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'Pathological Demand Avoidance' (PDA) is a controversial concept. First coined by Elizabeth Newson in the 1980s, it has attracted heated debate from many angles. However, many trusts have begun to adopt consensus position statements, and while these have also not been free from debate and controversy, ours allows us to comfortably view PDA as a recognisable profile within the autism spectrum, and so turn our attention to a different set of debates: what does it mean? What do we, as professionals, do? And how, if at all, is it different?

The defining feature of PDA is an avoidance of apparently ordinary demands, due to what many describe as an 'anxiety driven need for control'. These children often present with a cluster of other features: the surface sociability, extreme lability of mood and confusion of fantasy and reality are well recognised, but we are also spotting a hypersensitivity to others' emotional states, creativity, a love of animals, a lack of understanding of hierarchy and particularly high abilities to 'mask', especially in school.

Our clinical work teaches us much every day about what demands mean for those with PDA. The breadth of demands is big; they can be little tasks like picking up socks to big trips to school or further afield; they can be explicit instructions to act or implicit expectations from those supporting them; they are more obvious when from an external person or source but can also be internal demands such as needing the toilet, or even the urge to sleep. This breadth of demands is equalled by a depth of anxiety. This anxiety can present as a classic flight/flight/freeze presentation or a child using all the social strategies available to them to avoid, delay or try to control (sometimes experienced as 'manipulating') to prevent the anxiety they feel is coming.

As a team supporting parents working in a little-researched area, our approach is growing with our understanding. Many have found the conventional approaches for autism and behaviour (such as structure, routine, rewards and consequences) less effective or even contraindicated in this subset of the spectrum, and the approaches recommended by the PDA society including negotiation, flexibility, humour and disguising demands provide a useful jumping-off place for our work.

We have found hope in taking this further; drawing on the work of interpersonal neurobiology and borrowing ideas from therapeutic parenting and mindfulness, we are developing an approach rooted in connection, co-regulation, empathy, transparency, collaboration and as much freedom as parents can allow within clear safety boundaries. Contrary to classic anxiety models which require exposure before anxiety abates, when these children start to feel safe, heard and in control, they are able to learn to regulate and consistently choose to challenge themselves.

Our work is evolving daily, and explicitly based on practice-based evidence in the absence of clear guidelines for evidence-based practice. We are excited to attempt to establish some research and hopeful about connecting with other professionals to do so. But as we work tentatively in this direction, one thing strikes us. It's said that PDA parenting looks very different to parenting for others on the spectrum, and from 'classic' parenting models (largely based on possibly outdated behaviourist approaches and still widely taught in parenting groups). Instead we wonder if this different (possibly radical) approach to raising and supporting children is in fact 'gold standard' parenting, for those on the spectrum and off it.

Kristy Forbes (expert-by-experience) calls PDA a 'Pervasive Drive for Autonomy'. So when formulating our cases, and designing our approach, we think less about a pathology needing to be overcome, and instead about what Psychologists for Social Change deem the 5 qualities of a psychologically healthy society: agency, security, connection, meaning and trust.

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