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Sep 27, 2021 • 39 tweets • Richard_Autism/status/1442603696475435008

Something that has been bothering over the last two days. Is how some "PDA as an ASD" supporters seem to be confusing anxiety based RRBI's with autism's social communication issues.

Routed to DSM-5 autism criteria, Category A, social communication issues.
A—Deficits in social communication and interaction
A1—Deficits in social-emotional reciprocity
A2—Deficits in nonverbal communication
A3—Deficits in relationships
(Evers et al 2021).

Screenshot of actual DSM-5 category A autism traits, from here (for ease of convenience):
https://www.autismspeaks.org/autism-diagnosis-criteria-dsm-5

Also see: Answers to frequently asked questions about DSM-5 criteria for autism

DSM-5 Autism Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

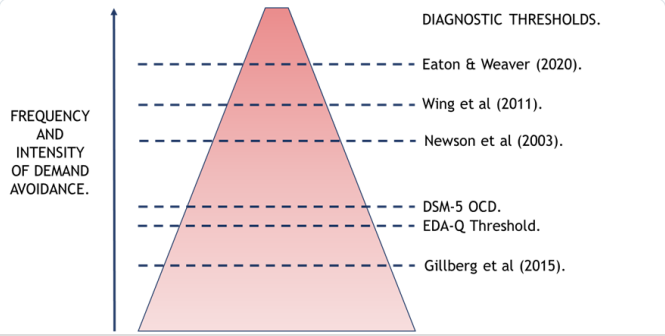
Specify current severity: Severity is based on social communication impairments and restricted repetitive patterns of behavior. (See table below.)

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

I am particularly critiquing Help4Psychology's insistence that PDA must be an ASD due to social communication issues, & their reported different ADOS scores for their version of PDA.

For detailed debate on how there are different versions of PDA, such as different diagnostic thresholds can be found here:



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…

Now, where am I going with this. The ADOS is an observational tool, often used to assess a person for autism. Some consider it to the gold standard for autism diagnosis. Others, think it is a bit naff, like: http://www.larry-arnold.net/Autonomy/index.php/autonomy/article/view/AR26/AR26

The ADOS itself mainly assesses for Category A, social communication issues, & a limited extent for Category B, Restricted, repetitive behaviour, interests or activities (RRBIs).

It is possible for a person to meet autism threshold on ADOS only with Category A scores. This is pointed out in Evers et al (2021).

How well are DSM-5 diagnostic criteria for ASD...

European Child & Adolescent Psychiatry - Five years after the publication of DSM-5 in 2013, three widely used diagnostic instruments have published algorithms designed to represent its...

https://link.springer.com/article/10.1007%2Fs00787-020-01481-z

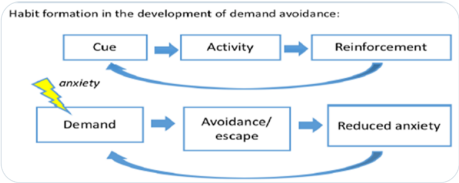
I have critiqued Help4Psychology's PDA research in considerable detail. So I do not wish to go into much of that detail again. Essentially, demand-avoidance they report for PDA presents gives different scores than seen in autism.

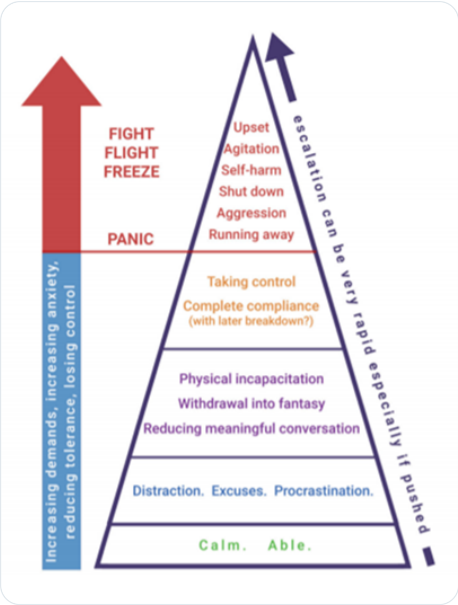
Help4Psychology suggest that demand-avoidance is caused by anxiety. How it is reported indicates those with displaying demand-avoidance are distressed, & sometimes increasingly so throughout the assessment.

