**PDA- Consider the literature.**

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Dear Editor.

A few years ago there was a short exchange regarding the nature of the proposed disorder Pathological Demand Avoidance (PDA). Clinically, PDA superficially appears similar to autism, due its having surface sociability and several anxiety based restricted and repetitive behaviours and interests (RRBIs), which centre on obsessive demand avoidance. Persons with PDA can also have atypical language development and speech delay (<https://tinyurl.com/y87kaw4f>). Initially, Rebecca McElroy explored the possibility it is a form of Attachment Disorder (<https://tinyurl.com/y7cs4x49>). Hilary Dyer countered that we should consider if PDA is a form of Autism Spectrum Disorder (ASD (<https://tinyurl.com/y7k79xyk>). I will highlight that there is little justification for viewing PDA as an ASD profile and that there is a good case to view its behaviours as associated with environmental factors or trauma.

PDA was originally proposed to be entirely genetic or biologically caused (<https://tinyurl.com/y87kaw4f>), consequently the behaviours and difficulties seen in PDA are not caused by environmental factors or by trauma. Our current understanding of mental disorders is that they lack any firm evidence for diagnostic biomarkers (<https://tinyurl.com/y5j6ypny>). Moreover, it is potentially negligent to view PDA behaviours as not originating from environmental factors or trauma (<https://tinyurl.com/y5plywee>).

There is substantial debate surrounding PDA. Crucially, the validity and specificity of PDA is not established (<https://tinyurl.com/ya6tzs8t>). Moreover, there is no consensus over how to conceptualise PDA, or how to diagnose it (<https://tinyurl.com/yaahlkc6>). PDA might be a form of Personality Disorder (<https://tinyurl.com/ycu8ghkp>). At least three Non-autistic persons are present in PDA research samples (<https://tinyurl.com/ydhqtg2p>; <https://tinyurl.com/y9n2xru5>); including one with Attachment Disorder with a total The Autism Diagnostic Observation Schedule (ADOS) score of one (<https://tinyurl.com/yb9crqwb>). PDA might be seen in up to a few percent of the human population (<https://tinyurl.com/y7wmu8o5>). PDA might not be caused by autism and thusly, is a “*double hit*” (<https://tinyurl.com/y8q8fpjr>), and that persons with PDA display possible precursors of Schizotypal Personality Disorder (<https://tinyurl.com/ya6tzs8t>). Similarly, a “*triple hit*” of autism, anxiety and conduct problems (<https://tinyurl.com/yaahlkc6>). Needless to say, if PDA is either: seen in non-autistic persons, its behaviours are not directly caused by autism, or is comprised of features external to autism; it cannot be an ASD subtype. Perhaps, PDA represents a new type of disorder (<https://tinyurl.com/ybh5fpqt>)?

There are clinical differences between PDA and autism, these include: (1) PDA strategies that involve novelty, spontaneity and humour contradict the traditional autism approaches that rely on structure; (2) The fantasy/ roleplay PDA trait is often absent or delayed in autistic persons (<https://tinyurl.com/y8he5fra>); (3) The frequency and variety of manipulative behaviours expressed by persons with PDA are not seen in autistic persons; (4) Surface sociability issues in PDA are attributed to deficits in social identity, not to deficits in Theory of Mind, as is the case for autism (<https://tinyurl.com/y87kaw4f>); (5) Dyer argues that anxiety drives a person with PDA’s need for control and its titular behaviours. The PDA literature recognises anxiety is a co-occurring difficulty for autism (<https://tinyurl.com/y8cxx8aq>). Collectively, these differences should exclude PDA from ASD and become the differential markers between the two conditions.

While Elizabeth Newson discovered PDA, it is often overlooked that she created her own diagnostic grouping “*Pervasive Developmental Coding Disorders*”, which contained: autism, dyslexia, dysphasia and PDA. Newson did this partly to make sense for caregivers and teachers. Furthermore, because she viewed ASD as being too narrowly defined (<https://tinyurl.com/yaboap2e>). Over time this diagnostic grouping evolved into Newson’s “*The Family of Pervasive Developmental Disorders*” diagram (<https://tinyurl.com/y87kaw4f>). Importantly, this diagram accepts Classic/ Kanner’s autism and Asperger’s Syndrome as both overlapping each other and based on the triad of impairment. PDA is conceptualised separate from triad of impairment, but connected via genetic and environmental links. PDA has 6 core traits, more than the triad of impairment and this matters as the latter underpins modern autism diagnostic practice (<https://tinyurl.com/ycr76deh>). The low functioning ASD pole contains additional learning difficulties, but these are co-occurring conditions to it. Classic/ Kanner’s autism can be diagnosed without these. The diagram also includes Specific Language Impairments, but this is not a recognised autism subtype or a Pervasive Developmental Disorder. A similar situation applies to how some PDA supporters view the Neurodevelopmental Disorder, Attention Deficit Hyperactivity Disorder (ADHD) as an ASD (<https://tinyurl.com/ybqrafof>). Effectively, PDA has never actually been an autism subtype.

Dyer worked almost exclusively with those she thought had PDA consequently she had selection bias from the comparatively limited exposure to what PDA might fully look like. Professor Christopher Gillberg posits PDA is common and is a co-occurring condition for: Anorexia Nervosa, ADHD, some behavioural phenotype syndromes, Epilepsy, Japanese construct of Hikikomori, Language Disorders, school refusal and selective mutism (<https://tinyurl.com/ybh5fpqt>). Vitally, it must be said absence of evidence is not evidence of absence. There is more evidence other professional’s opinions on PDA, like Rebecca McElroy, are as valid as Hilary Dyer’s.

Multiple studies suggest aetiology of PDA might be from environmental factors or trauma and supporting form of Attachment Disorder or Personality Disorder. The latter are viewed as maladaptive responses to stress. Some varieties are specifically associated to attachment difficulties, such as Borderline Personality Disorder. An interesting case study has possible signs of attachments issues (<https://tinyurl.com/ybqrafof>). There are associations between Conduct Disorder, ADHD and PDA (<https://tinyurl.com/yyncg4xo>). Two adult community samples found associations between PDA behavioural indicators of personality disorder (<https://tinyurl.com/y5k2f5wy>). That some research suggests that PDA can be explained by interaction of various common co-occuring conditions (<https://tinyurl.com/y2b6gzz9>), majority of these conditions are associated to childhood trauma/ aversive experiences (<https://tinyurl.com/y4m33ua8>). Many infants around the age of 6 transitioned into PDA, with the cause often being an aversive school experience and the main screening tool detects PDA in children who have suffered trauma or attachment difficulties (<https://tinyurl.com/yyq8vpot>). Many of the features assessed by PDA’s validated screening and diagnostic tools are associated with trauma (<https://tinyurl.com/y347g567>). Combined with the numerous problems fitting PDA in the autism spectrum, it is reasonable to view PDA’s aetiology as being related to trauma or aversive experiences.

We are in the age of participatory research for service users (<https://tinyurl.com/yykuljot>). Ethically research needs scientific method and not designed to support preconceived ideas. The empirical evidence mentioned and case studies discussed in this letter indicate that PDA is seen in non-autistic persons (<https://tinyurl.com/y45jwy2h>). These individuals have equal rights to a PDA diagnosis (<https://tinyurl.com/yxgqgjzh>) and research. Going forward there is a need for inclusive scientific method based PDA research.

Yours faithfully.

Mr Richard Woods.