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Commentary: PDA – public display of affection or pathological demand avoidance? – reflections on O'Nions et al. (2014)

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When you hear (or rather see) the acronym PDA being used these days, you usually associate it with shorthand for 'Public Display of Affection' and you think about acts of physical intimacy in the view of others. If you work as a clinician or researcher in the field of neurodevelopment, paediatrics, psychiatry or clinical psychology, it is possible that your primary associations may take a different route. A group of children presents with a rather peculiar type of oppositional behaviours, sometimes now subsumed under the label of 'pathological demand avoidance' syndrome, also increasingly referred to as PDA. Boys and girls with 'this kind of PDA' will do anything to avoid meeting demands of adults and children alike. The behaviours 'used' in maintaining avoidance range from openly oppositional or manipulative to 'extreme shyness', passivity and muteness. These behaviours in terms of expression of affection are rather the opposite of those associated with the commonly used meaning of PDA. However, the avoidant behaviour is quite often 'publicly displayed' and with no feeling for the inappropriateness of the, sometimes even, exhibitionist style of extreme demand avoidance (EDA).

Childhood-onset PDA (which will be what is assumed when referring to PDA in the remainder of this Commentary) has been suggested to be a variant of autism spectrum disorder (ASD) or of oppositional-defiant disorder (ODD), but it is more likely that any kind of early symptomatic syndrome eliciting neurodevelopmental clinical examinations (ESSENCE) (Gillberg, 2010), including language disorder, mild intellectual disability, ADHD, ODD *and/or* ASD could be the underlying or associated problem in PDA. Or, it could be the other way around: PDA is not a variant of any of these disorders, but represents a relatively unique behavioural phenotype with multiple comorbidities, much like any other 'child psychiatric disorder'.

The 'disorder' was first heard of in 1980, when Elisabeth Newson, in a speech to the East Midland Section of the British Paediatric Society, presented the first 12 cases of what she believed to be a 'new' and separate syndrome and that she referred to as PDA. Even though PDA has attracted quite a bit of clinical attention in the United Kingdom and other parts of Europe (including Scandinavia), virtually no research has been published in the field so far (Newson et al., 2003). Experienced clinicians throughout child psychiatry, child neurology and paediatrics testify to its existence and the very major problems encountered when it comes to intervention and treatment. It is therefore a major step forward that O'Nions and coworkers (O'Nions et al., 2014) have developed a new 'trait measure' for PDA ('the EDA-Q'), a measure that appears to hold considerable promise for research, and eventually for clinical practice. The instrument that they have developed is a 26-item parent questionnaire that appears to be easy to use and with preliminary good–excellent psychometric properties. Although the EDA-Q is in need of validation in studies on other (particularly in clinically diagnosed) groups of children and adolescents, and by other researchers, it already appears to mark a breakthrough in the – hitherto almost completely neglected – systematic study of an important clinical problem. It is to be hoped that the whole instrument will soon be published and made available to bona fide researchers, and at the next stage to clinicians.

PDA is not just encountered in ASD or ODD or as a 'separate entity'. According to my own 40 years of clinical experience, it is not at all uncommon in language disorder, ADHD (particularly inattentive subtype or 'ADD'), selective mutism, school refusal, anorexia nervosa, certain behavioural phenotype syndromes (including 22q11 deletion syndrome and Marfan syndrome) and epilepsy (C. Reilly, P. Atkinson, B. Neville & C. Gillberg, Submitted). It is, very likely, a label that would fit almost perfectly with the phenotype of the Japanese 'diagnosis' of Hikikomori. Even though no prevalence estimate of PDA yet exists, I am convinced that it is not an extremely rare phenomenon.

PDA is already a very real clinical problem, not just in the United Kingdom, but across the planet. Intervention and treatment currently rest almost exclusively on guesswork, clinical experience and trial and error. It is one of the most 'difficult-to-treat' constellations of problems in the whole of child and adolescent psychiatry. Strategies developed for ASD, ODD or ADHD are often ineffective and parents, teachers and clinicians may be driven half crazy by the child's stubborn refusal to cooperate and

by avoidant, manipulative and exhibitionist-style shocking behaviours.

There is a need for a concerted and comprehensive clinical research effort in the field. We need systematic information about diagnostic boundaries/criteria, prevalence, gender ratio, pathogenesis, comorbidity, natural outcome *and* treatment. The arrival of the EDA-Q on the 'scene' should be taken as the starting point for such an effort. O'Nions et al. are to be congratulated for their pioneering work.

May I also suggest that the 'condition' be renamed EDA (extreme demand avoidance), not just so as to avoid confusion with PDA (Public Display of Affection), but because there can be no argument that the demand avoidance is *extreme*, but there will always be those who will have problems determining if the avoidance is *pathological* or not.

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