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Child and Youth Mental Health Services

Pathological Demand Avoidance (PDA) in Autistic & ADHD Children

A guide for parents and caregivers



Dear Parents and Caregivers,

We understand the profound isolation of feeling completely stuck, the frustration of searching through advice that doesn't work, and the painful shortage of genuinely trustable resources. Raising and supporting a neurodivergent child carrying an intense need for autonomy can leave you feeling drained, uncertain, and deeply overwhelmed as a caregiver.

If you are currently navigating exhausting meltdowns, emotional distance, or the quiet ache of wondering whether you are doing enough for your child, I want to start by offering you this simple, essential truth: You are not failing, and you are not alone.

In our work alongside families, we have learned that behind every challenging behavior—whether it presents as sudden anger, intense resistance, deep anxiety, or tearful shutdowns—lies a young person attempting to navigate an emotional world bigger than their current capacity to understand or express. Behavior is the language of an unintegrated feeling, a sensory overload, or a silent plea for safety and co-regulation.

Throughout our work in expanding emotional literacy, developmental learning, and emotional regulation, our primary goal has been to help children build the inner vocabulary and somatic awareness needed to identify their feelings. When a child learns that an emotion is not a scary intruder but a temporary signal that can be named, held, and safely expressed, everything begins to shift.

Yet, true transformation never happens in isolation. The most impactful therapeutic work always flows through you—the parent. We have watched parents who felt completely exhausted and at their limit gently learn how to move from reactive survival mode into compassionate co-regulation. It is in those quiet, subtle moments—when an adult pauses, breathes, and offers a grounded, reassuring presence instead of demands—that a dysregulated child feels truly seen and safe.



Building emotional literacy and regulation in your child is not about achieving perfect discipline or seamless days. It is about creating a home environment anchored in connection over compliance, curiosity over judgment, and repair over perfection. On the days when patience wears thin and frustration takes over, please remember that rupture and repair are part of the human experience. Returning to your child with open arms and soft words teaches them that love and safety are unconditional.

Our hope in writing this reflection is to offer you validation, reassurance, and renewed gentle confidence. We have gathered these resources for you in the hope that they provide a small measure of support in the ocean of emotional milestones for you and your family. Your dedication to your child, even on the hardest days, is a quiet act of courage. With time, tailored strategies, and steady co-regulation, peace and understanding can be restored in your home.
Thank you for the love, resilience, and heart you pour into raising your children every day.

Warmly and with deep respect,

A Dedicated Clinical Team
Combining Professional Expertise, Academic Understanding, and Lived Experience

Pathological Demand Avoidance (PDA) in Autistic & ADHD Children

Pathological Demand Avoidance (PDA)—increasingly recognized within neurodiversity communities as a Pervasive Drive for Autonomy—describes a neurodivergent profile characterized by an innate, nervous-system-driven resistance to the demands of everyday life. Far from intentional defiance or willful disobedience, PDA is rooted in an autonomic threat response where any perceived loss of autonomy triggers acute survival panic.

Distinguishing PDA from ODD:

While Pathological Demand Avoidance (PDA) and Oppositional Defiant Disorder (ODD) can superficially present with similar outward behaviors, their underlying neurobiological mechanisms are fundamentally different.

PDA is driven by an automatic nervous system threat response, where demands trigger intense survival panic and a heightened need for autonomy to regulate extreme anxiety. In contrast, ODD is typically characterized by volitional opposition, intentional defiance, and rule-breaking behavior, occurring without the panic-driven threat response or severe autonomic shutdown seen in PDA.

1. Recognising the PDA Profile in Children and Teenagers Across Settings
The PDA profile presents uniquely because its primary features center around social avoidance strategies rather than traditional autistic social withdrawal.

Socially Mediated Avoidance: Before escalating to overt meltdowns, PDAers typically use sophisticated social maneuvers to bypass demands. These include distraction, changing the topic, offering elaborate excuses, negotiating alternative terms, procrastination, or retreating into fantasy roles and character play.

Equal Footing & Authority Resistance: PDA children and teens interact from an innate assumption of social equality. Traditional top-down authority structures (such as adult-child hierarchies) feel artificial, threatening, and intolerable.
Intense Mood Fluctuations Driven by Need for Control: A PDAer can shift rapidly from calm and engaging to distressed or explosive the moment their perceived control slips.

