

Discovering and Treating Pathological Demand Avoidance in the Wilderness

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Abstract

Pathological demand avoidance (PDA) was first observed and studied in the United Kingdom in the 1980s by Elizabeth Newson and her colleagues, developmental psychologists specializing in pervasive developmental disorders. PDA reminded these psychologists of autism, though it differed in important ways, including obsessive resistance to daily demands, ‘surface sociability,’ and imaginative play (Newson et al., 2003). This topic has drawn significant attention and has been debated as to whether PDA is a unique diagnostic profile within the autism spectrum or merely an over-pathologizing process of individuals’ autonomy and independence (Milton, 2013; Moore, 2020). PDA has an established following of professionals, family members and individuals. The discussion of this topic is of critical importance so that individuals affected by PDA who are being treated in outdoor behavioral healthcare (OBH) settings, also called wilderness therapy, and residential treatment settings in the United States are not misdiagnosed or treated inappropriately, thereby experience harm due to a misunderstanding on the part of professionals and parents.

Keywords: pathological demand avoidance, PDA, autism spectrum disorder, ASD, pervasive developmental disorder, PDD, outdoor behavioral health, OBH, wilderness therapy

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Outdoor behavioral healthcare (OBH) is an emerging field of behavioral healthcare which treats adolescents and adults (Russell & Hendee, 2000). A recent meta-analysis of wilderness therapy studies (Bettman et al., 2016) found that wilderness therapy produced moderate effect sizes of improved mental health and behavioral outcomes. DeMille et al. (2018) demonstrated that participants who attended an OBH treatment program were, as reported by their parents, functioning significantly better than the treatment as usual (TAU) comparison group one year following the program. Wilderness therapy, a residential form of OBH, has been employed to treat adolescents struggling with a variety of mental health and developmental disorders (Christensen, 2008; Cahill & Stireman, in press). The outcomes for clients with an autism spectrum disorder (ASD) diagnosis were not as favorable. Savidge (2020) investigated treatment effects of adolescent and adult clients who presented with an ASD diagnosis while attending an OBH program. Her results demonstrated mixed results for ASD adolescent clients. She related that with the adolescent sample studied; 49% reported ‘recovered’ or ‘improved,’ while 22% reported ‘no change,’ and 29% reported ‘deterioration’ in their functioning and symptoms.

Mental health practitioners in OBH face two primary responsibilities while working with young people. The first is a thorough examination of the diagnostic profile of the participants, and the second is formulating effective treatment strategies and implementing appropriate interventions based on diagnoses (Hoag et al., 2014). If one is not clear about what a client is struggling with, either the treatment will be less effective, or worse, may harm the client and create confusion for the family, and alienate the client from seeking mental health treatment in the future. Over the last year, the authors have become aware of another proposed diagnostic entity, that of pathological demand avoidance (PDA), and have begun to consider its presence and prevalence among clients who are treated in OBH programs. In review of the DSM-5 (American Psychiatric Association, 2013), there are clear cut demarcations of conditions and diagnoses, while in practice these clear boundaries are frequently blurred and diagnostic clarity is not always so evident. Additionally, despite the value added by the DSM-5 and ICD-11 (World Health Organization, 2019) categorization of diagnoses, it is a common understanding that these resources do not encompass all conditions that

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mental health and developmental professionals encounter and treat. Internet addiction, problematic internet use, and digital media overuse (Cahill & Stireman, in press; Dahl & Bergmark, 2020); and non-verbal learning disorder (NVLD) (Rubinstien, 2005) are profiles that come to mind. Diagnosis and treatment approaches continue to advance, and it is important to evolve with these.

History and Description of PDA

In the early 1980s, Elizabeth Newson, a British developmental psychologist, and her colleagues began seeing young people, referred for assessment, diagnosis, and treatment who reminded referring professionals of autism but differed in important ways (e.g., sociability and imaginative play) (Newson et al., 2003). It became clear to Newson and her colleagues a behavioral profile emerged in these young people that was not described by any diagnostic category at the time. They proposed a separate diagnosis named pathological demand avoidance (PDA) within the general diagnostic category of pervasive developmental disorders. Newson et al. (2003) defined PDA by eight key characteristics, including:

