

Practical Support Framework

Relationship before compliance. Safety, autonomy, co-regulation and individual fit.

Scientific context. PDA is not a standalone diagnosis in ICD-11 or DSM-5-TR. In practice and self-description, terms such as "PDA profile" or "marked demand avoidance" are used. Research remains limited and partly contested. This framework therefore uses PDA/demand avoidance as a descriptive working term, not as an explanation for every behaviour. Avoidance can have different underlying causes and must be understood individually. [1-5]

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Purpose of this framework

It describes my educational and caregiving approach when demands, transitions, sensory input or uncertainty quickly lead to stress. It does not replace medical, psychological or speech and language assessment. I do not diagnose and I do not provide therapy.

The order is deliberately practical: action first, methods second, background knowledge third.

1. Action first: priorities in everyday support

1. Secure safety and connection

In immediate danger, protect calmly, clearly and with the least intrusive action necessary. Safety is non-negotiable, but it does not require punishment or a power struggle. Outside immediate danger, connect first and clarify demands second.

Praxis: Near traffic, an adult physically stops a child if necessary without threatening or shaming them. Language is reduced and the event is discussed later, when settled.

2. Lower arousal before explaining

High stress reduces the ability to process language, rules and consequences. Adjust voice, pace, distance and sensory load before giving long explanations.

Praxis: After a demanding school day, offer quiet, water or a snack and minimal conversation. "How was your day?" can wait.

3. Remove unnecessary demands

Distinguish what is genuinely required for safety or health from habit or convention. Reducing avoidable friction preserves capacity for what matters.

Praxis: If shoes by the door are not unsafe, an exhausted moment does not need to become a battle about putting them on a shelf.

4. Support autonomy without decision overload

Real choice can support autonomy, but too many choices can also create pressure. When a child is depleted, a familiar default can be offered rather than another decision.

Praxis: When settled, the child chooses between two activities. When exhausted, the familiar option is quietly offered.

1. Action first: priorities in everyday support - continued

5. Allow processing time

Keep questions and instructions brief and then genuinely pause. Delay is not always refusal; sometimes processing simply takes time.

Praxis: "Your backpack is by the door." Then wait ten to fifteen seconds without adding another prompt.

6. Support task initiation

Executive-function difficulties can make starting hard. Break tasks down, prepare the first step or begin alongside the child. Calm co-presence can help.

Praxis: Instead of "Get ready", place the jacket nearby, show the first step and remain quietly available.

7. Consider sensory and basic physical needs

Noise, light, clothing, hunger, thirst, pain, fatigue and internal body signals can increase distress. Sudden major behaviour change should not automatically be given a psychological explanation.

Praxis: With unusual irritability, also consider pain, illness, sleep loss, hunger or sensory overload.

8. Reflect after recovery

After escalation, recovery comes before teaching. A later conversation may be useful but does not need to be immediate or mandatory. Stress can affect recall and language; amnesia should not be assumed.

Praxis: Later ask: "Is there anything we should do differently next time?" If the child does not want to talk, respect that.

2. Methods: relationship, autonomy and communication

Person-centred stance

Congruence, empathy and unconditional positive regard in the tradition of Carl Rogers set the relational tone. Care is not conditional on performance. Humanistic support is not boundaryless: adults remain responsible for safety, respect and their own boundaries.

Practice: "I can see this is too much right now. I am staying with you. I also cannot allow anyone to be hurt."

Autonomy, competence and relatedness

Self-determination theory describes autonomy, competence and relatedness as central psychological needs. [6] In practice: avoid unnecessary control, make success possible in small steps, and keep the relationship stable even when things are difficult.

Clear language rather than hidden power

Declarative or indirect language can reduce pressure, but it is not a rule. Direct statements are allowed and are often necessary for safety. Tone, timing, clarity and honesty matter.

- Helpful: short information, I-statements, genuine choices and enough processing time.
- Not a rigid rule: the word "no" is not banned. A calm and honest no with a reason may be safer than artificial wording.
- Written or visual support: notes, pictures and schedules are optional orientation tools, not compulsory checklists.

Praise, rewards and feedback

Evaluative praise or reward systems can create pressure for some children. That does not mean praise or rewards are universally harmful. I favour specific feedback, shared enjoyment and recognition without manipulation. If a child genuinely enjoys praise, it can of course be used.

Interests as a bridge

Interests, humour, role play or shared activity can support transitions when they genuinely fit the child. They are not used as tricks or leverage.

Practice: A child who is deeply building something is not abruptly pulled away. The adult briefly joins the topic and gives a clear, respectful transition warning.

Body doubling and co-presence

Quietly being in the same room or doing something in parallel can make task initiation easier without adding more prompts. It is an option, not a universal technique.