"While such excuses did, at times feel comical, it was always important to remember these were children whose anxiety appeared to be driving their need to be avoidant." (Eaton & Weaver 2020, p35).

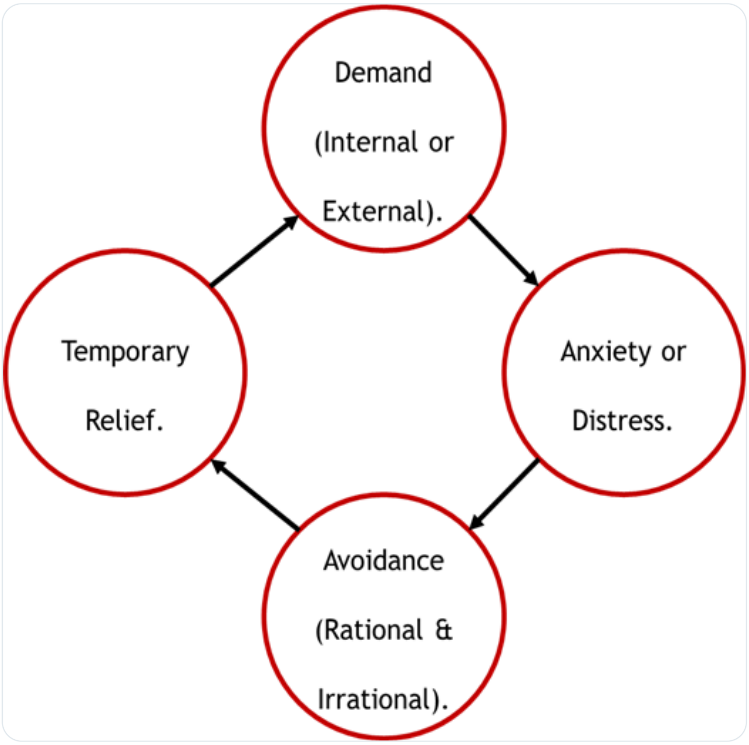
The point I am going here is that demand-avoidance in PDA is meant to developed & maintained through a generic negative-reinforcement process. At least if one accepts this particular research by O'Nions.

Images of how some argue how demand-avoidance is developed in PDA, & how more distressed a person is, more likely they are express more "extreme" behaviours.





Note that the demand-avoidance is meant to be driven by anxiety, or panic. It is a reason why I also using the OCD cycle I created the Demand Management Cycle.



Now, any reputable autism expert should be able to tell you anxiety is not a feature of autism. This is widely recognised clinically, such as with DSM-5 & NICE, and even within the PDA literature itself.

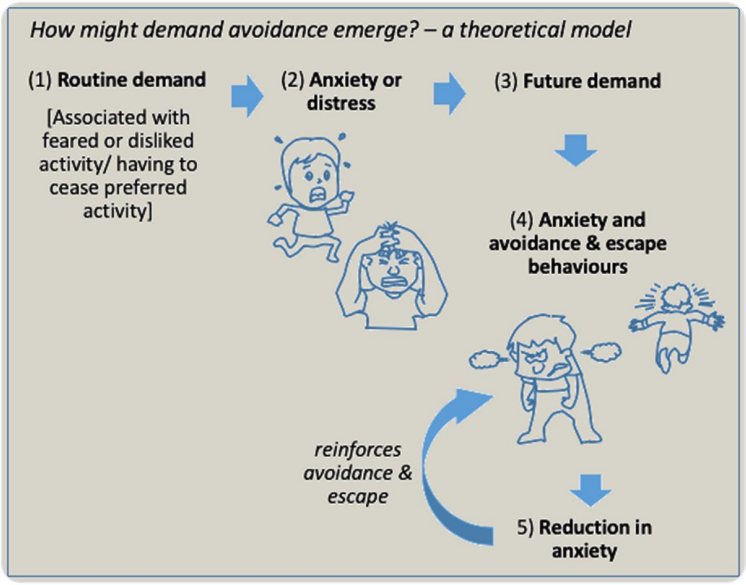
"If the socially strategic behaviour is seen for what it is e a scripted and limited strategy for ensuring predictability and control," (O'Nions & Eaton, 2021, p415).