- 1) an obsessive resistance to everyday demands and a tendency to use a range of ‘socially manipulative’ strategies to subvert requests (e.g., distraction, targeted shocking behavior, threats),
- 2) ‘surface sociability’—a superficial ability to manage social interaction, but with little evidence of a normal sense of social identity (e.g., believing themselves to be on a par with or superior to adults), and a lack of pride or shame, evident in socially shocking behavior viewed as infantile or bothersome by peers,
- 3) lability of mood and impulsivity motivated by an obsessive need for control,
- 4) comfortable in role play and pretending—often adopting borrowed roles when interacting with others (e.g., relating to peers in the manner of a teacher or other scripted roles),
- 5) early language delays due to passivity,
- 6) obsessive behavior often targeted at particular people or their characteristics,

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7) a passive early infancy history of delayed developmental milestones, and
8) neurological involvement (e.g., delayed milestones, clumsiness, and seizures).

At the time Newson et al. (2003) believed PDA to be within the spectrum of pervasive developmental disorders, but still different from autism and Asperger syndrome. They believed it required a separate diagnosis to capture its unique presentation and criteria. PDA has been studied and discussed over the last four decades and was presented in a recent review of mental health problems affecting children and adolescents (Ogundele, 2018). Despite the active discussion and following there has been some question about the actual existence of PDA as a profile of specific pathology (Malik & Baird, 2018; O’Nions et al., 2016), with some expressing concern about pathologizing appropriate resistance and individuality (Milton, 2013; Moore, 2020). Though debate on the topic continues, professionals in the UK have been assessing and treating individuals with PDA, a cluster of symptoms which lead to significant difficulty with daily functioning (Newson et al., 2003; O’Nions, Viding, Greven et al., 2014).

Currently PDA is not recognized by the DSM-5 or the ICD-11, and therefore has not been considered within the dominant OBH community. Researchers and clinicians familiar with this condition have characterized PDA within the spectrum of pervasive developmental disorders (Newson et al., 2003), and more recently, as a subtype or sub-group of ASD (O’Nions & Eaton, 2020). However, there is no agreed diagnostic algorithm to determine who should meet criteria and no consensus about whether PDA is a good candidate for inclusion as a sub-category within ASD in the future (O’Nions & Eaton, 2020).

Lord et al. (2012) conducted a large study examining whether categorical diagnostic subtypes of ASD could be supported. Results from the study supported the move from existing subgroups (e.g., autistic disorder, PDD-NOS, and Asperger's syndrome) to a dimensional description of core features of social affect and fixated, repetitive behaviors, together with characteristics such as language level and cognitive function. O’Nions and Eaton (2020) suggest that “thinking about PDA or extreme demand avoidance (EDA) dimensionally is useful in

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drawing parallels with the wider international research literature on demand avoidance in ASD.” Considering PDA as relating to and a variation of ASD dimensions can be useful. The reason for this is that PDA presents differently than prototypical autism (e.g., sociability and imaginative play), though PDA is found more frequently in individuals with ASD than in the general population (Gillberg et al., 2015).

Of significant note, the prevalence of PDA across sexes is believed to be roughly 1 to 1 (Newson et al., 2003), which is significantly different from prevalence rates of ASD across boys and girls, 4 to 1 (American Psychiatric Association, 2013). Clinicians and researchers continue to explore and study young people with these challenges so that they can better define the profile of PDA, determine accurate prevalence rates, and assess its presence through diagnostic measures (O’Nions, Christie, Gould et al., 2014; O’Nions, Viding, Greven et al., 2014).

One of the reasons it is important to consider and discuss this profile is that the symptoms overlap with other disorders that may lead to PDA being missed or incorrectly diagnosed and therefore inappropriately treated. Given the overlap in symptomatology of PDA with other mental health issues, it can be confused with oppositional defiant disorder, bipolar disorder, attachment disorder, personality disorders, dissociative disorder, and other behavioral presentations (Eaton & Weaver, 2020; O’Nions, Christie, Gould et al., 2014; O’Nions, Viding, Greven et al., 2014). It is relevant to note, Newson et al. (2003) argued that PDA is developmental in nature, presenting early in life. They state behaviors commonly seen within PDA are driven by one’s attempt to reduce anxiety and distress triggered by real or anticipated demands rather than from other etiologies, including trauma, biochemical, willful position, or poor parenting.