Internal Demands: Avoidance does not apply only to externally imposed tasks. PDAers regularly struggle to initiate self-care (eating, using the bathroom, sleeping) or activities they genuinely love because the body's internal cues act as internal demands.

The "Jekyll and Hyde" Contrast Across Settings:

School (Internalized / Masked): Many PDA youth mask intensely at school. Driven by a fear of standing out or losing social standing, they present as quiet, compliant, or passive learners (the fawn or freeze response), often at tremendous physiological cost.

Home (Externalized / The "Coke Bottle Effect"): Once in a safe environment, the bottled pressure releases. Caregivers often experience intense defiance, panic meltdowns, or aggression that school staff do not observe, leading to systemic invalidation of the family's reality.

Shutdown & Burnout: Prolonged unaccommodated demands lead to autistic catatonia, school attendance barriers, severe executive dysfunction, and chronic nervous system burnout.

2. Key Drivers: Why Demand Avoidance is Intense and Persistent

Demand avoidance in PDA is not an oppositional behavioral choice; it is an involuntary, neuroceptive threat response.

Faulty Neuroception (The Threat Detector): The autonomic nervous system constantly scans the environment for safety or danger. For a PDAer, demands, expectations, transitions, and direct questions are perceived as immediate threats to survival. The amygdala activates a fight, flight, freeze, or fawn response.

Autonomy as Safety: Autonomy is not a preference for PDA individuals; it is their baseline condition for feeling safe. An order, routine, or expectation removes choice, triggering panic.

The Escalation Hierarchy: As illustrated in the PDA Society escalation model, demand resistance begins with subtle, socially mediated strategies (procrastination, humor, withdrawal). If pushed past their tolerance threshold, the individual rapidly escalates to panic behaviors: running away (flight), verbal or physical aggression (fight), or dissociation and mutism (freeze).

Demand Stacking and the "Tolerance Bucket": Demands are cumulative. Sensory processing challenges (fluorescent lights, clothing textures), social navigation, fatigue, hunger, and unexpected events fill an internal bucket. When the bucket is full, a microscopic demand (e.g., "Put on your socks") triggers an explosive response because the nervous system has zero reserve capacity left.

3. Current Conceptualisation: Research, Clinical Practice, and Neurotypes

First described in the 1980s by UK child psychologist Elizabeth Newson, PDA was observed in children who showed autistic traits alongside significant social interest, pretend play, and an overwhelming resistance to ordinary demands.

- Diagnostic Status: PDA is not recognized as a separate stand-alone diagnosis in the DSM-5 or ICD-11. Instead, clinical consensus in regions such as the UK, Australia, and Scandinavia identifies PDA as a distinct dimensional profile or constellation of traits within the autism spectrum.

- The AuDHD Nexus: PDA traits occur with high frequency in individuals who are both Autistic and ADHD (AuDHD):

- ADHD executive dysfunction and dopamine seeking creates chronic friction with routine and task initiation.
- Autistic sensory sensitivities and rigid processing make unpredictable environments overwhelming.
- Rejection Sensitive Dysphoria (RSD), common in ADHD, compounds the vulnerability of PDAers to perceived criticism, instructions, or loss of equality.

The Failure of Standard Behavioral Interventions: Traditional approaches—such as Applied Behavior Analysis (ABA), token economies, star charts, and "consequence-based" parenting—reliably exacerbate distress. Why? Because a reward is simply a conditional demand ("Do this to get that"), and a consequence introduces coercion, elevating nervous system panic.

4. Increasing Confidence to Understand and Support a PDAer

Supporting a PDA child or teenager requires discarding conventional compliance models and rebuilding intuition around nervous-system co-regulation.

- Separate Capacity from Willingness: Acknowledge that a child's capacity fluctuates hour by hour depending on nervous system load. The fact that they completed a task yesterday does not mean they possess the physiological capacity to complete it today.
- Become a Co-Regulating Safe Harbor: You cannot regulate a dysregulated child with your own dysregulated nervous system. Staying grounded, speaking softly, slowing down your body language, and avoiding direct eye contact or towering physical postures de-escalates baseline threat detection.
- Validate the Underneath Emotion: Acknowledge their felt panic rather than arguing with their outward behavior: "I can see how overwhelming this feels right now. We don't have to figure it out this second."

5. Setting Realistic Expectations and Maintaining a Supportive Mindset

- **The "Low-Demand" Lifestyle:** Intentionally drop every demand that does not involve immediate safety. Non-essential hygiene, bedtimes, chores, formal table manners, and rigid attire can be scaled back or removed to allow a hyper-aroused nervous system to reset.

