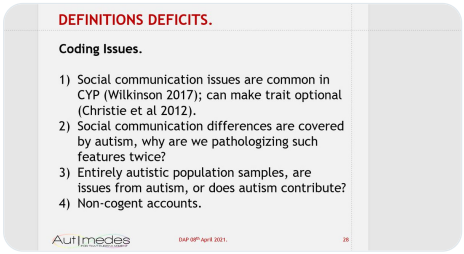
Someone wrote to me about the differences between Exposure Anxiety (EA, as written about in the book, Exposure Anxiety; The Invisible Cage) and Pathological Demand Avoidance (PDA). Here are my ref…

https://blog.donnawilliams.net/2008/06/17/exposure-anxiety-versus-pathological-dema…





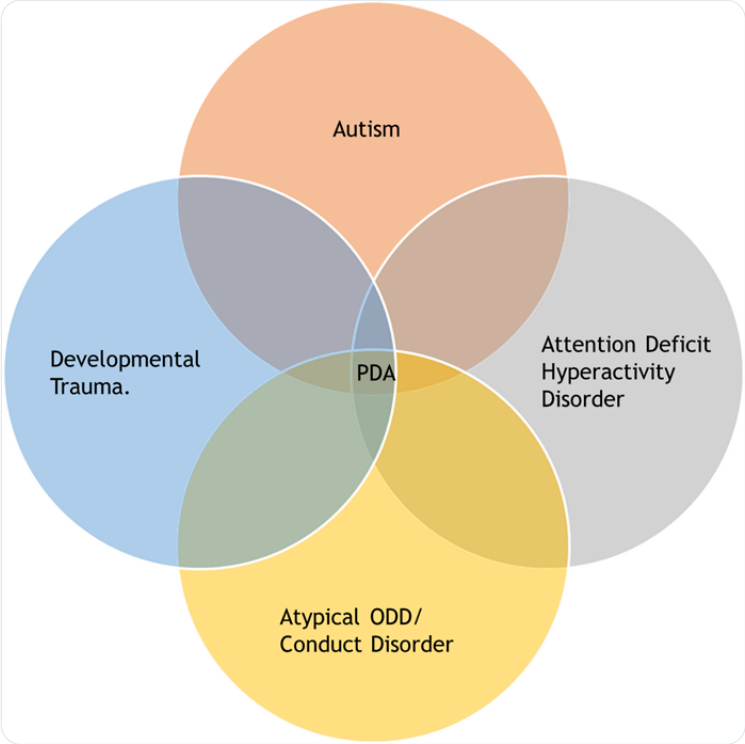




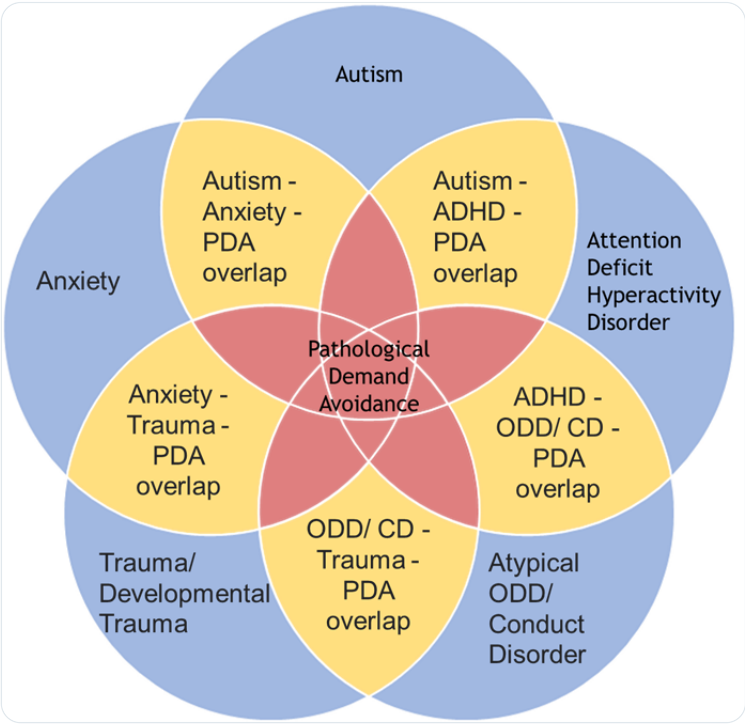
The being highly motivated and avoiding demands by choice, with it being viewed as a psychological in nature explains why most PDA tools have items with behaviours done with intent behind them.