Presence and Risks of PDA in OBH

Mental health professionals unfamiliar with this condition may not easily distinguish PDA from other behavioral or perhaps personality-based disorders from its neurodevelopmental nature (Eaton & Weaver, 2020). The diagnostic journey for individuals with PDA can be similar to the one with ASD. It is common for people with ASD to be evaluated but not diagnosed early in the evaluation process (Davidovitch et al., 2015), due to the evolving nature of the ASD profile. Similarly, it is important for individuals

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with PDA to be accurately diagnosed, otherwise they will not receive appropriate treatment. As OBH and other residential therapy professionals become familiar with the key characteristics of PDA, one diagnostic category to consider is: Other Specified Neurodevelopmental Disorder associated with Extreme (Pathological) Demand Avoidance (F88). It is also important to evaluate whether these individuals meet the criteria for ASD, as well as PDA. In this case, clinicians should diagnose ASD and add a specifier of PDA, drawing attention to these unique traits. Additionally, the specifier can be helpful to draw attention to a condition which has been described as not responding well to general autism guidelines and need appropriate modifications (Newson et al., 2003).

Positively, there have been efforts made to assess PDA by developing measures to identify and differentiate PDA from other disorders. O’Nions, Christie, Gould et al. (2014) developed the Extreme Demand Avoidance Questionnaire (EDA-Q), a parent completed, 26-item measure designed for research purposes rather than as a diagnostic tool. This instrument demonstrated promising psychometric properties with a high level of internal consistency. The EDA-Q provides cut-off scores to assist in evaluating the presence of PDA and differentiating between different disorders were also determined. These cut-off scores maximized both sensitivity and specificity to detect individuals with PDA. Similarly, O’Nions et al. (2016) evaluated the use of a clinician-rated measure for PDA by selecting 11 items from the Diagnostic Interview for Social and Communication Disorders (DISCO) (Wing et al., 2002). Subjects who scored high on these items were found to have a lack of cooperation, engage in what appeared to be manipulative behavior, and at times choose socially shocking behavior. They were also found to have difficulties in their relationship with other people, experience anxiety, and demonstrate sudden behavioral changes moving from loving behavior to aggression. O’Nions et al. (2016) suggest that these surveys provide useful clinician-rated measure of to assist in the diagnosis of PDA.

In OBH and other therapeutic residential environments, the risk of treating professionals seeing individuals with PDA through a purely behavioral or personality-based lens is significant. As a result, this could impact the way individuals affected by PDA are evaluated in their overall engagement of the program. The misunderstood young person with PDA

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will be left feeling confused and uncertain about what to do and how to engage in a process that seems insurmountable for them. As Savidge (2020) indicated in her investigation of ASD adolescent clients in OBH programs, 51% reported no change or a deterioration through the course of treatment. It could be theorized that at least some of these individuals may have had PDA in addition to ASD, and unfamiliar therapists and field guides did not know how best to approach and treat these individuals. Additionally, it is likely that for individuals with undetected PDA, their treatment plans would have been poorly designed and ineffective in treating their symptoms, leading to poorer outcomes.

Stress and Its Effects in PDA

Newson et al. (2003) described that anxiety interferes with individuals with PDA desire to exercise agency in moments of avoidance. Resistance to feared stimuli can be mistaken for defiance and willfulness. During these times, uninformed or misinformed adults and peers may move quickly to their own reactivity, including providing consequences and punishments for the undesirable behavior by the individual with PDA. The young person with PDA lacks flexibility in navigating daily expectations, and also struggles to manage their emotions and behavior in functional and adaptive ways (O’Nions, 2016). This is likely to impact their lives significantly and further contribute to poor interpersonal relationships. In working with young people with PDA, it is important for parents, teachers, paraprofessionals, and other caregivers to appreciate the underlying anxiety and how this drives the avoidance of perceived demands (Newson et al., 2003). Being clear about where this anxiety and avoidance originates will be helpful in addressing the emotion and reactivity in a supportive, understanding, and effective manner.