- **Radical Acceptance:** Accept your child's timeline rather than societal developmental markers. PDAers often take non-linear, self-directed paths to functional independence.

- **Pick Your Battles Relentlessly:** Categorize demands into a three-tiered system:

- **Non-Negotiables (Safety):** Seatbelts, holding hands near traffic, acute medical needs. Keep these minimal and firm.

Negotiable / Flexible: Schoolwork formats, clothing choices, bedtime routines. Open these up to joint problem-solving.

Dropped Demands: Everything else. Let them go without guilt.

Shedding Caregiver Guilt: Decondition yourself from external judgment (e.g., from relatives or educators who misunderstand low-demand parenting as "permissive" or "spoiling"). Low-demand approaches are therapeutic accommodations for a disabled nervous system, not a lack of structure.

6. Evidence-Informed Strategies for Home, School, and Therapy

The PANDA framework, developed by the PDA Society, outlines the essential pillars of effective accommodation:

P — Pick battles: Drop unnecessary expectations; prioritize physical and emotional safety.
A — Anxiety management: Recognize demand avoidance as fear; provide advance predictability without rigidity.
N — Negotiation and collaboration: Treat the child as an equal partner in problem-solving.
D — Disguise and manage demands: Rephrase direct demands into indirect, collaborative formats.
A — Adapt tolerations: Match demands to real-time capacity; remain flexible when tolerance is low.

Home Settings

Declarative Language: Replace imperative commands ("Put on your shoes") with observational statements ("The shoes are near the door," or "I'm heading outside in five minutes"). This removes the directive pressure and lets the child's brain independently initiate the action.

Indirect Requests: Frame tasks humorously, playfully, or via a third party (e.g., talking to a pet, writing a silly note, using visual props instead of verbal commands). Genuine Choice: Rather than "Eat your dinner," offer autonomous choices: "Would you prefer to eat at the table, on the floor, or take it on a tray to your room?"

School Settings

Relational Safety First: PDA youth learn from people they trust, not institutions they fear. A designated key adult who interacts without demands or judgment is the single most effective school-based accommodation.

Flexible Engagement & Output: Allow non-traditional methods of demonstrating knowledge (typing, voice recording, drawing, or co-creating projects).

Drop Public Behavioral Displays: Remove public sticker charts, clip-up/clip-down boards, and attendance awards, which induce severe shame and trigger autonomic fight-or-flight responses.

Sanctuary Spaces: Provide unconditional access to quiet, low-sensory breakout rooms without requiring the student to justify their distress or earn permission.

Clinical & Therapy Settings

Non-Directive, Interest-Led Sessions: Abandon structured worksheets, standardized drills, or rigid agendas. Therapy must follow the PDAer's special interests and current passions.

Zero Performance Pressure: We avoid testing, quizzing, or assigning home practice tasks. Emphasize side-by-side collaboration (such as parallel play, building together, or shared gaming) rather than face-to-face evaluation.

7. Strategies PDA Youth Find Genuinely Helpful

When asked directly what helps them feel regulated, children and teenagers with a PDA profile highlight these specific practices:

"Don't Tell Me What to Do—Ask Me What I Think": Teens report that commands immediately trigger an involuntary bodily urge to say "No," even when they want to do the task. Asking for their input preserves autonomy and invites cooperation.
Give the Real 'Why': Arbitrary rules ("Because I said so") trigger immediate resistance. PDA youth respond far better to transparent, logical explanations based on practical mechanics or genuine personal impact.

Offer an Unconditional Escape Route: Knowing they can leave an event, drop a class, or pause a conversation whenever they need to drastically reduces baseline anxiety, making participation far more likely.

Side-by-Side Co-Presence (Body Doubling): Rather than standing over them supervising, quietly working on your own project nearby provides gentle momentum without perceived judgment or control.

Decompression Without Surveillance: After school or social events, PDA youth need complete freedom from questions, check-ins, or expectation of conversation. Uninterrupted time with safe hyperfixations allows their nervous system to recalibrate.

Humor and Novelty: A playful, absurd reframing dissolves tension faster than earnest reasoning. Irony, banter, and silly challenges neutralize perceived demands by removing seriousness and control dynamics. Declarative language replaces commands, direct questions, and conditional demands with statements that share information, observe physical reality, or think out loud. For a PDA nervous system, an imperative ("Put on your shoes") is interpreted as an immediate loss of autonomy and a neuroceptive threat. A declarative statement ("The sneakers are by the front door") provides neutral data, leaving cognitive space for the individual's brain to process the context and initiate the action voluntarily.