I can see why some might say, I am being rigid on PDA, by not viewing it as an ASD. I would point to the strong case, WHY PDA is not an ASD, and the examples about me being open minded on it.

Example, my edited version of Soppitt, 2021, p299, diagram of how PDA relates to other conditions.

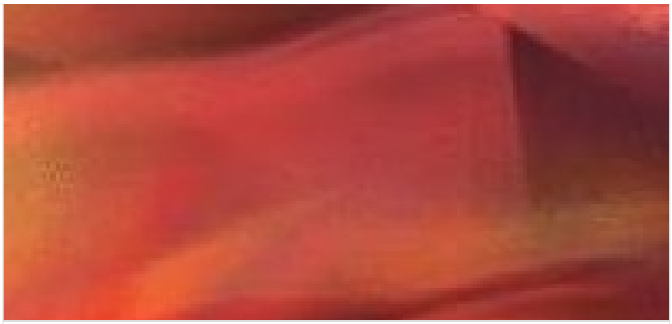


My version of the diagram, I added anxiety to it, to reflect certain research results. In my view I would personally remove autism from it, but in order to reflect some research results, autism should be included.



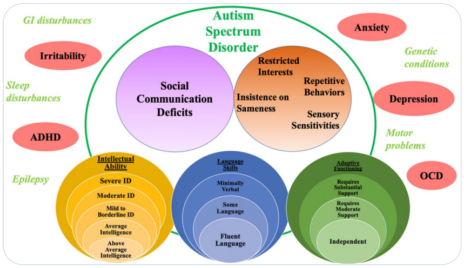
Example of how I conceptualise PDA vs DSM-5 autism, is here. First image is from Rosen et al (2021). Second image is my one, mapping PDA features relative to Rosen et al (2021) image.

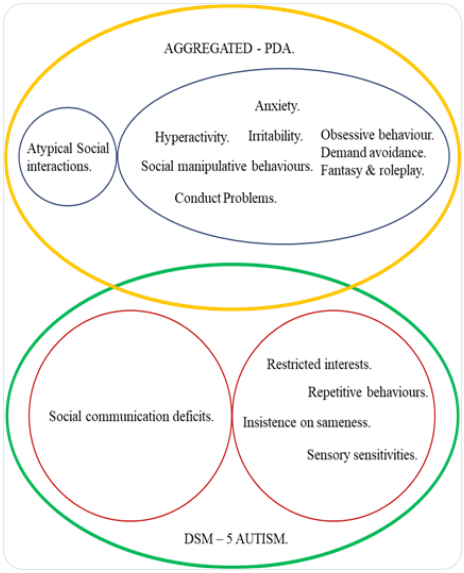
PDA features should hallow DSM-5 autism criteria.



The Diagnosis of Autism: From Kanner to DSM-III to DSM-5 and Beyond
In this paper we review the impact of DSM-III and its successors on the field of autism—both in terms of clinical work and research. We summarize the

https://link.springer.com/article/10.1007/s10803-021-04904-1





I would also add, it is large journey that has came about from much reflection reading on PDA, to go from rebranded autism:

Pathological demand avoidance: my thoughts on looping effects and c…
(2017). Pathological demand avoidance: my thoughts on looping effects and commodification of autism. Disability & Society: Vol. 32, No. 5, pp. 753-758.

https://www.tandfonline.com/doi/full/10.1080/09687599.2017.1308705

To PDA is a pseudosyndrome to resulting from interaction of autism and various co-occurring conditions:

(PDF) Demand avoidance phenomena: circularity, integrity and validity…

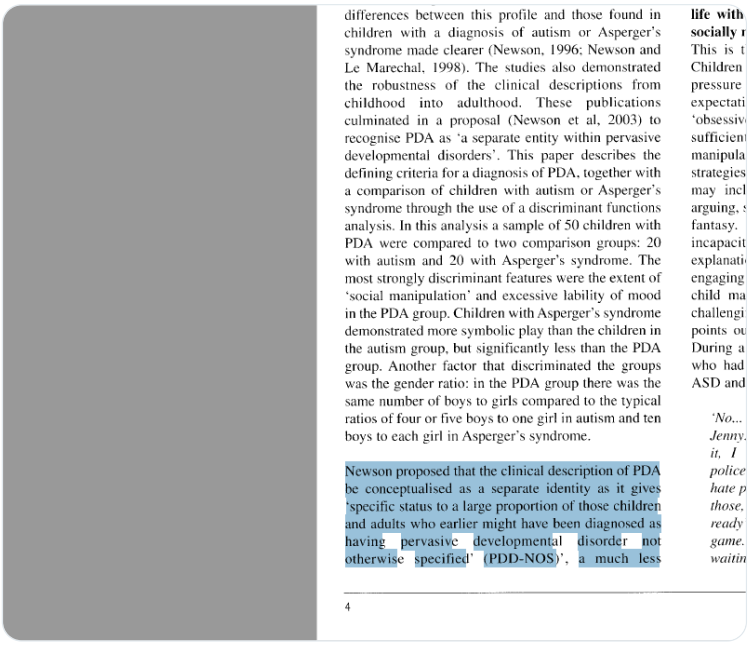
PDF | This article explores key reasons for justifying the proto impairment of Demand Avoidance Phenomena (DAP), by investigating the integrity and... | Find, read and cite all the research you need …

https://www.researchgate.net/publication/337146735_Demand_avoidance_phenomen…

Through to current position of PDA probably is a new type of common Disorder: https://thepsychologist.bps.org.uk/pda-new-type-disorder#:~:text=Clinically%2C%20PDA%20superficially%20appears%20similar,language%20development%20and%20speech%20delay.

If you compare this to journey to some prominent PDA is an ASD supporters, it is very striking the difference path to present positions.

Take Christie 2007, that PDA was needed to replace many persons who received a PDD-NOS diagnosis (I am unsure if Christie understood Newson's PDD-NOS is not the same as the DSM-4 one though).
https://www.ingentaconnect.com/contentone/bild/gap/2007/00000008/00000001/art00002



differences between this profile and those found in children with a diagnosis of autism or Asperger's syndrome made clearer (Newson, 1996; Newson and Le Marechal, 1998). The studies also demonstrated the robustness of the clinical descriptions from childhood into adulthood. These publications culminated in a proposal (Newson et al, 2003) to recognise PDA as 'a separate entity within pervasive developmental disorders'. This paper describes the defining criteria for a diagnosis of PDA, together with a comparison of children with autism or Asperger's syndrome through the use of a discriminant functions analysis. In this analysis a sample of 50 children with PDA were compared to two comparison groups: 20 with autism and 20 with Asperger's syndrome. The most strongly discriminant features were the extent of 'social manipulation' and excessive lability of mood in the PDA group. Children with Asperger's syndrome demonstrated more symbolic play than the children in the autism group, but significantly less than the PDA group. Another factor that discriminated the groups was the gender ratio: in the PDA group there was the same number of boys to girls compared to the typical ratios of four or five boys to one girl in autism and ten boys to each girl in Asperger's syndrome.

Newson proposed that the clinical description of PDA be conceptualised as a separate identity as it gives 'specific status to a large proportion of those children and adults who earlier might have been diagnosed as having pervasive developmental disorder not otherwise specified' (PDD-NOS)', a much less

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Newson's PDD-NOS includes those not meeting clinical threshold for either: Autism/ Asperger's Syndrome/ PDA/ Specific Language Impairments (including dyslexia & dysphasia). So includes many non-autistic persons.

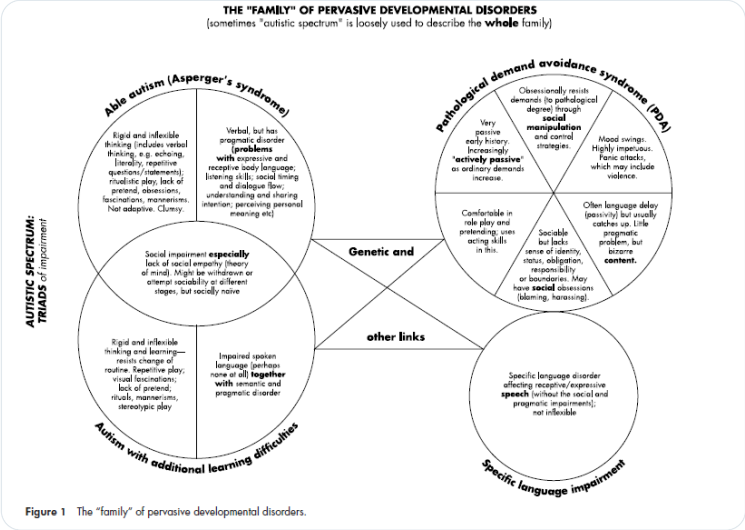
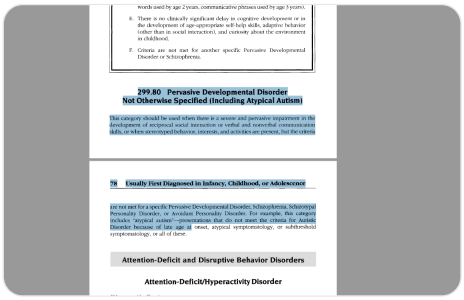


