

Pathological Demand Avoidance—Informed Reformulation After Poor Response to Direct Autism Intervention: A Case Report

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Abstract

Objective: To describe reformulation in an autistic child whose response to direct intervention was poorer than his demonstrated cognitive abilities predicted, and whether this discrepancy could signal a pathological demand avoidance (PDA) profile.

Method: This retrospective case report integrated caregiver history, assessment records, school observations, teacher documentation, intervention records and questionnaires for an Iranian boy who entered a micro-school at 4 years 10 months. Analysis examined whether demonstrated skills varied with interpersonal demand and changed when pressure was reduced.

Results: The child demonstrated preschool skills spontaneously and through play, yet often failed to access comparable abilities when requests became direct, repeated, monitored, praised, or linked to rewards. Pressure was associated with escalating avoidance and distress. This demand-sensitive discrepancy in cognitive performance across direct and lower-pressure conditions prompted PDA-focused reassessment. After the school reduced nonessential direct demands and used shared control, indirect requests, and role-mediated participation, teachers observed less freezing and crying within two to three weeks, followed by gains in engagement, communication, physical participation, and eating.

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Discussions: An established autism diagnosis may not provide a complete clinical formulation when intervention progress is inconsistent with demonstrated cognitive abilities. Poor performance under direct interpersonal demands, particularly when comparable abilities become more accessible under indirect, lower-pressure conditions, may warrant reconsideration and PDA-focused screening before pressure is intensified. Concurrent medication and service changes preclude causal attribution to the school reformulation alone.

Keywords: autism spectrum disorder, pathological demand avoidance, intervention response, clinical formulation, screening

1. Introduction

Autism spectrum disorder is a heterogeneous neurodevelopmental condition, with substantial variation in developmental profiles, support needs, co-occurring conditions, and trajectories (Hyman et al., 2020; Lord et al., 2020). Intervention effects likewise vary across children, outcomes, and study methods, and meta-analytic evidence cautions against assuming that a diagnostic label or broad intervention category will predict an individual child's response (Sandbank et al., 2020, 2023). When progress is unexpectedly limited, clinical reassessment should revisit the formulation, intervention goals and implementation, contextual barriers, and co-occurring conditions (Hyman et al., 2020). Less attention may be paid to a different possibility: the interpersonal form of intervention itself may influence whether the child can access and demonstrate skills that are already present (Green et al., 2018; O'Nions & Eaton, 2020).

This possibility is particularly relevant in structured autism services. Adult-initiated instructions, prompts, repetition, performance monitoring, feedback, and contingencies are components of many behavioral and educational procedures, although their balance differs across programs (Hyman et al., 2020; Schreibman et al., 2015). Such procedures can support meaningful gains for many children, but effects vary across outcomes and intervention contexts (Sandbank et al., 2020, 2023). For a child whose arousal and avoidance rise sharply when an activity becomes an explicit interpersonal demand, however, greater directness may produce a paradox: the more clearly the adult requests an acquired response, the less available that response becomes (Green et al., 2018; Newson et al., 2003; O'Nions & Eaton, 2020). If this pattern is interpreted only as noncompliance or insufficient learning, intervention intensity may increase while functioning deteriorates (Green et al., 2018; O'Nions & Eaton, 2020).

Pathological demand avoidance (PDA), also termed extreme demand avoidance (EDA), describes a proposed profile involving pervasive resistance to everyday demands, varied avoidance strategies, a strong need to retain control, and escalation when pressure to comply increases (Newson et al., 2003; O'Nions et al., 2014a, 2014b). PDA is not a standalone diagnosis in DSM-5-TR or ICD-11. Its boundaries, stability, mechanisms, and distinction from anxiety, oppositional behavior, trauma, sensory distress, executive difficulty, and contextual mismatch remain contested (Green et al., 2018; Kamp-Becker et al., 2023; Kildahl et al., 2021; O'Nions & Eaton, 2020; Stuart et al., 2020). Accordingly, the term is used in this report as a provisional clinical formulation describing demand-sensitive functioning, not as proof of a discrete disorder.

The contested status of PDA does not remove the practical recognition problem. The EDA-Q and its refined short form, the EDA-8, quantify caregiver-reported resemblance to PDA/EDA descriptions (O’Nions et al., 2014a, 2021). Yet systematic and scoping reviews show that the evidence base remains methodologically limited, strongly concentrated in UK samples, heavily reliant on caregiver report, and sparse in relation to intervention and service-level decision making (Haire et al., 2024; Kildahl et al., 2021). Studies of educational experiences and practicing psychologists likewise describe substantial service challenges and a lack of clear empirically grounded guidance for supporting marked demand avoidance (Gore Langton & Frederickson, 2016, 2018; Haire et al., 2023; Truman et al., 2024). Evidence from outside the UK remains comparatively limited, although population and service research has been reported in the Faroe Islands and Ireland (Doyle & Kenny, 2023; Gillberg et al., 2015). Neither EDA-Q nor EDA-8 has been formally adapted or validated for Persian-speaking services. More importantly for the present case, autism teams need a structured way to recognise when unexpectedly poor outcomes—rather than an initial diagnostic question—should prompt PDA-focused screening and broader reformulation.