Declarative Language Conversion Chart

Category	Typical Imperative (Avoid)	Why It Triggers Threat	Declarative Script (Say Instead)	Contextual Delivery Note
Hygiene	*"Brush your teeth right now."*	Imposes immediate control; triggers resistance to sensory assault.	*"The toothbrush has the strawberry paste ready on the counter."*	Walk away after stating; do not stand and watch.
Hygiene	*"You smell, go take a bath or shower."*	Induces shame; demands a high-friction sensory transition.	*"I'm running a warm shower and turning on the dim light in the bathroom."*	Focus on sensory comfort; pair with zero immediate pressure to enter.
Hygiene	*"Let me brush your hair, it's a tangled mess."*	Threatens physical boundaries and autonomic safety.	*"The wide-tooth comb and detangler spray are sitting right by the sofa."*	Offer side-by-side availability while they are engaged in a special interest.

Category	Typical Imperative (Avoid)	Why It Triggers Threat	Declarative Script (Say Instead)	Contextual Delivery Note
Hygiene	*"Did you wash your hands with soap?"*	Interrogative questioning triggers defensiveness or lying to self-protect.	*"There's a fresh warm towel and the foaming soap by the sink."*	Frame as an observation of available resources, not an audit of compliance.
Hygiene	*"Put on clean clothes, we're going out."*	Multi-step motor planning demand coupled with sensory uncertainty.	*"The soft cotton hoodie and seamless joggers are laid out on the chair."*	Pre-select sensory-safe clothing together during regulated windows.
Transitions	*"Turn off your console/iPad now; time is up."*	Abrupt loss of dopamine, control, and immersion in a safe interest.	*"I see you're in the middle of a build. I'm setting this 10-minute timer on the counter so you can find a safe saving spot."*	Place the timer out of direct line-of-sight; respect their game progress.
Transitions	*"Put your shoes and coat on, we are late."*	Urgency and external panic stack onto sensory and motor demands.	*"The car is unlocked and warming up; I'm grabbing my keys and heading out to the driveway."*	Announce adult movement rather than commanding child movement.
Transitions	*"Get out of the car, we've arrived."*	Pressures immediate orientation to an altered environment.	*"We've arrived at the clinic. There's no rush—we have 4 minutes to just sit here and listen to this track finish."*	Creates an intentional transition buffer to recalibrate the nervous system.
Transitions	*"Stop doing that and come help me carry the bags."*	Forces an abrupt task-switch across monotropic focus channels.	*"These grocery bags are surprisingly heavy; I'm wondering if one of us could grab the cold milk carton."*	Uses "I wonder" to invite collaboration without a direct instruction.
Transitions	*"Say goodbye and thank you to grandma."*	Social performance demands; forces eye contact and scripted reciprocity.	*"Grandma is waving by the door as we leave."*	Model the greeting or farewell yourself without demanding mimicry.
School	*"Open your notebook and write down the date."*	Top-down classroom authority triggers fight-or-flight freeze.	*"The date is up on the white board for whenever you're ready to set up the page."*	Provide low-stakes written anchors in the room instead of verbal prompts.
School	*"Start your math worksheet; question 1 is easy."*	Minimizing task difficulty invalidates internal executive dysfunction.	*"Number 1 has a pretty neat pattern. I'm going to do number 2 on my scrap paper and see what happens."*	"Parallel work" / body doubling. Start working yourself to draw them in.

Category	Typical Imperative (Avoid)	Why It Triggers Threat	Declarative Script (Say Instead)	Contextual Delivery Note
School	*"What is the answer to this question, [Name]?"*	Public surveillance triggers social exposure panic and mutism.	*"Some people think the answer is X, while others think it might be Y. It's an interesting debate."*	Direct questions shut down access to speech; open hypotheses invite engagement.
School	*"Pack your backpack and clean up your desk."*	High cognitive load and executive planning fatigue at day's end.	*"The bell rings in five minutes; I notice your pencil case and folder are on the floor."*	Point out physical cues; offer non-verbal assistance side-by-side.
School	*"Go to room 14 for your therapy session."*	Abrupt change of environment, adult, and expectation.	*"Sarah from speech is here in the quiet nook. I'm walking over that way if you want to walk with me."*	Offer shared locomotion and co-presence rather than an order to relocate.
Mealtimes	*"Eat your vegetables / Take two more bites."*	Interoceptive and sensory control violation; triggers immediate gag/refusal.	*"The broccoli has garlic salt on it today; there's extra ranch dressing on the bench if anyone wants it."*	Separate food presence from the demand to consume it.
Bedtime	*"Go to sleep right now; close your eyes."*	Sleep is an internal biological demand; commanding it causes insomnia and panic.	*"The room is dark and cool. The audio book is set on a 30-minute sleep timer."*	Shift focus from "sleeping" (impossible to force) to "resting the body."