The primary issue for individuals with PDA involves resisting or avoiding daily expectations and real or perceived demands. Those with PDA find it anxiety-provoking and stressful to face things like waking up, going to school, eating, keeping a schedule, or even doing the things they enjoy doing (PDA Society, 2021). As these individuals confront everyday demands, they can experience significant mood changes and what appear to be disruptive and problematic behaviors (Newson et al., 2003). Newson and her colleagues (2003) indicate that behavioral consequences are not effective in the same way as when working with prototypical ASD without

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PDA. Individuals with PDA may perceive the demand as worse than any positive or negative consequence provided to them, and it is often seen as impossible to cope with or meet expectations or demands. Like many anxiety-based presentations, people with PDA are quickly reinforced for avoiding these stresses or everyday expectations or demands. It is helpful to consider the abundance of demands encountered in an OBH program, including social, emotional, cognitive, physical, sensory, and daily demands. It is likely that OBH programs unfamiliar with this condition would apply commonly used behavioral methods with these individuals, which will be largely ineffective with PDA clients (O’Nions & Eaton, 2020). It is important for OBH programs to consider other types of therapeutic approaches as they encounter individuals with PDA.

Treatment Considerations

O’Nions and Eaton (2020) relate: It is helpful to remember that children with a PDA profile are not deliberately difficult. If the socially strategic behaviour is seen for what it is - a scripted and limited strategy for ensuring predictability and control, rather than labelled as ‘manipulative’, the child’s behaviour can be reframed in a more compassionate way (p. 8).

It is important that professionals not view behavior as willful or defiant (e.g., oppositional defiant disorder), rather view it as an inability to act. The PDA Society characterizes PDA as a tug of war between the brain, heart, and body (PDA Society, 2021). Individuals with PDA may want to perform the task/expectation in front of them, which is what differentiates them from behavioral disorders, but their brain tells them they can’t, and their body shuts down due to their fear (defensive) response. Given the anxiety and stress individuals with PDA experience, the activation of their autonomic nervous system is likely implicated in their response to stress (Porges & Carter, 2017), and will need to be addressed.

Newson et al. (2003) posited that individuals with ASD only do not follow the same treatment patterns as those with ASD and PDA. Specifically, familiar and practiced routines are often helpful to individuals with purely ASD. However, for individuals who also experience PDA, those routines are often perceived as stressful expectations and demands, producing a fear response and shutting down through avoidance behavior. As a result, individuals with PDA need some modifications, as well as an

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approach which supports their path towards greater level of functioning in the face of anxiety-provoking demands (Newson et al., 2003).

The PDA Society references the ‘PANDA’ approach for caregivers and professionals who work with, treat and support individuals with PDA (PDA Society, 2021). PANDA stands for **P**ick battles, **A**nxiety management, **N**egotiation and collaboration, **D**isguise and manage demands, and **A**daptation. This approach involves seeing the person, exploring their interests, and positive engagement. For more information on this approach, refer to <https://www.pdasociety.org.uk/about-us-landing/our-ambassador/>. This society suggests that relationships with people with PDA should be ‘person-centered’ and based on a partnership of trust, flexibility, and collaboration. They suggest careful consideration of the words and language used, as well as a balance of demands when speaking with an individual with PDA.

Other practitioners have also noted the importance of a calm and collaborative process with an individual with PDA (Sherman & Vincent, 2021). Creating a sense of control for the individual is an important aspect of the treatment approach and avoiding the parent or task-oriented role. The authors note that the person with PDA will react with rigidity to a sense of being told what to do, and it is helpful for requests to be worded indirectly and avoid the word ‘you’. Creating a sense of teamwork, and suggesting, “We are on the same team! Let’s work together” is important. One should be prepared for the individual to react and resist, work with the young person’s ambivalence, and not react to failure. Sherman and Vincent (2021) further suggest framing things as a race or challenge or using humor by directing demands to other people or objects in the room.

While there is no specific treatment that has been empirically tested and validated for clients with PDA, practitioners have looked to the PDA Society to understand, assess, and treat this developmental condition in individuals. It is critical that OBH programs and other residential treatment programs learn how to best approach and treat this group of individuals. Practitioners need an understanding of how this clinical issue manifests and what conditions it may be similar to, so by extension, professionals can provide safe and effective treatments to this unique population.

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Identifying Applicable Clinical Theories and Approaches

This section will review a variety of theories and approaches when working with people with PDA and their families. Given the lack of research on specific clinical empirically supported treatments for individuals struggling with PDA, the authors will discuss approaches that treat aspects of PDA to assist professionals encountering and treating this profile (PDA Society, 2021).

