Modification of the Coventry Grid Interview (Flackhill et al, 2017) to include the Pathological Demand Avoidant profile

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Editorial comment

The authors are a Consultant Clinical Psychologist (JE), a Higher Assistant Psychologist (KD) and a Specialist Speech and Language Therapist (EH). Their paper aims to build on the instrument developed by Moran (2010) and added to by Flackhill et al (2017). The Coventry Grid Interview was designed to be used by clinicians as part of a comprehensive assessment process and not as a stand-alone diagnostic tool. There is often diagnostic confusion over the differences between children presenting with autism and those with attachment disorders and some children have both. This paper adds further to the Coventry Grid Interview by including items which might help to identify children with a Pathological (or Extreme) Demand Avoidant profile. There is much debate and controversy surrounding PDA with some arguing it is a subgroup and part of the autism profile and others querying its value and validity. Some autistic adults use the term Rational Demand Avoidance to highlight the fact that often autistic people are asked to meet demands which are unreasonable, irrelevant and inappropriate, and are thus avoided. Other professionals in the field believe there are some children who are qualitatively different from autistic children and who require and respond to a different approach. As yet, PDA is not included as a separate diagnostic category in the diagnostic manuals and research is ongoing to determine whether there are sufficient and distinct differences for a separate diagnostic category to be developed.

Introduction

The Coventry Grid (Moran, 2010) was developed by a group of clinicians in the West Midlands and written up by Heather Moran. It has subsequently become a useful tool used by clinicians and social work teams alike to assist in differentiating between autism and attachment difficulties. This paper aims to build upon the work carried out by Flackhill et al (2017) who adapted the Coventry Grid into a clinical interview format – the Coventry Grid Interview. The primary author of this paper (JE) was also involved with the initial clinical discussions regarding the development of the Coventry Grid as part of the West Midlands Regional ASD working party and has extensive experience of assessing autism as part of an NHS multi-disciplinary team. Over the past few years, she has become increasingly interested in the PDA or EDA profile (Extreme Demand Avoidance). Some researchers and clinicians use the term 'pathological' as originally suggested by Professor Elizabeth Newson, a Consultant Clinical Child Psychologist) in the 1980s. Others prefer the term 'extreme' demand

avoidance. Together with a consultant paediatrician and, more recently, a team of Speech and Language Therapists, psychologists and occupational therapists, the first author has had the opportunity to assess around 300 children thought to have a PDA or EDA profile.

Flackhill et al (2017) discussed the issue of PDA in their paper and acknowledge that PDA as a description of behaviour or as a diagnostic entity in its own right, has been controversial to say the least and has provoked a huge amount of academic discussion and debate. A recent article in the Lancet by Professor Jonathan Green and his colleagues (Green et al, 2018) concluded that there is currently insufficient research evidence to support PDA as a specific behavioural profile. As Flackhill et al, observe, PDA or EDA is not included in the DSM 5 or in the forthcoming ICD-11, and although the National Autistic Society now describes it as being a behavioural profile on the autism spectrum and Wing and Gould incorporated it into the DISCO-11 as a 'subcategory' of autism, others cited by Flackhill et al have pointed to overlaps with ADHD (Attention Deficit Hyperactivity Disorder) and Conduct Disorder.

Current understanding of the PDA/EDA profile

In the original paper by Elizabeth Newson (Newson, 2003) a group of children were studied who had some features of autism but who did not completely fit the autistic profile, although there were similarities. The PDA type children though were noted to have superficially better social and communication skills and to exhibit better imaginative play than children with more typical autism. They were also found to be extremely emotionally labile and had an extreme need for control. Their serious 'meltdowns' closely resembled panic attacks and they had an almost obsessive avoidance of everyday demands and requests. At the time, the profile was considered relatively rare. A paper by Gillberg et al (2015) on a total population study of youths aged 15 to 24 years in the Faroe Islands noted that the overall prevalence rate for autism was around one per cent. Of this one per cent, they felt that 13 per cent of the children had a PDA profile. Although this is a small percentage, it still equates to a significant number of young people.

Growing awareness/increase of children with a PDA profile

During almost ten years' experience of working as part of an autism assessment team in the West Midlands between 2002 and 2011, very few children with a PDA profile were assessed. It seems likely that these children were seen by general Child and Adolescent Mental Health Service (CAMHS) practitioners. It is also likely that the children's difficulties were viewed to be the result of poor or disrupted attachment. Perhaps because of the growing awareness of the PDA profile and increased openness of parents in discussing the extreme challenges they experience, referrals have increased, both from families and from local teams where professionals have deemed some children 'too complex' for their expertise.