Four Traps That Invalidate Declarative Language

The "Disguised Imperative" (False Declarative):
Trap: "I noticed you haven't put your shoes on yet, so you need to do that."
Adding an imperative clause at the end or emphasizing a frustrated tone immediately reveals the underlying demand.

Correction: State only the observation and stop talking: "The boots are by the door."

The "Expectant Pause" & Eye-Contact Pressure:
Trap: Saying a declarative sentence, then leaning forward, staring intently at the PDAer, and waiting for immediate compliance. Direct gaze and hovering presence register as surveillance and coercive pressure.

Correction: Deliver the observation casually while looking away, moving to another task, or exiting the immediate room. Give processing space.

Treating "I Wonder" as a Stealth Question:
Trap: "I wonder why you haven't finished your math yet?"
This is a passive-aggressive interrogation, not declarative curiosity.
Correction: "I wonder if using the calculator for the first three problems makes this less exhausting."

Not Allowing Enough Latency Time:
PDA individuals frequently require 30 to 90 seconds (or several minutes during periods of high demand stacking) to internally register an observation, process threat safety, decide to engage, and initiate motor movement.
Correction: Count silently to 30 before considering any additional non-intrusive support.

Resource 1: 1-Page Declarative Language Cheat Sheet for School Staff

Core Rule: Replace commands and direct questions with neutral observations, shared curiosity, and self-talk. Speak to share information—not to enforce compliance.

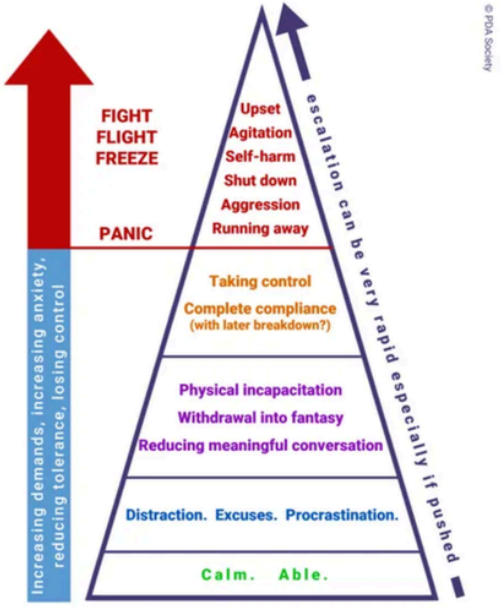


Image credit: PDASociety.org.uk

Quick Substitution Guide

Situation	Don't Say (Imperative / Threat)	Say Instead (Declarative / Neutral)
Starting a Task	*"Open your book to page 45."*	*"We're looking at page 45 for the diagram."*
Direct Questioning	*"What is the answer to question 3?"*	*"Question 3 has two different possibilities—it's tricky."*
Transitioning	*"Pack away your materials; it's recess."*	*"The bell is in 2 minutes; the supply bins are open on the back counter."*
Disruptive Energy	*"Sit down and stop talking."*	*"I'm having trouble hearing the presentation over the noise."*
Task Stalling / Freeze	*"Why haven't you started yet?"*	*"Number 1 looks long. I'm going to grab a highlighter and mark the key words."*
Seeking Assistance	*"Raise your hand if you need help."*	*"I'm hanging out right by this side table if anyone wants a second pair of eyes."*
Leaving the Room	*"Sit back down; you didn't ask for a pass."*	*"The calm break cards are on the front corner of your desk whenever you need one."*

Essential Delivery Rules for Educators

Drop the Hover: Once you state a declarative sentence, look away, attend to another student, or take two steps back. Hovering converts a declarative statement into a non-verbal command.