Figure 1 The "family" of pervasive developmental disorders.

DSM-4 PDD-NOS, is for those not meeting threshold for either Asperger's/ Autistic Disorder. PDD-NOS in this view is an ASD subtype.

Newson's PDD-NOS is not an autism subtype.
https://adc.bmj.com/content/88/7/595

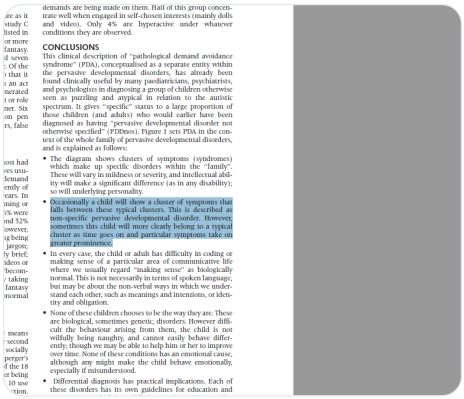

299.80 Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria

Usually First Diagnosed in Infancy, Childhood, or Adolescence

Attention-Deficit and Disruptive Behavior Disorders

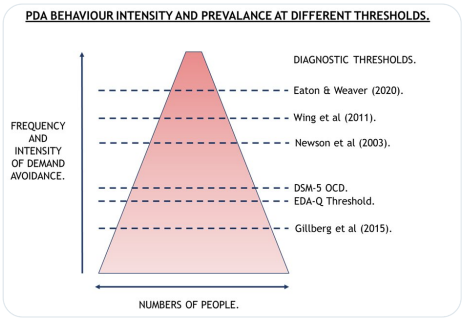
Attention-Deficit/Hyperactivity Disorder

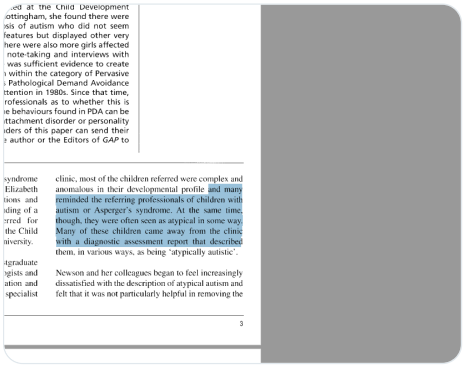

CONCLUSIONS

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.
- In every case, the child or adult has difficulty in coding or making sense of a particular area of communicative life where we usually regard "making sense" as biologically normal. This is not necessarily in terms of spoken language, but may be about the non-verbal ways in which we understand each other, such as meanings and intentions, or identity and obligation.
- None of these children chooses to be the way they are. These are biological, sometimes genetic, disorders. However difficult the behaviour arising from them, the child is not wilfully being naughty, and cannot easily behave differently; though we may be able to help him or her to improve over time. None of these conditions has an emotional cause, although any might make the child behave emotionally, especially if misunderstood.
- Differential diagnosis has practical implications. Each of these disorders has its own guidelines for education and

The starting position of Newson's work, is that PDA is relatively common & seen in non-autistic persons. This is reflected in Christie's article, not all of Newson's cohort would have received a diagnosis of a DSM-4 autism subtype.




clinic, most of the children referred were complex and anomalous in their developmental profile and many reminded the referring professionals of children with autism or Asperger's syndrome. At the same time, though, they were often seen as atypical in some way. Many of these children came away from the clinic with a diagnostic assessment report that described them, in various ways, as being 'atypically autistic'.

Newson and her colleagues began to feel increasingly dissatisfied with the description of atypical autism and felt that it was not particularly helpful in removing the

Since then, there has been research that viewed PDA to be a rare autism subtype, using an arbitrary threshold of 30% or less for PDA traits.