Greenspan and Weider (1999) discuss addressing ASD from a developmental approach. Developmental approaches are relationship-based, child-centered, and play-based, which help to teach individuals with ASD skills in social relationships and engagement (Wagner, et al., 2014). Features and characteristics of PDA are common across the autism spectrum. These include lack of co-operation, changes in mood, blaming others, poor social awareness, rigidity, and anxiety (O’Nions et al., 2016). Given the overlap of ASD and PDA, developmental approaches could be useful when designing treatment interventions for individuals with PDA.

Individuals with PDA struggle with global functioning, impaired by their anxiety and fear of demands, their desire for control of situations they find stressful, pathologic avoidance of stressful situations, and cognitive rigidity. Given the myriad of issues that present with these complex individuals, professionals will more effectively serve individuals with PDA when a comprehensive treatment planning approach is taken, including: anxiety management, anger management and emotional regulation skills, distress tolerance skills, social skills training, psychotropic intervention, sensory integration techniques, mind-body awareness techniques, cognitive therapy, behavioral therapies, healthy lifestyles, and family therapy (O’Nions & Eaton, 2020; Sherman & Vincent, 2021).

PDA shares characteristics of anxiety disorders, wherein both general and specific fears are experienced. Individuals with PDA are hyper-focused on their fear of demands and anticipated outcomes, and rigid about their avoidance of situations and people they perceive as placing these demands on them. Over-control is also a feature of PDA, a struggle to deal with uncertainty, similar to that of individuals who experience ASD and OCD. There is high comorbidity in developmental disorders, anxiety disorders, and neurocognitive; American Psychiatric Association, 2013;

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Hoffman, 2012; Hoffman and Hudack, in press). Clinical treatments addressing these conditions may be fruitful to explore.

When confronted with demands, individuals with PDA can become highly emotionally dysregulated, similar to aggression observed in some individuals with ASD (Kanne & Mazurek, 2011). If these individuals are unable to escape through avoidance, individuals may mobilize a ‘fight or flight’ response to regain a sense of control (O’Nions & Eaton, 2020). Behavioral and psychological approaches addressing emotional dysregulation are important to practice (Lucyshyn et al., 2015; Porges & Carter, 2017), and psychopharmacology intervention may also be important to consider (McDougle, et al., 2003; Parikh, et al., 2008).

Related to the issue of emotional and behavioral dysregulation, family members and professionals may accommodate the individual in an effort to soothe the person or avoid the fallout from high levels of dysregulation (O’Nions & Eaton, 2020). Though, in so doing, they reinforce the problem behaviors and the belief that one cannot cope with stress (Hoffman, 2012). The family system is important to consider while treating these individuals in order to help others avoid reinforcing maladaptive ways of coping.

Given that individuals with PDA experience stress responses to feared stimuli, leading to an activated sympathetic nervous system, it is important to consider interventions and conditions that help to regulate the autonomic nervous system (ANS). One such related theoretical approach is the Stress Reduction Theory (SRT) (Ulrich et al., 1991). Ulrich and colleagues (1991) found that individuals exposed to natural environments experienced health benefits by engaging the parasympathetic nervous system. This leads to calming a dysregulated ANS, leading to improved recovery of the ANS, contributing to behavioral regulation, emotional regulation, and increasing cognitive flexibility.

The Polyvagal Theory (PT) described by Porges and Carter (2017) discusses three systems of the ANS as being behaviorally linked to three global adaptive domains of behavior: 1) social communication, 2) defensive strategies of mobilization, and 3) defensive strategies of immobilization. They theorize that body and mind are intimately connected, and both need to be considered when working with people

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experiencing states of stress and displaying defensive strategies. This appears consistent with the behaviors of individuals with PDA. This theory suggests it is important to help people find safety through their bodily experience, along with helping them cognitively. The PDA Society conducted survey research of individuals with PDA, and they found that respondents describe a neurological tug-of-war between brain, heart, and body (PDA Society, 2021), which seems to tie to PT well. Given this survey data, the description of anxiety and need for control, and connection to the ANS and stress response, mind-body therapeutic techniques would appear to be an effective treatment strategy with PDA. Meditation, breathing exercises, chants, and body posture exercises are all suggested methods to help regulate the vagal system (Porges & Carter, 2017). Voluntary regulated breathing practices have been shown to be effective with anxiety disorders, stress, and depression (Brown & Gerbarg, 2005).