Respect the 30-Second Rule: A PDA nervous system requires substantial latency to process safety, evaluate the request, and initiate motor execution. Count silently to 30 before intervening or repeating.

Side-by-Side Positioning: Avoid standing directly in front of the student or towering over their desk. Kneel or sit at an angle to place your eyes level with or slightly below theirs.

Acknowledge Capacity Drops: If a student could complete a task yesterday but refuses today, their autonomic bucket is full. Reduce cognitive volume immediately rather than enforcing standard output.

Resource 2: Adapting Declarative Language for Teens (Ditching "Therapy Speak")

Teens have highly tuned social radars. Overly gentle scripts, sing-song tones, or canned phrases like "I notice that you're feeling frustrated" or "I wonder if..." feel manipulative and condescending, immediately triggering resistance.

To adapt declarative communication for teenagers, shift to authentic peer-level transparency, logistical data-sharing, and shared humor.

Traditional "Therapy-Speak"	Authentic Teen Declarative
"I notice you haven't started your essay."	*"That essay prompt is absolute garbage."*
"I wonder if you'd like to take a shower?"	*"Hot water is all yours. The bathroom is clear."*
"You seem angry. Let's use a coping skill."	*"Fair enough. I'll be in the kitchen if you need me."*

1. Validate the Absurdity (Aligning Against the System)

Teens respond when adults acknowledge that a rule, expectation, or assignment is frustrating, boring, or inconvenient:

Instead of: "You need to finish this history module to pass."
Try: "This curriculum is pretty dry. The rubric only requires three bullet points to get credit, so you can do the bare minimum and get it out of the way."

2. Share Raw Logistical Facts (No Coaching Attached)

Remove all advice, emotional labeling, or implied expectations. Deliver raw information and give them space to react:

Instead of: "Put your phone away and get ready, the orthodontist appointment is soon."
Try: "We have to pull out of the driveway at 3:15 to make the 3:45 slot." (Then walk away).

Resource 3: Step-by-Step Low-Demand Bedtime Protocol

Bedtime is often the most volatile period for a PDA individual. Sleep is an unavoidable biological demand, the autonomic nervous system is exhausted from a day of masking, and the quiet, dark environment removes sensory distractions, allowing racing thoughts and anxiety about the next day to surface.
The goal is to eliminate the demand of "going to sleep" and replace it with "low-sensory decompression and resting the body."

Phase 1 (90 Minutes Out): Drop the evening social demand stack and transition into self-directed dopamine.
Phase 2 (45 Minutes Out): Shift to sensory-safe hygiene with flexible, side-by-side autonomy.
Phase 3 (In Bed): Engage brain anchors (audiobooks, podcasts) to bypass anxious internal monologues.
Phase 4 (Settling): Maintain zero sleep pressure with low-presence adult co-regulation.

Phase 1: The Evening Decompression Buffer (90–60 Minutes Out)

Eliminate Curfew Reminders: Avoid countdowns like "10 minutes until bedtime!" Countdowns trigger anticipatory panic.
Sensory Environment Shift: Gradually dim overhead lights and switch to warm, indirect lamps throughout common living areas. Reduce house volume without making an explicit announcement.
Sustained Dopamine Access: Do not cut off safe hyperfixations abruptly. Let them transition smoothly by keeping comforting media or creative projects accessible.

Phase 2: Low-Demand Hygiene (60–30 Minutes Out)

Decouple Hygiene from Sleep: Move showers, baths, or tooth brushing to earlier in the afternoon or right after dinner so they are not associated with the threat of bedtime.
Offer Sensory-Safe Workarounds: If brushing teeth is unbearable: Use unflavored or fruit-flavored non-foaming paste, disposable finger wipes, or a quick mouthwash rinse.

If changing into pajamas triggers sensory resistance: Sleeping in soft, clean day clothes (like seamless joggers and an oversized tee) is completely acceptable.
Declarative Setups: Place supplies in plain sight rather than giving instructions: "Clean towels and fresh water are on the counter."

Phase 3: The Sanctuary Bed Setup (30–0 Minutes Out)

Reframe the Goal: Explicitly state: "You don't have to sleep tonight. Your only job is to let your body rest in bed." This removes performance anxiety around falling asleep.
Implement "Brain Anchors": Silence allows demand-related anxiety and existential dread to spiral. Provide continuous, low-threat auditory input to occupy the brain's focus:

- Audiobooks of familiar, comforting stories.
- Sleep podcasts with monotone, calming hosts.
- Brown noise, rain tracks, or low-frequency soundscapes.
- Tactile and Proprioceptive Support: Heavy blankets, compression sheets, or body pillows provide regulating nervous system input.