Guess who who was a co-author to the paper (rhetorical)?

Identifying features of 'pathological demand avoidance' using the Diag…
The term 'pathological demand avoidance' (PDA) was coined by Elizabeth Newson to describe children within the autism spectrum who exhibit obse

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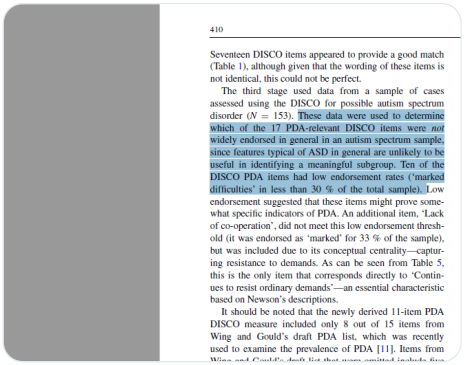

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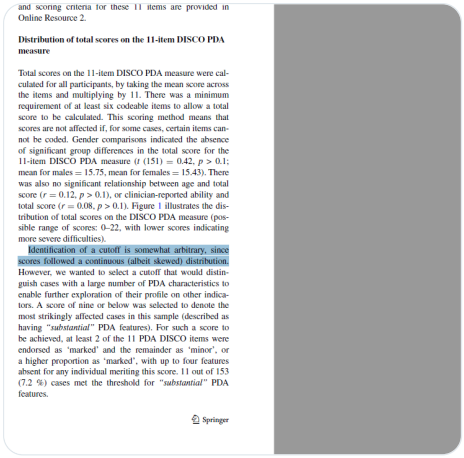
Seventeen DISCO items appeared to provide a good match (Table 1), although given that the wording of these items is not identical, this could not be perfect.

The third stage used data from a sample of cases assessed using the DISCO for possible autism spectrum disorder (N = 153). These data were used to determine which of the 17 PDA-relevant DISCO items were *not* widely endorsed in general in an autism spectrum sample, since features typical of ASD in general are unlikely to be useful in identifying a meaningful subgroup. Ten of the DISCO PDA items had low endorsement rates ('marked difficulties' in less than 30 % of the total sample). Low endorsement suggested that these items might prove somewhat specific indicators of PDA. An additional item, 'Lack of co-operation', did not meet this low endorsement threshold (it was endorsed as 'marked' for 33 % of the sample), but was included due to its conceptual centrality—capturing resistance to demands. As can be seen from Table 5, this is the only item that corresponds directly to 'Continues to resist ordinary demands'—an essential characteristic based on Newson's descriptions.

It should be noted that the newly derived 11-item PDA DISCO measure included only 8 out of 15 items from Wing and Gould's draft PDA list, which was recently used to examine the prevalence of PDA [11]. Items from



and scoring criteria for these 11 items are provided in Online Resource 2.

Distribution of total scores on the 11-item DISCO PDA measure

Total scores on the 11-item DISCO PDA measure were calculated for all participants, by taking the mean score across the items and multiplying by 11. There was a minimum requirement of at least six codeable items to allow a total score to be calculated. This scoring method means that scores are not affected if, for some cases, certain items cannot be coded. Gender comparisons indicated the absence of significant group differences in the total score for the 11-item DISCO PDA measure (t (151) = 0.42, p > 0.1; mean for males = 15.75, mean for females = 15.43). There was also no significant relationship between age and total score (r = 0.12, p > 0.1), or clinician-reported ability and total score (r = 0.08, p > 0.1). Figure 1 illustrates the distribution of total scores on the DISCO PDA measure (possible range of scores: 0–22, with lower scores indicating more severe difficulties).

Identification of a cutoff is somewhat arbitrary, since scores followed a continuous (albeit skewed) distribution. However, we wanted to select a cutoff that would distinguish cases with a large number of PDA characteristics to enable further exploration of their profile on other indicators. A score of nine or below was selected to denote the most strikingly affected cases in this sample (described as having "*substantial*" PDA features). For such a score to be achieved, at least 2 of the 11 PDA DISCO items were endorsed as 'marked' and the remainder as 'minor', or a higher proportion as 'marked', with up to four features absent for any individual meriting this score. 11 out of 153 (7.2 %) cases met the threshold for "*substantial*" PDA features.