3. Methods: transitions, sensory support and the body

Prepare transitions

Many children benefit from advance notice, clear information and one manageable next step. Some prefer routines; others experience rigid plans as pressure. Structure is therefore adapted collaboratively rather than assumed.

Practice: "We leave in ten minutes. You can finish this round; your jacket will be ready afterwards."

Decompression after school and groups

A low-demand buffer after socially or sensorily demanding situations may help. Differences between school and home can relate to masking, fatigue, different expectations, relationship or many other factors. They do not prove a single cause.

Stimming and self-chosen regulation

Repetitive movement or sound can support self-regulation and should not be stopped merely for social appearance when it is safe. Autistic adults frequently describe stimming as regulatory. [7]

Deep pressure and weighted items: voluntary, never imposed by an adult

If a child already likes familiar sensory tools, options may include a familiar weighted blanket, a heavy cushion on the legs or another self-chosen proprioceptive input. No adult body pressure, no "bear hug" as a regulation technique and no restraint. A randomised trial found no objective sleep benefit from weighted blankets in autistic children, although many children and parents preferred them. [8]

Eating, toileting and personal care

Coercion and shame are avoided. Persistent difficulties are not automatically explained by demand avoidance. Pain, weight loss, constipation, dehydration, significant food restriction or other health concerns warrant medical assessment.

Echolalia and language

Echolalia can have communicative, emotional or self-regulatory functions and should not be dismissed as meaningless repetition. However, the popular "Gestalt Language Processing / Natural Language Acquisition" stage model is not currently supported as an established clinical treatment framework. Language support should be individualised and evidence-informed. [9,10]

Sleep

Calm evening routines, reduced light and a predictable framework may help. Sleep problems have many possible causes. Medical or medication advice belongs with qualified clinicians.

4. De-escalation and crisis support

Principle: During escalation, the goal is not compliance. The goal is safety and a return to a more manageable state. Low-arousal-informed support reduces confrontation, language and avoidable stimulation.

Six steps in the moment

- 1. Regulate your own behaviour: quieter voice, slower movement, neutral and kind facial expression.
- 2. Reduce language: no debate, moral lecture or long questioning.
- 3. Give space: increase distance, do not force eye contact, do not block the exit unless safety requires it.
- 4. Reduce stimulation: decrease audience, noise, light and extra demands where possible.
- 5. Protect safety: remove dangerous objects; in immediate danger, use only the physical intervention needed to prevent harm.
- 6. Support recovery: offer water, quiet, a familiar activity or a snack if that fits the child.

Repair without shame

Later, if useful, explore early warning signs and what might help next time. Do not demand an apology while the child is still highly distressed. Repair can happen later in a concrete and dignified way.

Practice: After an outburst, first restore safety and calm. Later: "Would you like us to think together about what might help earlier next time?"

Touch and professional boundaries

Physical contact is not a standard calming method. Touch is age-appropriate, context-appropriate and clearly wanted or initiated by the child. The exception is immediate protection from danger. Professional warmth includes reliable relationship and clear boundaries.

When school attendance breaks down

School refusal and absence are multifactorial and may involve anxiety, neurodevelopmental differences, social experiences, overload or physical health concerns. [11] It should not automatically be explained as "PDA" or "School Can't". Helpful responses involve shared assessment, graded adjustments and collaboration with family, school and relevant professionals.

5. Professional stance and collaboration

Parents as a central source of knowledge

Parents know their child's history, daily patterns and previous strategies. Their observations are taken seriously without treating every interpretation as a diagnosis. The aim is a shared, testable working hypothesis.

Practice: "What reliably helps at home? What makes things worse? Which early signals do you see? What should I definitely avoid?"

Privacy at handovers

Difficult events are not discussed in detail in front of the child. Doorway handovers stay brief; sensitive topics are moved to a separate conversation.

Observation before interpretation

First document what was actually seen or heard. Interpretations are labelled as hypotheses. This protects against quick labels such as "manipulative", "lazy" or "provocative" and also against assuming that every behaviour must be caused by PDA.

Example: Observation: "He places the pencil case on the floor, turns to the wall and does not answer for 40 seconds." Hypothesis: "The task demand or room noise may have become too much."

Structured reflection

After difficult situations, Gibbs- or Borton-style questions are useful: What happened? What came before it? What did I contribute? Which hypotheses are supported and which remain open? What will I change next time?

Professional scope

- I do not diagnose and I do not replace psychotherapy, medicine, occupational therapy or speech and language therapy.
- I work with existing diagnoses and professional recommendations when parents choose to share them.
- If safety, health or development raise concerns, I recommend appropriate assessment rather than explaining medical issues pedagogically.
- Safeguarding, dignity, privacy and transparent agreements take priority over any method.