Additionally, the PT suggests that the vagus nerve is involved in what is called the Social Engagement System (SES) (Geller & Porges, 2014; Wagner, 2016). Geller and Porges (2014) suggest that the SES is a proposed third part of the ANS, which has previously been considered a two-part system. The SES has a more nuanced response than the sympathetic and parasympathetic nervous systems. This theory describes the neural mechanisms through which physiological states communicate safety and threat to oneself and others (Porges & Carter, 2017). The SES allows individuals to engage effectively with those around them when positively activated while sensing safety. When an individual senses safety, this system allows for greater flexibility in coping styles, including positive social engagement and initiation and general openness and problem solving. When an individual senses threat, this system leads to more rigid and maladaptive ways of behaving including ‘fight or flight’ behaviors, and shutting down (Porges & Carter, 2017). Teaching individuals with PDA ways to engage the SES ‘state of safety’ may lead to increased cognitive flexibility and willingness to engage demands previously experienced as stressful and avoided. Additionally, practitioners engaging with individuals with PDA can aid in the positive activation of the SES through a present, client centered therapeutic relationship (Geller, 2018). This type of relationship is likely to lead to a ‘state of safety’ which will aid individuals with PDA to be more relaxed, more open to learning, and practice new behaviors introduced by their practitioners. The practice

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of present, client centered therapeutic relationships the PT promotes is consistent with the PANDA approach suggested by the PDA Society (PDA Society, 2021).

Mindfulness and acceptance-based therapies including Dialectical Behavior Therapy (DBT; Linehan, 2014), Acceptance and Commitment Therapy (ACT; Hayes et al., 2012), Acceptance Based Behavioral Therapies (ABBT; Roemer & Osillo, 2020; Treanor et al., 2011) and Radically Open Dialectical Behavior Therapy (RO DBT; Lynch, 2018) could be useful with these individuals to more effectively regulate their ANS, and challenge their beliefs about demands and their need for control over uncertain situations, thus helping them feel safe. Mental health professionals have applied these approaches to individuals who have ASD, OCD, Anxiety Disorders, and BPD; each of which share characteristics with PDA.

Case Example

Kevin was a 16-year-old male who presented for treatment as a result of academic failure due to severe school avoidance and unwillingness to do schoolwork. This pattern of behavior had escalated over several years. Of great concern, Kevin displayed aggression in the home when confronted about academic avoidance and parents' expectations to wake up and go to school. These confrontations triggered him to be physically aggressive with his father and threaten his father with a knife as well as to harm himself. Instead of engaging with his personal and academic responsibilities, Kevin was engrossed with online gaming, often playing throughout the night. If his gaming was restricted, it often led to threats, blowups, and property damage. Kevin had attended a therapeutic boarding school and had returned home for 6 months before his parents reached their threshold and sought more intensive treatment. His parents expressed some dissatisfaction with the previous therapeutic boarding school as "they didn't seem to push him hard enough" and encouraged the wilderness therapy program to challenge him more consistently to "break the pattern of avoidance of almost everything."

Early in treatment, it was thought that a precipitating event for Kevin's decompensation following his previous treatment was his parents' divorce. Kevin described feeling like being in treatment was the cause of

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his parents' separation. He said that the divorce was a traumatic and upsetting event for him. Early in his wilderness experience, the therapeutic process explored the divorce as trauma or loss, and how it contributed to his struggle to meet daily expectations. At that time, Kevin had undergone psychological testing and was diagnosed with ADHD, ODD, and Major Depressive Disorder. While being evaluated, it was noted that Kevin demonstrated at least a superficial sense of social skills, reciprocity in social communication, at least when it was a topic of interest, ruling out ASD. His parents described him as having an active fantasy life growing up, playing with imaginary friends, and enjoying adventure stories with wizards and witches. Kevin had a strong attachment to the Harry Potter and Percy Jackson series. As a child he was described as stubborn and preferred to be alone unless his peers played games in the way he wanted. His parents described him as "controlling" of his friends while growing up. This pattern of behavior also seemed to lead to a loss of various friends over the years. Once Kevin discovered online gaming, his social engagement changed dramatically. He rarely engaged with people in real life except when at school.

Upon arriving at the wilderness therapy program, he reluctantly greeted his field guides and was outfitted with his gear. He appeared notably unhappy and nervous but was cooperative upon admission into the program. However, on Kevin's second day, he refused to get up, spending much of the day in his sleeping bag, and even though there was a great meal that day due to a holiday, he appeared uninterested in attending the celebration.

