Richard Woods @Richard_Autism

Mar 25 • 18 tweets • Richard_Autism/status/1507423605495410689

Generating a table to inform materials for a PDA Seminar. So I created this table on two pages comparing different conceptualisations of PDA diagnostic levels, based on number of important areas of functioning (settings) demand-avoidance features are expressed in.

Table 1: Comparing various conceptualisations of Pathological Demand-Avoidance diagnostic thresholds, by areas of important functioning demand-avoidance features present in.

DSM-5 Oppositional Defiant Disorder Specifiers.	**DSM-5 Attention-Deficit/Hyperactivity Disorder.**	**DSM-5 Autism.**	**Help4Psychology PDA Definitions.**	**DSM-5 Obsessive-Compulsive Disorder.**	**DSM-5 Oppositional Defiant Disorder.**	**Transactional-stress model (Woods, 2021).**
"*Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).*" (APA, 2013, p462).	Not Applicable.	Not Applicable.	"*These are the children who start to display avoidant behaviour and challenging behaviour in response to a particular stressor (often school). This usually becomes more apparent around the age of 5-7, but can appear at the transition to High School.*" "*Rational Demand Avoidance*" (Eaton, 2018, p20). Proponents of the term Rational Demand Avoidance to describe all persons with PDA disagree with hot RDA is used in this context.	"*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.*" (APA, 2013, p237).	"*The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.*" (APA, 2013, p462).	"*the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.*" (APA, 2013, p21).
"*Moderate: Some symptoms are present in at least two settings.*" (APA, 2013, p463).	"*Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities). There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.*" (APA, 2013, p60).	Not Applicable.	Not Applicable.	Not Applicable.	Not Applicable.	Not Applicable.
"*Severe: Some symptoms are present in three or more settings.*" (APA, 2013, 463).	Not Applicable.	"*Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.*" (APA, 2013, p50).	"*demand avoidance had been present since early infancy and presented across contexts and time features of demand avoidance were noted in the child during the assessment process avoidance was pervasive and often seemed illogical or perverse (eg the child may be unable to eat when hungry) avoidance was not limited to a specific activity (or activities) or activities in a specific context (eg school)*" (Eaton & Weaver, 2020, p37).	Not Applicable.	Not Applicable.	Not Applicable.

I have used the DSM-5 Oppositional Defiant Disorder to do this (pp.462-463) & where possible quoted the diagnostic trait from a dx category equivalent to a quote on page 21, to note threshold where a feature is pathologised as a Disorder.

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

Table lists: ADHD, autism, OCD, ODD dx thresholds. Additionally, Help4Psychology Extreme Demand Avoidance & Rational Demand Avoidance definitions, with my own transactional stress model for PDA.

Mild level PDA corresponds to demand-avoidance features been expressed in one area of important functioning (either: educational, occupational, social, home, daily living activities).

Moderate level PDA corresponds to demand-avoidance features expressed in two areas of important functioning.

Severe level PDA corresponds to demand-avoidance features expressed in two important areas of functioning.

Before going further, I need to say I did check comparable dx thresholds for two attachment disorders in DSM-5 & BPD, but they lack equivalent criteria that maps easily into the above table (although BPD is pervasive). So they are not included.

While my transactional stress model for PDA does not intrinsically view PDA as a Disorder, the stressed &/ or distressed a person is, the more settings they will express demand-avoidance features in. My PDA model is equivalent to models which views PDA as a Disorder.

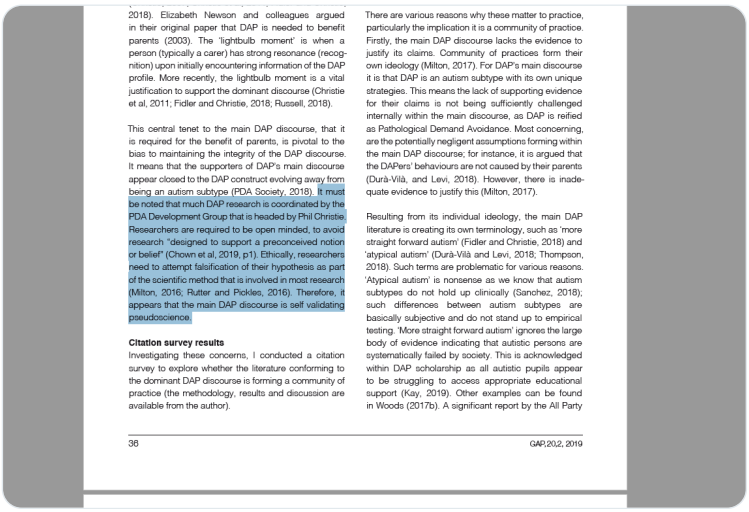
There are some interesting things to take from the table. That it is possible for PDA to be a neurodevelopmental disorder, if demand-avoidance features are expressed in only settings/ areas of important functioning.