Key features of Pathological Demand Avoidance

Outlined below are the key features listed by the PDA society. The PDA society is a 'not for profit' organisation which was set up primarily to support individuals and their families who identified with this behavioural profile. Additional items or observations (in italics) have been added from the experiences of children assessed by the authors.

1 Early history

Newson's original description of the children she identified as having the PDA profile used the term 'passive' to describe their behaviour in infancy. In our experience, this is somewhat misleading. Many of the children we assess suffered from quite significant colic and/or reflux, leading them to present as fussy and difficult to comfort. We prefer the use of the term 'self-contained'. Children with this profile rarely seek out the company of familiar adults simply for the pleasure of spending time with them and tend to seek attention initially to get needs met.

All parents report the presence of demand avoidant behaviours emerging from a very early age (often pre-one year). In infants this often presents as diffi- culties changing nappies, putting a coat or shoes on, and placing the infant in their car seat or pushchair. Refusal to follow an adult-determined route when out walking can also be a feature with dropping to the floor or running off being relatively common.

2 Resisting and avoiding the ordinary demands of life
This might include getting up in the morning, joining a family activity or getting dressed, to name but a few. This may be the case even when the person wants to do what has been suggested, such as watching a film that they have been looking forward to. When initial avoidance strategies, such as those described below fail; the situation can quickly escalate and some individuals may resort to more extreme measures to avoid the demand such as shouting, swearing, hitting and damaging property. Others may, shut down, withdraw or run away.

3 Using social strategies as part of the avoidance
Many children make comments to distract adults from their request such as, 'I like your earrings, where did you get them from', or by making excuses – 'I can't walk because my legs are broken', or delaying – 'I'll do it in ten minutes', or by withdrawing into fantasy – 'I'm a cat and cats don't wear clothes' and drowning out your request with noise 'I can't hear you because I'm singing – la, de, la, de, la .....'.

4 Appearing sociable on the surface
Children with a PDA profile may have a (superficially) more socially acceptable use of eye contact. Their conversational skills may appear better than others on the autism spectrum, but still often lack depth in their understanding. For instance, not seeing a difference between themselves and an authority figure, having difficulty in adjusting their own behaviour in response to the needs of others and not always understanding how, or why their behaviour can affect others at an emotional level and thus have a negative impact on their relationships. There are generally more difficulties with the pragmatics, or social use of language, with people with the PDA profile often failing to follow the accepted social norms around conversation.

5 Excessive mood swings and impulsivity
Individuals with the PDA profile can have great difficulty in regulating their own emotions and controlling their reactions to situations and people. The individual can rapidly switch from happy and engaging – to angry or sad in seconds, often with no visible build-up or warning to others. This may be in response to the pressure of demands and perceived expectations.

Parents of children with the PDA profile often report that they feel they are 'walking on eggshells', constantly fearful of an outburst or 'meltdown'.

'Meltdowns' can be extreme and can last for hours. Some children will damage property, engage in self-harm or physically attack parents and caregivers. Some may threaten to kill or hurt others. They often have very little memory of an incident afterwards.

Some children, as they grow older, may become more self aware, develop improved social understanding and become more skilled at self regulating their emotions. This can reduce some of the more challenging behaviour as they mature into their teenage or adult years.

6 Being comfortable in role play and pretence – sometimes to an extreme extent
Many children with the PDA profile take on the persona of a figure of authority in role play scenarios to such an extent that they believe they are that person. This role may often require them to oversee and direct others and as such, remain in control of the play (eg taking on the role of a teacher when playing with peers). Role play can be used as a strategy to avoid demands made by others such as, 'I can't pick that up because I'm a tractor and tractors don't have hands' or role playing the compliant child in school to reduce demands by flying under the radar. Withdrawing into fantasy can also be a form of self-protection, a place where they can go to when real life becomes too difficult to manage and to cope with. The lines between reality and pretence can sometimes become blurred.

Many children with the PDA profile will excessively watch YouTube video clips and copy the accent, mannerisms and actual speech of the person making the video. Some adopt the persona of the YouTuber.