This paper reports an Iranian preschool child with an established autism history and demonstrated learning ability whose progress remained markedly below expectations during direct intervention. The case is used to examine two linked questions: what features justified considering a PDA profile despite confirmed autism, and what changed when the educational-therapeutic environment was reformulated. The report is intentionally limited to the recognition and early post-reformulation period; longer-term follow-up is outside its scope.

2. Method

2.1 Design and reporting approach

A retrospective, single-case design was used. The report follows the CARE case-report principles where applicable, including a chronological account, diagnostic reasoning, intervention description, outcomes, competing explanations, and caregiver perspective (Gagnier et al., 2014). The paper does not test treatment efficacy or diagnostic accuracy. Its analytic purpose is clinical and hypothesis-generating: to determine why intervention performance appeared disproportionately low relative to the child’s demonstrated competence and whether the pattern justified PDA-specific screening.

2.2 Information sources and case window

Information was integrated from the mother’s developmental history and written narrative, available autism assessment records, school intake and progress notes, contemporaneous naturalistic observations by school staff, a detailed teacher account of post-reformulation teaching, records of external autism services, medication and service changes, and recorded EDA-Q and EDA-8 totals. The primary case window begins with entry to the micro-school in summer 2024 and ends when the separate autism-center service concluded in March 2025. A written

caregiver account provided in April 2025 was used only as a retrospective perspective on early change. Later quantitative and longitudinal observations were not analyzed for this report.

2.3 Formulation framework

The chronology was organized around four clinically testable observations: (a) whether the required skill had been demonstrated in another context; (b) whether directness, repetition, monitoring, praise, or contingency systematically reduced access to that skill; (c) whether the pattern recurred across activities, people, settings, or information sources; and (d) whether reducing interpersonal pressure or sharing control was followed by improved participation. These observations were considered together with alternative explanations, including task difficulty, anxiety, sensory overload, communication mismatch, attentional and executive demands, fatigue, learned escape, adverse prior experiences, and medical or pain-related factors.

2.4 Ethical safeguards

The child is referred to by the pseudonym “Sam,” and identifying details have been minimized. The report concerns information generated during routine clinical and educational care; no research-specific intervention was introduced. Written informed consent for publication of the de-identified case information was obtained from the child’s mother.

3. Case Presentation and Clinical Course

3.1 Developmental and diagnostic history

Sam entered an autism-focused educational-developmental micro-school at 4 years 10 months. His mother described early language and conceptual learning as broadly timely or advanced. He pronounced difficult words accurately and learned colors, shapes, and numbers in both Persian and English before preschool. The developmental picture was nevertheless uneven. Sensory sensitivities, repetitive questions, restricted eating, difficulty with transitions, inconsistent social response, weak help-seeking and nonverbal communication, attentional regulation difficulty, and emotional dysregulation were reported. He also disliked being praised or filmed and sometimes stopped an activity when he became the focus of attention.

A competence-performance discrepancy was apparent before specialist schooling. At approximately 3 years, Sam appeared to understand an instruction to place one cone on another but deliberately placed it elsewhere. At approximately 4 years, he could answer familiar questions and follow simple directions at home but did not demonstrate the same abilities for unfamiliar assessors. Early kindergarten attendance was marked by limited verbal interaction with peers, intrusive physical attempts to initiate contact, difficulty remaining in the classroom, and conflict around rules. Earlier play- and occupation-oriented services were also characterised by marked resistance and little observable progress.

Autism had been supported across three professional assessments from separate clinical sources before and during the 2024 referral pathway, using caregiver interview, clinical observation, developmental information, and autism-related rating-scale evidence. Available descriptions varied between mild and moderate autism. The autism formulation is not disputed in this report: Sam continued to show clinically meaningful social-communication, sensory, behavioral-flexibility, and regulation needs. At the same time, vocabulary, conceptual learning, memory, and spontaneous acquisition of preschool concepts appeared stronger than his performance during structured assessment or teaching suggested. No formal intelligence-test result was available; therefore, this report refers to demonstrated learning ability rather than assigning an IQ level.

At a separate autism clinic, a locally modified Persian Gilliam Autism Rating Scale form was completed by a clinic assessor on 30 July 2024 and yielded a recorded total of 62. Because the modifications, norms, and equivalence to a published GARS edition could not be verified, the score is included only as part of the historical diagnostic record and is not interpreted as a valid severity estimate.