OCD is interesting in how it gives a figure that demand-avoidance would need to be expressed for at least one hour per day, or significant distress in the person, or impact functioning in at least one area of important functioning.

ODD is similar to OCD, but demand-avoidance can be pathologised if it is associated with distress in either person expressing demand-avoidant behaviour, OR other persons around the person, like family, peer group, work colleagues. Or causing impairment to at least one setting.

ODD wording is interesting, in how impact of the demand-avoidance can be pathologised for the impact it CAUSES TO OTHER PEOPLE.

Help4Pscychology Extreme Demand Avoidance is equivalent to autism threshold, which impairments to all important areas of functioning. Suggesting an unethical & unscientific bias towards what PDA is (PDA Profile of ASD).



2018). Elizabeth Newson and colleagues argued in their original paper that DAP is needed to benefit parents (2003). The 'lightbulb moment' is when a person (typically a carer) has strong resonance (recognition) upon initially encountering information of the DAP profile. More recently, the lightbulb moment is a vital justification to support the dominant discourse (Christie et al, 2011; Fidler and Christie, 2018; Russell, 2018).

This central tenet to the main DAP discourse, that it is required for the benefit of parents, is pivotal to the bias to maintaining the integrity of the DAP discourse. It means that the supporters of DAP's main discourse appear closed to the DAP construct evolving away from being an autism subtype (PDA Society, 2018). It must be noted that much DAP research is coordinated by the PDA Development Group that is headed by Phil Christie. Researchers are required to be open minded, to avoid research "designed to support a preconceived notion or belief" (Chown et al, 2019, p1). Ethically, researchers need to attempt falsification of their hypothesis as part of the scientific method that is involved in most research (Milton, 2016; Rutter and Pickles, 2016). Therefore, it appears that the main DAP discourse is self validating pseudoscience.

Citation survey results

Investigating these concerns, I conducted a citation survey to explore whether the literature conforming to the dominant DAP discourse is forming a community of practice (the methodology, results and discussion are available from the author).

There are various reasons why these matter to practice, particularly the implication it is a community of practice. Firstly, the main DAP discourse lacks the evidence to justify its claims. Community of practices form their own ideology (Milton, 2017). For DAP's main discourse it is that DAP is an autism subtype with its own unique strategies. This means the lack of supporting evidence for their claims is not being sufficiently challenged internally within the main discourse, as DAP is reified as Pathological Demand Avoidance. Most concerning, are the potentially negligent assumptions forming within the main DAP discourse; for instance, it is argued that the DAPers' behaviours are not caused by their parents (Durà-Vilà, and Levi, 2018). However, there is inadequate evidence to justify this (Milton, 2017).

Resulting from its individual ideology, the main DAP literature is creating its own terminology, such as 'more straight forward autism' (Fidler and Christie, 2018) and 'atypical autism' (Durà-Vilà and Levi, 2018; Thompson, 2018). Such terms are problematic for various reasons. 'Atypical autism' is nonsense as we know that autism subtypes do not hold up clinically (Sanchez, 2018); such differences between autism subtypes are basically subjective and do not stand up to empirical testing. 'More straight forward autism' ignores the large body of evidence indicating that autistic persons are systematically failed by society. This is acknowledged within DAP scholarship as all autistic pupils appear to be struggling to access appropriate educational support (Kay, 2019). Other examples can be found in Woods (2017b). A significant report by the All Party

The purpose of the table is encourage people to think about HOW a features are pathologised & constructed in a Disorder. Also, how arbitrary it can be to favour anyone outlook on PDA over another.

It also shows that my PDA model can be equated to other conceptualisations of PDA. Just as other models for PDA can be compared to each other in an equivalent manner.

The table can be used to encourage reflection, in how ones bias impacts their construction of PDA, & how they research PDA.

The table should be a useful tool to interrogate underlying assumptions about PDA.

Just resharing images of two pages the table is across.

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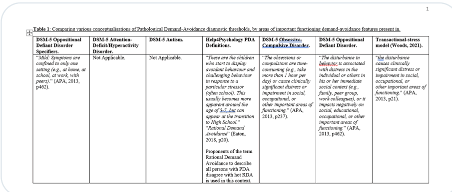

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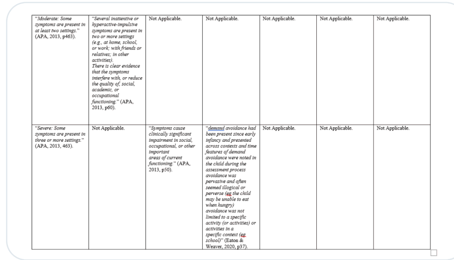

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Thank you in advance.

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