7 'Obsessive' behaviour that is often social in nature
Children with the PDA profile may often become obsessive about other people, either real or fictional, from either a love or hate perspective, which can make relationships very tricky. Newson et al (2000) noted that the demand avoidant behaviour itself also has an obsessive quality. People with the PDA profile may often appear to

have better social communication and interaction skills than other individuals on the autism spectrum. But this understanding of social interaction and communication can often be at a surface level only and lacking in depth of understanding. Individuals may copy and mimic the social interactions of those around them as a means of coping and fitting in. Also, the apparent verbal fluency of some people with the PDA profile can disguise genuine difficulties in understanding and processing verbal communication. These characteristics mean that some of their difficulties in these areas may be less obvious at first. This can make it extremely difficult for clinicians to assess in a short clinic appointment.

Individuals with the PDA profile can be controlling and dominating, especially when they feel anxious and are not in control of their environment. They can also be very affectionate, charming, sociable and chatty, when they are calm and feel safe. This conflicting and variable presentation of character can be confusing for parents and professionals alike.

The behaviour of an individual with the PDA profile can also vary between different people and different settings. Sometimes a child can appear very anxious at home but remain relatively passive at school (a learnt coping strategy known as masking). However, this is often at the expense of more complex and challenging behaviour at home, where the child often feels safe to release their pent-up anxiety. In situations like this, parents can be made to feel very inadequate and become isolated. For other children, the demands at school can lead to severe 'meltdowns', within the school environment and this can lead to multiple school exclusions from an early age. Some children can experience such high anxiety in school that they become school refusers.

8 Sensory differences

Just as in others with autism, people with the PDA profile can often experience over or under-sensitivity in any, or all, of their senses: sight, smell, taste, touch, vestibular, proprioception or hearing. There also appear to be issues for people with PDA around interoception. Interoception is the recognition of internal bodily signals and poor interoceptive ability can lead to difficulties in recognising hunger or thirst and very often leads to difficulties with toileting. Many of the children we have assessed are reported to have difficulties with knowing when they need to use the toilet and often do not recognise the signals until it is almost too late. Some also struggle to recognise the bodily signals associated with their emotions and can go from apparently calm to raging in seconds.

How the PDA responses were developed for the Coventry Grid

The first author, along with a full multi-disciplinary team working within NICE (National Institute for Care and Clinical Excellence) guidelines for the assessment and diagnosis of children on the autistic spectrum has assessed a significant number of children who are suspected of having the PDA profile. A vast amount of data has so far been collected about all aspects of these children's development, cognitive ability, communication and sensory profile. Some of these children are referred by parents who feel this profile fits their child, others are referred by local and national Clinical Commissioning Groups for a second opinion or specialist assessment. In addition, some children are referred by Social Care under Section 17 (Child in Need) of the Children's Act, after either their parents have requested support or a safeguarding concern has been raised.

From an initial viewpoint that this profile could probably be better explained by either autism with anxiety or attachment difficulties, as a team, we have all been struck by the striking similarities in both presentation and developmental history that we have observed in these children and young people. Children and families have travelled for assessment from all over the world and the clinical picture is very similar. We are also in the fortunate position that we are also commissioned to assess very complex children, post-adoption who have all, almost without exception, experienced developmental trauma and/or poor attachment and whose behaviour, on the surface, can look very similar to PDA. They do not, however, have autism.

By working through the Coventry Grid Interview, we have added the typical presentation we have seen in the young people assessed and have highlighted the similarities and differences observed between PDA

and attachment disorder, and believe it demonstrates why PDA falls more accurately under the broad autism spectrum diagnosis.

Validity and reliability and limitations

Clearly as a new instrument, predictive validity and reliability are yet to be established for the CGI (Flackhill et al, 2017). The same applies for this extension of the CGI to include PDA. As also described in the Flackhill et al (2017) paper, the instrument is currently limited in terms of its usefulness due to there being no diagnostic cut-off scores and only limited evidence of reliability. The same will be true of this current iteration. However, as Flackhill et al point out, it is not intended to be a stand alone diagnostic tool and certainly should not be used by those inexperienced in the area. It is simply intended as a very much needed aid to the thinking and formulation process which should occur in any diagnostic assessment.

