Richard Woods @Richard_Autism

May 20 · 18 tweets · Richard_Autism/status/1527780197516382208

@milton_damian @Allison66746425 @Georgin24661487 @Andylowarousal @KatyBenson20 @Neurodiversit19
For anyone interested in PDA.
PDA Society is conducting a survey into research priorities of PDA.

Probably worth completing if you are for/ against PDA.
https://forms.office.com/pages/responsepage.aspx?id=ZjO7TrW5PU-dMb7qD3P6ZppkTARlbzpOmXCxaDTCBK9UMjRZU0tIMjY3RTVTUzI5Tjc5RFZZTThVVS4u

I have looked at some of the questions, & some are problematic (putting it mildly).

For example:
"Identification of PDA
From what age can PDA be identified? Can someone be PDA and not Autistic? Is it possible to have a reliable 'scale' for measuring all PDA traits?"

I think there are more fundamental questions to ask about PDA identification than those suggested. Also the axiology & methodology used in such research is likely to bias the results, reproducing poor quality research...

E.g. one would expect PDA to look different in autistics versus non-autistics. If one is researching PDA in non-autistics with tools validated on suspected autistic persons, one would expect the tool would show group differences between autistics PDAers and non-autistic PDAers...

While if one uses a tool which has been validated on a mixed group of autistic PDAers and non-autistic PDAers like the EDA-Q in O'Nions et al 2014a, the research should produce results of PDA is seen in autistics and non-autistics...

This has been the case in results from: Absoud (2019); Flackhill et al (2017); Reilly et al (2014); Eaton (2018). In order to suitably answer this question one needs to fundamentally revise axiology PDA research and stop assuming "PDA Profile of ASD"...

In order to ask is PDA is seen in non-autistic persons. One needs to first establish a diagnostic threshold for PDA, i.e., when does it count as a Disorder. Which is why I am researching for it my PhD!!!!!

https://www.youtube.com/embed/Bd60T6y6q-Y

In order to do that, I am not assuming PDA is a distinct anything. I am focusing purely on its demand-avoidance traits, the anxiety based RRBIs.

https://www.youtube.com/embed/7cCYoHV4li8

Cause once you know what threshold PDA counts as a Disorder at, one can then start assuming what PDA is, like assuming PDA is a "Profile of ASD".

They are missing a vital step in order to answer questions around identification & diagnosis.

"anecdotally, clinicians who recognise EDA report that they find a clear distinction between autism and EDA... In practice, it seems that clinicians are identifying a difference between the two which does not seem to be translating into research." White et al 2022, p7.

Book presently working through for background reading is Desperate Remedies by Andrew Scull. At point where it discusses spurious 1920s assertion Schizophrenia & Epilepsy rarely co-occurred with each other. We know this is not to be the case today.

Why am I mentioning this & the White et al 2022 quote?
Spurious assumption Schizophrenia & Epilepsy rarely co-occur together was based on anecdotal evidence & clinical intuition, which is exactly same fracking situation we see with those claiming "PDA Profile of ASD".

It is a massive assumption to think, that your experience, means that others views on PDA are mistaken. It is a massive assumption, unethical & risk to have "PDA Profile of ASD" as an axiom in PDA research based on your experience.

Why do I try to be inclusive of different views on PDA?
Many reasons, mainly because I am not stupid enough to assume any one view on PDA must be better/ more valid/ stronger than another's...

Many experts & research results suggest PDA is seen in non-autistic persons, so I revised my views to reflect the diverse opinions on the different groups PDA presents in.

Being open-minded to respect divergent views on PDA is important to producing good PDA theory & PDA research.

@threadreaderapp Please could you unroll?

Thank you in advance.

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