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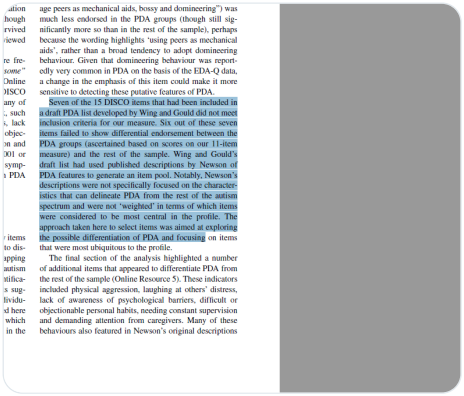
An important to point consider here, is that this research went out of their way to view PDA as an ASD subgroup. This contradicts Newson's approach to PDA.
https://adc.bmj.com/content/archdischild/88/7/595.full.pdf?with-ds=yes

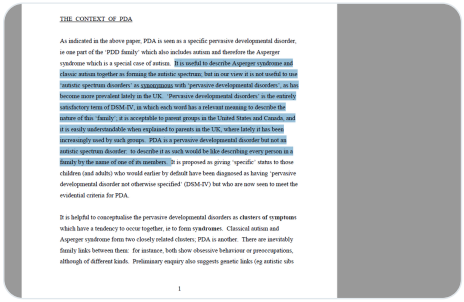


…ation …hough …rvived …iewed re fre- *some"* Online DISCO any of , such , lack objec- on and 001 or symp- PDA items to dis- apping autism tifica- s sug- lividu- d here which in the

age peers as mechanical aids, bossy and domineering") was much less endorsed in the PDA groups (though still significantly more so than in the rest of the sample), perhaps because the wording highlights 'using peers as mechanical aids', rather than a broad tendency to adopt domineering behaviour. Given that domineering behaviour was reportedly very common in PDA on the basis of the EDA-Q data, a change in the emphasis of this item could make it more sensitive to detecting these putative features of PDA.

Seven of the 15 DISCO items that had been included in a draft PDA list developed by Wing and Gould did not meet inclusion criteria for our measure. Six out of these seven items failed to show differential endorsement between the PDA groups (ascertained based on scores on our 11-item measure) and the rest of the sample. Wing and Gould's draft list had used published descriptions by Newson of PDA features to generate an item pool. Notably, Newson's descriptions were not specifically focused on the characteristics that can delineate PDA from the rest of the autism spectrum and were not 'weighted' in terms of which items were considered to be most central in the profile. The approach taken here to select items was aimed at exploring the possible differentiation of PDA and focusing on items that were most ubiquitous to the profile.

The final section of the analysis highlighted a number of additional items that appeared to differentiate PDA from the rest of the sample (Online Resource 5). These indicators included physical aggression, laughing at others' distress, lack of awareness of psychological barriers, difficult or objectionable personal habits, needing constant supervision and demanding attention from caregivers. Many of these behaviours also featured in Newson's original descriptions



THE CONTEXT OF PDA

As indicated in the above paper, PDA is seen as a specific pervasive developmental disorder, ie one part of the 'PDD family' which also includes autism and therefore the Asperger syndrome which is a special case of autism. It is useful to describe Asperger syndrome and classic autism together as forming the autistic spectrum, but in our view it is not useful to use 'autistic spectrum disorders' as synonymous with 'pervasive developmental disorders', as has become more prevalent lately in the UK. 'Pervasive developmental disorders' is the entirely satisfactory term of DSM-IV, in which each word has a relevant meaning to describe the nature of this 'family'; it is acceptable to parent groups in the United States and Canada, and it is easily understandable when explained to parents in the UK, where lately it has been increasingly used by such groups. PDA is a pervasive developmental disorder but not an autistic spectrum disorder: to describe it as such would be like describing every person in a family by the name of one of its members. It is proposed as giving 'specific' status to those children (and adults) who would earlier by default have been diagnosed as having 'pervasive 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, ie 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

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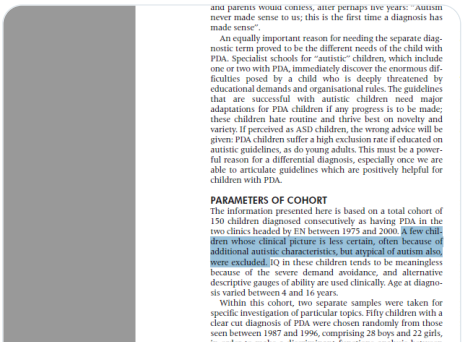


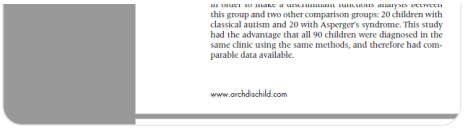
and parents would confess, after perhaps five years: "Autism never made sense to us; this is the first time a diagnosis has made sense".