Concluding comments

It is likely that distinguishing attachment difficulties from underlying neurodevelopmental conditions (which it appears that PDA is more likely to be) will continue to present clinical challenges. Many adopted and fostered children will have experienced an adverse start in life, which often includes exposure to domestic violence (and associated maternal stress) both in utero and during their first years of life. A number will also have experienced a significant degree of impoverishment and lack of adequate and appropriate stimulation necessary for healthy cognitive development. As a consequence of these early adverse experiences, these children frequently present with chronic hypervigilance and symptoms of post-traumatic stress and many will have been given a diagnosis of ADHD (Attention Deficit Hyperactivity Disorder). However, it is likely that many of the reported symptoms of ADHD they exhibit are a function of a need for sensory stimulation, resulting from sensory deprivation in early life.

It also the case that many of the birth mothers of these children are known to have misused drugs. The research on the effects of exposure to environmental pollutants, addictive substances, drugs, malnutrition, excessive stress, etc. is steadily growing and there is evidence that suggests chemical and/or physical factors acting during the sensitive time windows of the brain's development can cause mental, behavioural, emotional and/or cognitive disorders and/or traits. These effects often present as challenges with learning, and issues around attention, focus, and emotional regulation, frequently resulting in extremes of behaviour and what are often described as 'meltdowns'.

However, if when a child and family are assessed, there do not appear to be any obvious risk factors in terms of the development of unhealthy attachment or what could be described as 'developmental trauma', it would seem worth exploring the possibility of a neurodevelopmental disorder, even if this presents in an atypical way. This would save parents from feeling that they have to 'prove' themselves to professionals when they present with a child whose behaviour is concerning and/or extremely challenging. It is to be hoped that the use of a tool such as the Coventry Grid Interview and the present modification, may help clinicians in their formulation and thus avoid unnecessary distress for both families and children.

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Appendix 1:
The Coventry Grid Interview plus Pathological Demand Avoidance

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
Routine				
1	Do they have problems with the build up to events such as birthdays or Christmas and find it hard to share excitement with others?	AS: YES Score 1	ATT: NO	PDA: YES – these types of events are often anticipated on the surface but sabotaged due to high levels of anxiety. Score 1
2	Do they get distressed, or avoid anniversaries of life events / times such as Christmas, possibly because of difficult memories (as opposed to the social and sensory overload of gatherings and the change in routine)?	AS: NO	ATT: YES Score 1	PDA: NO
3	Does everything tend to revolve around his or her special interests?	AS: YES Score 1	ATT: NO	PDA: YES but special interests will often be less intense, often more related to demands or perceived demands. They also tend to change more quickly and are not returned to. Score 1
Difficulties with eating				
4	Is food restricted by texture or colour?	AS: YES Score 1	ATT: NO	PDA: YES but not as much as more typical AS presentation (which is often 'beige' food). Food preferences tend to go through phases. Score 1
5a	Is restricted diet about maintaining sameness?	AS: YES Score 1	ATT: NO	PDA: YES but can also be about need for control. Young people can suddenly stop eating a previously favoured food and then blame parents for offering it. Score 1
5b	Does your child have a tendency to binge eat?	AS: NO	ATT: YES Score 1	PDA: YES but may be due to sensory issues about recognising hunger and/or fullness after a meal. Many children also confuse feelings of anxiety for hunger. Score 1
6	Does your child hoard food?	AS: NO	ATT: YES Score 1	PDA: NO

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
Language				
7	Does your child use language repetitively?	AS: YES Score 1	ATT: NO	PDA: NO but may engage in repetitive questioning about things they want to have or do.
8	Does your child use made up words?	AS: YES Score 1	ATT: NO	PDA: NO
9	Does your child have overly formal/ stilted language or have an odd tone of voice?	AS: YES Score 1	ATT: NO	PDA: NO but may adopt an unusual or copied accent or conversational style
10	Does your child over use 'stock' phrases or words (e.g. basically, actually, or phrases from the TV?)	AS: YES Score 1	ATT: NO	PDA: YES but this can be difficult to spot as often occurs when the young person is taking on the persona of someone else. Score 1
11	Does your child say things to shock/ for a reaction?	AS: NO	ATT: YES Score 1	PDA: YES often to avoid demands Score 1
Treasured objects				
12	Does your child try to make others approve of, or envy his/ her possessions?	AS: NO	ATT: YES Score 1	PDA: NO
13	Does s/he deliberately destroy treasured objects when angry?	AS: NO	ATT: YES Score 1	PDA: YES but not always with deliberate intent – objects often broken during 'meltdown' or as a means of avoiding a demand. Score 1
14	When given a new toy, does s/he still favour old toys?	AS: YES Score 1	ATT: NO	PDA: NO