Initially, the therapist and field guides followed through with the parents' requests and challenged Kevin to meet daily expectations by being firm and sharing clear expectations. It quickly became clear that was not an effective way to interact with Kevin. In fact, it seemed to push Kevin further away, as he withdrew from his guides and other students. He appeared agitated and retreated, though he did not display aggression with anyone in the program.

This pattern largely ensued for many weeks, where Kevin refused to participate in most aspects of the program. For example, soon after joining the group, Kevin spent the first 12 days in the same campsite, often refusing to get out of bed, staying in his sleeping bag most of the day, not

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eating or drinking adequately, and missing or refusing his medications. At times, it seemed as though the demands of the day and the group reduced in size, Kevin would come out of his sleeping bag and attempt to connect, albeit minimally. Other times, Kevin found something that the field guides or students said upsetting, off-putting, or demanding, and as a result, he returned to his sleeping bag.

One of the turning points in his engagement during the first month of the program seemed to coincide with spending time with an especially kind, caring, and patient field guide. This field guide seemed to connect well with Kevin and encouraged him to hike two times during that week. The field guide took time with Kevin to listen and foster a relationship while also learning about Kevin's interests. The field guide attempted to make the experience and expectations of the day more fun by engaging in fantasy and banter. This was seen as a significant success, and other field guides made future attempts to mirror this approach. For several weeks the group was able to hike as often as three times a week. Kevin began to complete more therapeutic assignments and treatment goals, fulfilled many of his daily expectations, and overall demonstrated more effort. It seemed like he had turned the proverbial corner. As he showed more focus and engagement, more was expected of him. However, this increased effort was not sustained, and his pattern of withdrawal and avoidance returned. Staff wondered if the encouraging approach became less effective, or if the increased demands placed on Kevin led him to revert to old patterns of avoidance.

Over the next few weeks, the progress seemed to disappear as Kevin returned to 'digging in his heels' and resisting meeting daily program expectations, including not meeting his own basic needs like eating or drinking. It seemed that as pressure increased and more was expected of him, Kevin withdrew. Regularly, when guides, other students, and his therapist attempted to engage with him and encourage him to do his part, he would share, "I can't." Due to the significant interference his behavior had on the rest of the group, the therapist designed an intervention where Kevin worked with two dedicated staff, essentially creating a group of one. This intervention was used as an opportunity for him to practice the daily skills without the pressure of the group and general program structure.

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While on this individualized intervention, an especially engaging and gregarious field guide stepped in as the lead guide for the week. Over the course of the week, Kevin and his assigned field guides hiked 22 miles, which was more than he had hiked in the previous six weeks that he had been in the program. During this hike he shared many stories and events of personal shame. Kevin shared that he wanted to do well academically but could not get himself to go because he felt overwhelmed much of the time. He expressed feeling guilty and ashamed about his trouble, and when his father [or others] pressured him, it made it worse. Kevin expressed that it felt like he was cornered and didn't know how to cope.

As the individualized intervention came to a close, he returned to the group. It was immediately clear that Kevin had more skills in managing daily expectations and was more invested in his therapeutic process. However, it soon became clear that a level of 'stuckness' was still present with Kevin, as his resistance continued to present intermittently for what seemed like no apparent reason. He struggled to make strong connections to the group, and he seemed to avoid or appear agitated with field guides that were direct, loud and demanding.

During his last month in the program, it was discovered that the most successful way of approaching Kevin was to involve him in a system that utilized incentives that he was personally interested in. Prior to this, a variety of arbitrary rewards and consequences were attempted, and most seemed ineffectual in helping him shift his behavior. In many ways, the relationship we had developed with Kevin allowed us to take some steps with him. As the therapist brainstormed this incentive idea with him, it was initially presented as something the therapist was not attached to, and also did not think would work. Kevin had shared that he enjoyed playing Dungeons and Dragons (D & D), a role-playing game, and wanted to play it while in the wilderness. As they discussed this opportunity, the therapist shared that he could earn some character sheets or printouts from the different D & D books or other things that interested him. They discussed that Kevin did not want to do a 'token economy' intervention as he already tried that at a previous program. However, they discussed that it would be different, only focusing on positive behaviors. This allowed Kevin to focus on prosocial behaviors and successfully complete Activities of Daily Living

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(ADLs). He expressed reluctance but was willing to try this because he was excited about playing D & D with the other students and field guides.