An equally important reason for needing the separate diagnostic term proved to be the different needs of the child with PDA. Specialist schools for "autistic" children, which include one or two with PDA, immediately discover the enormous difficulties posed by a child who is deeply threatened by educational demands and organisational rules. The guidelines that are successful with autistic children need major adaptations for PDA children if any progress is to be made; these children hate routine and thrive best on novelty and variety. If perceived as ASD children, the wrong advice will be given: PDA children suffer a high exclusion rate if educated on autistic guidelines, as do young adults. This must be a powerful reason for a differential diagnosis, especially once we are able to articulate guidelines which are positively helpful for children with PDA.

PARAMETERS OF COHORT

The information presented here is based on a total cohort of 150 children diagnosed consecutively as having PDA in the two clinics headed by EN between 1975 and 2000. A few children whose clinical picture is less certain, often because of additional autistic characteristics, but atypical of autism also, were excluded. IQ in these children tends to be meaningless because of the severe demand avoidance, and alternative descriptive gauges of ability are used clinically. Age at diagnosis varied between 4 and 16 years.

Within this cohort, two separate samples were taken for specific investigation of particular topics. Fifty children with a clear cut diagnosis of PDA were chosen randomly from those seen between 1987 and 1996, comprising 28 boys and 22 girls,


this group and two other comparison groups: 20 children with classical autism and 20 with Asperger's syndrome. This study had the advantage that all 90 children were diagnosed in the same clinic using the same methods, and therefore had comparable data available.

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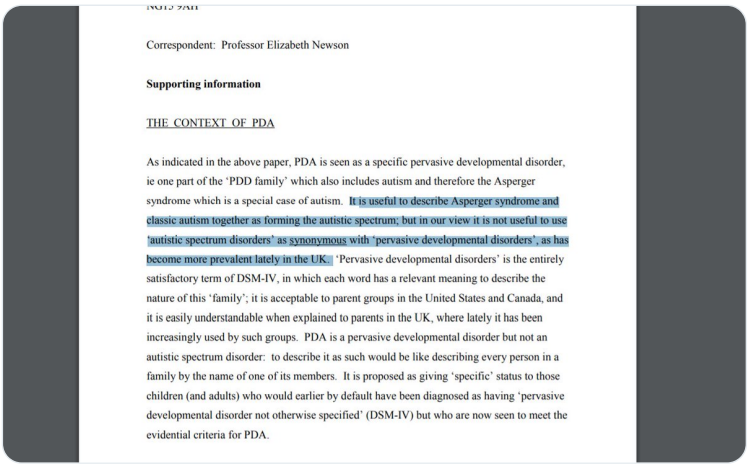
"Clearly, “hanging together as an entity” is not enough if that entity is not significantly different from both autism and Asperger’s syndrome, either separately or apart" (Newson et al, 2003, p599).

Point is Newson, is trying to make PDA an Autism subtype/ profile/ subgroup (anything part of the autism spectrum). She is trying to justify PDA is clinically needed because it is different & therefore not autism.

Must also be said, it seems Newson appreciated her PDD-NOS does not conform to accepted DSM-4 PDD-NOS and accepted "autism spectrum", as she viewed "autistic spectrum" to only consist of Asperger's & Kanner's autism.


Correspondent: Professor Elizabeth Newson

Supporting information

THE CONTEXT OF PDA

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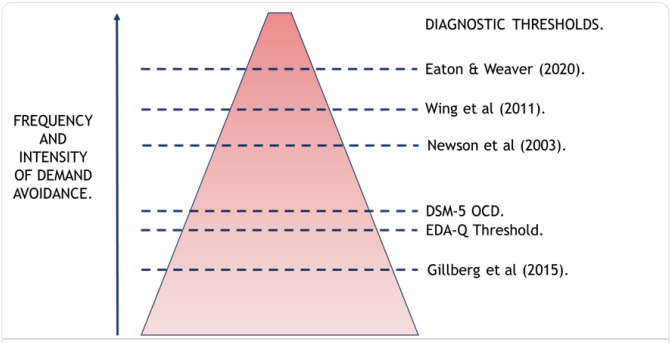
Where am I going with this, simple answer, more recent even narrower PDA definitions, adopted by a PDA is an ASD diagnosing clinic.