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
Play				
15	Does your child collect and order/ arrange particular toys or objects?	AS: YES Score 1	ATT: NO	PDA: YES often dolls' houses will be 'arranged' but not played with or the child will insist upon collecting a whole set of a particular toy but then never play with them. Score 1
16	Does your child prefer to play alone?	AS: YES Score 1	ATT: NO	PDA: YES unless others will play by their rules. They often 'need' to control/direct the play of others and can become distressed if this cannot happen and may choose to play alone instead. Score 1
17	Does your child play mechanically with toys rather than creating stories about them (eg lining up and ordering?)	AS: YES Score 1	ATT: NO	PDA: NO although this is often a starting point. They may first arrange toys, then go on to create or recreate a scene they have observed, with the emphasis on arranging rather than lining up. Score 1
18	Does your child play dramatic or traumatic games which may mirror things that have happened in their own lives?	AS: NO	ATT: YES	PDA: NO
19	Does your child play with unusual things?	AS: YES Score 1	ATT: NO	PDA: NO
20	Does your child play a limited range of activities?	AS: YES Score 1	ATT: NO	PDA: YES and can often 'flit' between activities Score 1
21	Can your child take on different roles in pretend play?	AS: NO (although some females can)	ATT: YES Score 1	PDA: YES but little flexibility in the role play. It is usually the same role, played in the same way Score 1
22	Does your child struggle to end role play games?	AS: NO	ATT: YES Score 1	PDA: YES – can often stay in role for long periods of the day Score 1

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
Social interaction				
23	Does your child seek to provoke strong emotional reactions in others?	AS: NO	ATT: YES Score 1	PDA: YES but usually to avoid demands or to aid their ability to read/understand emotions in others (they appear to be only able to interpret extremes) Score 1
24	Does your child show an awareness of his/ her own role in interactions?	AS: NO	ATT: YES Score 1	PDA: NO – often is unaware that his or her need for control in interactions may alienate others
25	Does your child struggle to understand how interactions with teachers may be different from interactions with friends/peers?	AS: YES Score 1	ATT: NO	PDA: YES – often questions why adults have authority and may see self as on a par with adults. Score 1
26	Does your child show less of an awareness to share than you would expect for his/ her age?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
27	Are they aware but too anxious to share and so hoard possessions?	AS: NO	ATT: YES Score 1	PDA: NO
28	Does your child steal or take things to hoard?	AS: NO	ATT: YES Score 1	PDA: NO
Mind reading				
29	Does s/he refer to other people's views and feelings?	AS: NO	ATT: YES Score 1	PDA: NO
30	Does s/he think you know about situations when you have not been present?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
31	Is s/he aware of the types of information you are interested to hear about (eg what went well at school today)?	AS: NO	ATT: YES Score 1	PDA: NO
32	Does your child exaggerate and elaborate stories?	AS: NO NB some females with AS can create fantasy worlds into which they retreat	ATT: YES Score 1	PDA: YES often will develop elaborate fantasy worlds which can be quite believable but are often 'borrowed' from films or YouTube. Score 1

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
33	Is s/he hypervigilant to others' feelings and actions, especially anger?	AS: NO	ATT: YES Score 1	PDA: YES may appear highly sensitive to other peoples' feelings but may struggle to interpret correctly. May think people are angry/shouting at them if a louder than usual voice used. Score 1
34	Does s/he ever find it hard to distinguish fact from fiction?	AS: YES Score 1	ATT: NO (Unless related only to threats)	PDA: YES Score 1
35	Does s/he often tell sophisticated lies	AS: NO	ATT: YES Score 1	PDA: NO – may tell very obvious lies and be easily caught out or tell lies that are superficially creative but not sophisticated enough to deceive a more discerning observer.

Communication

36	Does your child seek to get their needs met by making loud or unusual noises for attention?	AS: NO	ATT: YES Score 1	PDA: YES: may intentionally disrupt others in order to avoid demands or to reinforce what they do/do not want to do. Score 1
37	Does s/he give detail in pedantic fashion and give excessive detail?	AS: YES Score 1	ATT: NO	PDA: NO. However, they can 'over answer' questions in order to control an interaction.
38	Does she have a poor awareness of others in a conversation?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
39	Does he/she understand jokes and sarcasm?	AS: NO Score 1	ATT: YES	PDA: NO Score 1
40	Does he/she seem overly sensitive to tone of voice?	AS: NO	ATT: YES Score 1	PDA: YES often hyper aware but unable to correctly interpret Score 1
41	Does your child worry his/her needs won't be met if you are running late for them?	AS: NO	ATT: YES Score 1	PDA: YES to an extent but associated with high levels of anxiety about things not being as they should be or as the child wishes, usually related to need for control. Score 1