6. Background: what is established and what remains open?

Autism

Autism spectrum disorder is described in ICD-11 under 6A02. Diagnosis is based on persistent differences in social communication/interaction together with restricted, repetitive or sensory characteristics beginning in development. [1]

PDA and marked demand avoidance

PDA is not a standalone ICD-11 or DSM diagnosis. Literature and practice sometimes use wording such as "autism with a PDA profile" or "demand avoidant traits". Systematic reviews in 2021 and 2026 describe limited, heterogeneous research and substantial problems with definition and measurement. [2-5] The practical implication is to take lived difficulty seriously without creating false certainty about cause or diagnosis.

Anxiety, uncertainty and autonomy

Anxiety and intolerance of uncertainty are discussed as possible correlates. People with lived experience also describe a strong need for autonomy. These explanations do not apply in the same way to every child and should not be presented as a single proven mechanism.

ODD is not simply "conscious defiance"

Oppositional defiant disorder is a clinical diagnosis with defined behavioural and emotional features. Distinguishing it from anxiety, autism, ADHD, trauma, developmental factors or demand avoidance requires qualified assessment. It should not be reduced to a choice to disobey. [1]

Stress physiology without false precision

It is well supported that stress affects attention, language processing, impulse control and behaviour. Polyvagal theory, however, remains scientifically disputed; major claims have been criticised and defended in ongoing literature. This framework therefore does not depend on specific polyvagal claims. [12]

Masking, exhaustion and burnout

Masking and cumulative demands can contribute to major exhaustion. "Autistic burnout" has mainly been described in qualitative research with autistic adults and should not be used as an automatic explanation for children. [13]

7. What I deliberately avoid turning into rigid rules

- No diagnosis from behaviour alone. Demand avoidance is a description, not an automatic cause.
- No universal ban on "no", praise, boundaries or structure. The individual child's response matters.
- No claim that meltdowns at home prove trust. Context differences can have many causes.
- No blanket claim that schools or authorities typically misjudge families. Misunderstandings are addressed with careful observation and evidence.
- No bear hugs, adult-imposed deep pressure or restraint as a regulation technique.
- No GLP/NLA stages as established language diagnosis. Echolalia is respected; communication support is individualised.
- No neurobiological absolutes. Terms such as "emergency system", "blocked hippocampus" or "existential threat" are not used as a universal explanation for every behaviour.
- No automatic PDA explanation for school absence, eating, toileting or pain. Health and context are considered as well.

Core idea: The label does not determine the support. The child does - their signals, strengths, family, safety and what can be observed to help in real life.

When additional specialist assessment matters

- new or severe pain, weight loss, dehydration, major sleep or toileting problems
- self-injury, suicidal thoughts, severe aggression or repeated acute danger
- clear loss of previously established skills
- persistent school absence with high distress
- speech or communication questions where specialist speech and language assessment is appropriate

8. One-page summary for parents

How I work with your child

- I first build trust and learn your child's individual signals.
- I am clear and reliable without creating unnecessary power struggles or shame.
- Homework, daily routines and leisure are structured so the child can experience as much agency and competence as possible.
- Movement, nature, play, interests and humour matter just as much as quiet and recovery.
- I bring additional practical experience with ADHD, autism and marked demand avoidance. A diagnosis is not a requirement for my childcare.
- I discuss difficulties collaboratively with parents and keep sensitive topics out of conversations in front of the child.
- Safety and professional boundaries are non-negotiable. Physical contact is not used as a calming technique and is never forced.

My aim: A child should not have to perform perfectly in order to feel accepted. At the same time, children need an adult who stays calm, reliable and responsible.

This document describes my educational and caregiving approach. Individual agreements with parents and existing professionals take priority.

References and evidence notes

This list combines diagnostic standards, systematic reviews, research and clearly identified practice frameworks. Not every method has the same level of evidence; contested models are therefore not presented as settled neurobiology.

- [1] World Health Organization. Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders. Geneva: WHO; 2024. Autism spectrum disorder 6A02; Oppositional defiant disorder 6C90.
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References and evidence notes - continued

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[12] Grossman P. Fundamental challenges and likely refutations of the five basic premises of the polyvagal theory. *Biological Psychology*. 2023;180:108589. doi:10.1016/j.biopsycho.2023.108589. Note: the theory remains actively debated in the literature.

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[14] Rogers CR. *On Becoming a Person*. Boston: Houghton Mifflin; 1961. Classic foundation of person-centred practice.

[15] McDonnell AA. *Managing Aggressive Behaviour in Care Settings: Understanding and Applying Low Arousal Approaches*. Wiley-Blackwell; 2010. Practice framework for non-confrontational crisis support.

Note: This is an educational and caregiving framework, not a medical guideline.