Phase 4: Settling & Adult Exit

Parallel Low-Demand Co-Presence: If the child cannot tolerate being alone, sit nearby engaged in a quiet, non-interactive task (reading a book with a book-light, journaling). Do not stare at them or monitor whether their eyes are closed.

Predictable Check-Ins: If they fear abandonment upon your exit, offer scheduled check-ins without them needing to call for you:

"I'm going downstairs to make tea. I'll pop my head in to check on you in 10 minutes."

Emergency Midnight Snacks: Keep accessible, non-spoilable protein/carb snacks (granola bars, crackers, water bottle) right next to the bed so middle-of-the-night hunger does not turn into an overwhelming logistical task.

References and Resources

Books & Publications

- Fidler, R., & Christie, P. (2019). Collaborative and Flexible Strategies for Teaching Learners with a PDA Profile. Jessica Kingsley Publishers. (Essential guide for educators and practitioners).
- Sherwin, J. (2021). Declarative Language Handbook: Using Language to Encourage Peer Interaction, Problem Solving and Inner Guidance. Communication Enrichment Press. (Core resource for non-demand communication).
- Duncan, S. (2021). The Parent's Guide to Pathological Demand Avoidance: Strategies for Raising a Child with PDA. Jessica Kingsley Publishers. (Practical home strategies).
- Ehlers, S., & Gillberg, C. (2000). The Essential Guide to PDA. (Clinical overviews for families and multidisciplinary teams).

Lived Experience & Advocate Platforms

- Kristy Forbes – inTUNE Pathways (kristyforbes.com.au): Australian autistic/PDA advocate and educator offering courses, webinars, and family support focused on neurodivergent-affirming practices.
- Sally Cat PDA (sallycatpda.co.uk): Lived-experience graphic designer and advocate known for visual explanations of the PDA internal state and autonomic nervous system responses.
- Raelene Dundon – OAM / Autism Advocates: Clinical psychologist specializing in positive behavior support, declarative language, and PDA profile accommodations.
- Steph's Two Nerves (stephstwonerves.com): Personal account and blog focusing on adult PDA, burnout recovery, and low-demand living strategies.

Organizations, Communities & Web Portals

- The PDA Society (UK) (pdasociety.org.uk): The global lead organization for PDA information, training materials, booklet downloads, and family support networks.
- Reframing Autism (reframingautism.org.au): Australian neurodivergent-led organization offering resources on neurodiversity-affirming approaches and demand avoidance support.

- Embrace Autism (embrace-autism.com): Academic-backed research hub offering psychometric screening tools, including adult and pediatric EDA scales.

- PDA North America (pdanorthamerica.org): Regional advocacy organization providing educational resources, local support networks, and practitioner training.

Clinical & Academic Literature

- Newson, E., Le Maréchal, K., & David, C. (2003). Pathological demand avoidance syndrome: A necessary distinction within the pervasive developmental disorders. Archives of Disease in Childhood, 88(7), 596–600.
- Egan, V., Linenberg, O., & O'Nions, E. (2019). The Extreme Demand Avoidance Questionnaire – Adult version (EDA-QA): Initial development and validation. Journal of Autism and Developmental Disorders, 49(10), 4190–4201.
- O'Nions, E., Happé, F., Viding, E., & Noens, I. (2021). Extreme Demand Avoidance in Children with Autism Spectrum Disorder: Refinement of a Caregiver-Report Measure (EDA-8). Advances in Neurodevelopmental Disorders, 5(3), 269–281.
- Woods, R. (2020). Demand avoidance phenomena: circular reasoning, normative beliefs and the pathologising of autistic behaviour. Good Autism Practice (GAP), 21(1), 28–40.

Key Practical Tools & Frameworks

- Low-Arousal Approach: Strategies developed by Studio 3 (studio3.org) focused on reducing stress, managing crisis gently, and avoiding power struggles.
- Pervasive Drive for Autonomy Perspective: Conceptual framework recasting demand avoidance as anxiety-driven safety-seeking behavior rather than non-compliance.
- Collaborative & Proactive Solutions (CPS): Dr. Ross Greene's model (livesinthebalance.org) for solving problems collaboratively without relying on traditional demand-based structures.



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