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
	Executive functioning			
42	Does waiting have an emotional significance? (eg do they relate waiting to neglect or to having or losing emotional control over someone?)	AS: NO	ATT: YES Score 1	PDA: NO – not necessarily emotional control, but may try to maintain physical control
43	Does waiting upset your child because it upsets their routine?	AS: YES Score 1	ATT: NO	PDA: YES but it appears more about their need for control and an apparent inability to wait for demands/requests to be met. Score 1
44	Does s/he dislike getting a hug from another person when s/he as not initiated this?	AS: YES Score 1	ATT: NO	PDA YES Score 1
45	Does the child seem unaware of personal space?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
	Sensory issues While children and young people with attachment difficulties often present with sensory processing issues, these are often more trauma related. These questions attempt to distinguish trauma related sensory processing issues from AS type sensory issues. It is important that the CGI is only used at the end of a full multi-disciplinary Stage 2 assessment which includes a full family, educational and developmental history and autism specific diagnostic tools (eg ADOS and ADI). If the CGI identifies several sensory processing issues, the young person should be referred to an Occupational Therapist for a full sensory processing assessment.			
46	Pain/temperature threshold Is your child's awareness of hot and cold or pain unusual?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
	Eating			
47	Does your child seek or avoid particular foods or textures?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
48	Does your child use food to self-soothe or comfort?	AS: NO Score 1	ATT: YES	PDA: NO but might appear this way due to lack of awareness of body signals that they are full or they are unable to distinguish between feelings of anxiety and hunger. Score 1
49	Does your child use food to control, hoard, or create an emotional response from key figures?	AS: NO	ATT: YES Score 1	PDA: NO

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
Motor				
50	Does your child tend to bump into things, spill drinks or trip over?	AS: YES Score 1	ATT: NO	PDA: NO – tends to be less obvious motor clumsiness than in more typical autism
51	Is your child able to learn new motor skills easily? (eg ride a bike, swim)	AS: NO Score 1	ATT: YES	PDA: YES – again less obvious than in more typical autism
Movement				
52	Does your child seek or avoid movement but not recognise the associated dangers involved?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
53	Does your child intentionally seek out risk through movement?	AS: NO	ATT: YES Score 1	PDA: NO – behaviour may look risky but it is not intentional – usually to meet an internal need. Poor social imagination leads to poor ability to predict consequences.
54	Does your child swing between over and under activity throughout the day?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
Tactile				
55	Does your child seek or avoid exploring through touch?	AS: YES Score 1	ATT: NO	PDA: YES Score 1
56	Does your child seek deep pressure (eg firm hugs?)	AS: YES Score 1	ATT: NO	PDA: YES Score 1
57	Is your child overly sensitive to texture of clothing (eg labels in clothing, seams?)	AS: YES Score 1	ATT: NO	PDA: YES Score 1
Auditory				
58	Is your child unable to filter out sounds so that it impairs their function with every day activities (eg noises outside; conversations; hum of machines?)	AS: YES Score 1	ATT: NO	PDA: YES Score 1
59	Is your child more hypervigilant to sounds associated with a previous trauma?	AS: NO	ATT: YES Score 1	PDA: NO

	Question	Autism Spectrum (AS)	Attachment (ATT)	Pathological Demand Avoidance (PDA)
Visual				
60	Is your child often seeking or avoiding visual stimuli? (eg wearing sunglasses, seeking patterns, lining up coloured pencils or engaging in finger movements in front of their eyes)	AS: YES Score 1	ATT: NO	PDA: NO
61	Does your child scan the environment and seek and recall information essential for maintaining their safety?	AS: NO	ATT: YES Score 1	PDA: NO
Smell				
62	Does your child seek or avoid smells (eg sniffing food before eating it?)	AS: YES Score 1	ATT: NO	PDA: YES Score 1
63	Is your child reactive to smells associated with key attachment figures or key events?	AS: NO	ATT: YES Score 1	PDA: NO

Total number of responses pointing towards AS	
Total number of responses pointing towards Attachment Difficulties (ATT)	
Total number of responses pointing to a PDA profile	