The point of above quote is that, even by "leading" "PDA as an ASD" "experts", that social demand avoidance behaviours are viewed as RRBIs.

I am going to draw back to the DSM-5 autism criteria, Category A (social communication issues) traits.

The entire point of the social demand avoidance features, hypothesised to terminate/ affect social interactions to have aversive demands withdrawn.

Image is from O'Nions & Eaton 2021, p414.



Consider that avoidance traits in PDA include:
Comfortable in role play and pretending.
Consistent mood swings & impulsivity.
Frequent & intense actions.
Often with extreme behaviours, like violence when angry or panic attacks.
Social avoidance behaviours.

Now these features, & behaviours will naturally have an impact with how a person interacts with other persons, for the avoidance traits, this is the purpose of them, to remove aversive demands placed by others/ environment.

I have already mentioned previously, if a person is highly aroused, & often displaying such features (presumably by trauma), it will lead to chaotic & inconsistent social interactions; partly from the PURPOSE of avoidance features.

If someone is frequently experiencing social interactions & expressing features described with PDA, they often naturally have chaotic worldviews, with deficits in social identity, pride & shame.

Likewise, if a person is frequently, & often expressing the avoidance features associated with PDA, & Consistent mood swings & impulsivity; it is highly likely to adversely impact social relationships the person has.

This makes sense it is often cognitively & emotionally exhausting to around a person who is essentially unpredictable, & expressing features/ behaviours which is difficult for those displaying them, & those around the person, to manage/ regulate.

It is natural for many persons in that situation to have anxiety, or to feel like they are "walking on eggshells". So it is unsurprising that many persons frequently expressing PDA behaviours will have issues forming & maintaining relationships/ friendships.

The point I am trying to make is that any person, who frequently expresses demand-avoidance features associated with PDA, over an extended period of time, can reasonably be expected to conform to DSM-5 autism category A (social communication issues) traits.

Does this make the person expressing these anxiety based RRBI's autistic? Hell no, does it!

Reason for this is that DSM-5 definition for Disorder includes:

"Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." (APA 2013, p20).

Most disorders within the DSM-5 have a phrase similar to this:

"the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." (APA 2013, p21).

This matters that, the central impairment in most Disorders can impact social functioning, i.e., having social issues due to RRBIs, or trauma, does not mean that a person has autism features, or "autistic traits" or "broader autism phenotype".

There are also issues with how social communication issues are common in Disorders, for example social stories are widely practiced outside of autism.

For some, the most egregious thing, is that it appears that "PDA as an ASD" supporters could be pathologising features twice, once for PDA, and then for autism. This is a no-go on the DSM-5.
https://eng.hejlskov.se/about-the-diagnosis-oppositional-defiant-disorder-odd/

The problem is, considering Help4Psychology view PDA as an ASD, we cannot be sure if their ASD & PDA diagnoses are autistic for autism features, or its clinicians conflating anxiety based RRBIs with autism social communication issues.

We already know they seem to have issues with viewing their experience is sufficient to definitely view PDA, while it contradicts the literature, with their apparent pervasive lack of non disclosure of conflicts of interests.

E.g. Help4Psychology would argue their experience is enough to argue PDA is developmental in nature. Despite the fact their views are open confirmation bias from PDA developmental features being generic & seeming not to cluster with demand-avoidance features.

Just because the clinic might specialise in diagnosing autism in females, does not mean their views on PDA cannot be biased. If anything, considering their stance their experience is enough to ignore divergent literature, probably is biased.

This is why it is bothering me. My concerns are reasonably, & probably valid.

@threadreaderapp Please can you unroll?

Thank you in advance?

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