This weekly incentive system was a collaborative effort with Kevin and often followed a discussion-oriented to, ‘What do you want to earn this week?’ The goals and point system were within reach because he designed the point system himself. Initially, he wanted to earn a drawing pad, then a comic book. Over time he earned additional personal items, including D & D character sheets, sections of the D & D player’s handbook, and finally, some dice. Each week he became more eager to discuss things he wanted to earn than the previous week. The discussion of earning rewards dominated the early part of therapy sessions. Kevin identified which behaviors were worth various amounts of points, often at a rate lower than what the guides and his therapist would have expected. Each week he added behaviors that he thought were relevant to his overall growth areas.

Kevin tracked his points each day over the coming weeks. Having him earn points for positive behaviors only took away the temptation to ‘give up’ after getting stuck with one part of the day, which helped him recover from a ‘bad morning’ or a ‘bad day’. Nonetheless, he continued to struggle with typical daily responsibilities, including cleaning his cup, helping with chores, and hiking. At times, it was important to negotiate a way forward as not to fully withdraw or selectively pick the expectation or activity for which he would engage. Kevin often seemed to do better with positive support and when distracted by talking about things he enjoyed (i.e., D & D, video games, and favorite books and movies).

Previous attempts at rewards or reinforcements seemed ineffective because frequently, by the second day, Kevin would give up, which looked like not getting up for the day or hiking with the group. Ongoing points for positive choices or behaviors, rather than removing points for not completing a task, seemed to provide a reason to care about the next part of the day, as he could still earn points even when periods of regression or resistance occurred. At the end of each week, Kevin would proudly list the number of points he had earned, and for the last four weeks he was in the wilderness program, he set record after record for his efforts.

As noted above, the idea was to empower Kevin to want to do things, push through his anxiety, or practice ways of managing it more

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effectively, so he could join in more of the daily expectations and group activities. Focusing on the positive seemed helpful for him, especially when it appeared to be his idea. As it became clear that he typically resisted increasing demands and expectations, the therapist and field guides approached this part of him differently and began working on anxiety management and helping him regulate and work on acceptance of stress while changing his thoughts about various tasks.

While Kevin was not a typical wilderness therapy participant in many ways, more of these students are presenting for treatment for the same reasons. Being creative and finding ways to connect seemed to help him complete the program on an upswing and with significant pride and hopefulness. Kevin still had days when he avoided, withdrew, and shut down, sometimes having difficulty articulating the trouble he was having, and yet he engaged more fully in the program more consistently.

Conclusion

The diagnosis of pathological demand avoidance (Newson et al., 2003), a proposed subtype of autism spectrum disorder, has been observed and discussed for four decades. While it is still not recognized as a disorder in the DSM 5 or the ICD 11 (American Psychiatric Association, 2013; World Health Organization, 2019), we have begun to experience it and see it in OBH programs. It is vital that professionals at OBH and residential therapy programs become aware of this symptom presentation and not just see PDA as a behavioral or personality-based issue. Accurate diagnosis and understanding are critical to design an effective treatment plan for clients with whom mental health and associated professionals work (Hoag et al., 2014). It is not helpful to over pathologize a person, believing a problem exists where it does not (Milton, 2013; Moore, 2020); while it is equally unhelpful to not address a problem which causes significant interference in multiple aspects of one's life (American Psychiatric Association, 2013). A lack of understanding can lead to misdiagnosis, inappropriate treatments, and ultimately treatment failure.

Working with clients who have PDA, as described in the case example, requires significant effort, creativity, and flexibility on the part of the treatment professionals. In the absence of research regarding empirical treatments for PDA, the authors suggest utilizing therapies that target

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similar symptom presentations. Therapeutic interventions applied to individuals with pervasive developmental disorders and other mental health disorders are not going to ‘fix’ the problem, and improvements are often not consistently sustained. Training or retraining of the brain and its associated neurological systems takes time and repetition (Hoffman, 2012; Porges & Carter, 2017; Roemer & Osillo, 2020). The PDA Society (www.pdasociety.org.uk) provides many helpful resources, information, and ways of connecting with others who experience PDA and work with and treat clients with PDA.

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