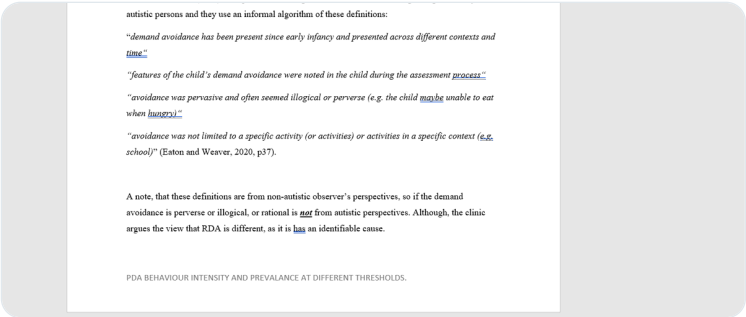
I set out here, these definitions are incredibly narrow, compared to other PDA diagnostic thresholds.



PDA BEHAVIOUR INTENSITY AND PREVALANCE AT DIFFERENT THR…

PDA BEHAVIOUR INTENSITY AND PREVALANCE AT DIFFERENT THRESHOLDS. NOTES ON WRITING THIS BLOG POST. This blog post has been written over a course of the last few of months. It particular in the last s…

https://rationaldemandavoidance.com/2021/04/25/pda-behaviour-intensity-and-prevala…



autistic persons and they use an informal algorithm of these definitions:

"demand avoidance has been present since early infancy and presented across different contexts and time."

"features of the child's demand avoidance were noted in the child during the assessment process."

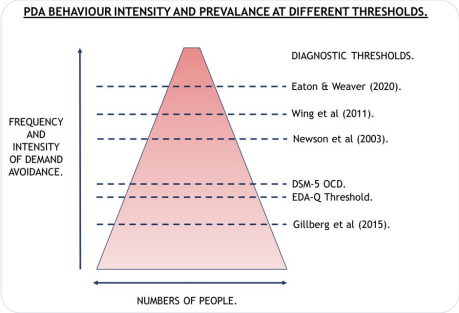
"avoidance was pervasive and often seemed illogical or perverse (e.g. the child maybe unable to eat when hungry)."

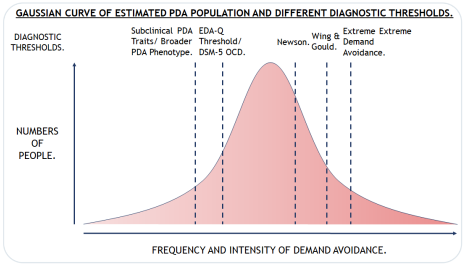
"avoidance was not limited to a specific activity (or activities) or activities in a specific context (e.g. school)" (Eaton and Weaver, 2020, p37).

A note, that these definitions are from non-autistic observer's perspectives, so if the demand avoidance is perverse or illogical, or rational is ***not*** from autistic perspectives. Although, the clinic argues the view that RDA is different, as it is has an identifiable cause.

PDA BEHAVIOUR INTENSITY AND PREVALANCE AT DIFFERENT THRESHOLDS.

So, what we have had from prominent PDA is an ASD supporters, is a progressive narrowing of PDA, from Newson's to what I refer to as "Extreme Extreme Demand Avoidance".





Bare in my mind my previously posted blog post has been described as:

"having done an absolutely first class job of summarising all the past literature and perspectives on PDA. No one else has done anywhere near as good, or as thorough, a job as you have."

Reasons why I call this narrowly defined PDA as "Extreme Extreme Demand Avoidance", can be found here:

Where am I going with this. It seems inherently problematic to view me as being dogmatic/ closed minded on PDA, when I have progressively evolved my view in open minded manners, while others have adopted narrower/ rigid interpretations on PDA.

I will end this thread here.

@threadreaderapp please could you do your thing (unroll these tweets)?

Thank you in advance.

I need to point out that Newson was NOT trying to make PDA autism, if anything she seems to make a concerted effort to make PDA NOT autism. We know she viewed PDA to NOT be autism over at least a 20 year time period.

@threadreaderapp Please could you unroll?

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