3.2 Concurrent autism intervention and the below-expected response

Micro-school attendance began with 30- to 60-minute familiarization visits and gradually increased to a full 08:00-14:00 day. School goals included peer communication, preschool learning, self-help, motor participation, and classroom routines. At the external autism clinic, Sam's mother received training in play, interaction, and visual schedules during August and September 2024. Individual sessions described by the clinic as applied behavior analysis (ABA) began in October 2024, three days per week for approximately three hours per session. The external clinic and micro-school operated concurrently but did not share a clinical formulation or coordinate treatment changes.

Outcomes were substantially poorer than expected from the skills Sam demonstrated in familiar and self-initiated contexts. During individual ABA sessions, he reportedly completed almost no tasks independently; his mother sometimes entered the session to obtain any responding. In the micro-school, direct instructions commonly evoked a recognizable sequence: "I don't know," "I can't," "you do it," or "I want to go," followed by silence or freezing, crying, nail picking, and, at times, hair pulling or hitting his head or legs. Repetition, insistence, close observation, reward contingencies, and the expectation that a successful action would be repeated tended to intensify rather than resolve the impasse. A visual schedule helped him know when the activity would end but did not reliably restore access to the requested skill.

The same actions could appear under different conditions. Sam sometimes completed equivalent tasks at home, spontaneously, in pretend play, or when adult attention was directed elsewhere. He could abandon an enjoyable action after realizing that he was being watched, praised, filmed, or might be asked to repeat it. Even an expectant smile could be experienced as pressure. The clinically important finding was therefore not refusal alone. It was that the probability of performance changed sharply when an action became an explicit, monitored interpersonal demand.

In mid-November 2024, the external clinic independently changed ABA from individual to group delivery because the child did not appear to have a global cognitive limitation and resistance was most prominent during one-to-one tasks. When adult attention was distributed, Sam completed some preferred activities with his mother present. Group ABA continued through March 2025. This change was not based on the micro-school's later PDA formulation. Because services overlapped and were not coordinated, the relative effects of clinic and school procedures cannot be separated.

Table 1. *Timeline of the recognition and early reformulation phase*

Period	Context	Clinical meaning
Before summer 2024	Multiple autism-related assessments and earlier play/occupation-oriented intervention	Autism-related needs were documented, but structured performance was repeatedly lower than ability demonstrated at home.
July 30, 2024	External autism-clinic assessment	Locally modified Persian GARS record: total 62; retained only as historical information.
Aug-Sep 2024	Gradual micro-school entry; caregiver training at external clinic	Familiar, low-pressure contact was better tolerated; visual scheduling mainly clarified when demands would end.
Oct-mid-Nov 2024	Individual ABA, approximately 9 h/week, concurrent with micro-school	Minimal independent task responding; caregiver sometimes entered sessions. School staff observed pressure-linked freezing and distress.
Mid-Nov-Dec 2024	External clinic independently shifted to group ABA; micro-school began systematic review	Distributed adult attention allowed some preferred responding, while the competence-performance discrepancy became central to school formulation.
December 2024	Multi-source PDA-focused review	Caregiver history, school observation, teacher records, and informal EDA questionnaire totals converged on a demand-sensitive working formulation.

Period	Context	Clinical meaning
Dec 2024-Mar 2025	PDA-informed micro-school adaptations; external group ABA continued; fluoxetine was initiated during this period	Reduced freezing and crying within about 2-3 weeks, followed by broader but non-linear early gains; group ABA ended in March, and overlapping changes preclude causal attribution.

3.3 PDA-focused reassessment

The existing autism diagnosis was retained, but it no longer served as a sufficient formulation of the treatment response. The micro-school team and caregiver reconsidered the case around a different question: why did Sam lose access to an already demonstrated ability when another person requested, monitored, evaluated, repeated, or rewarded it? The pattern was compatible with descriptions of PDA/EDA because pressure appeared to increase avoidance and emotional escalation, while indirectness and self-initiation increased access to the same behavior.

In December 2024, the school psychologist orally translated the EDA-Q and EDA-8 for Sam's mother. Recorded totals were 61 and 21, respectively. These results increased concern but were not treated as validated Persian scores or diagnostic confirmation: the translation had not undergone formal cultural adaptation, and complete item-level records were unavailable. The questionnaires were considered alongside caregiver examples, developmental history, direct naturalistic observation, teacher documentation, and variation in response across demand conditions.

The resulting formulation was autism with severe demand-sensitive avoidance consistent with a PDA/EDA profile. This wording is deliberately formulation-based. Anxiety, sensory sensitivity, attentional and executive load, intolerance of uncertainty, prior adverse experiences of pressure, learned escape, and contextual mismatch could have contributed to the same pattern. PDA screening did not replace these explanations; it changed what the team observed and how demands were tested. The central working hypothesis was that perceived interpersonal control reduced functional access to competence.

3.4 Reformulation of the micro-school environment

The micro-school did not remove learning goals or all limits. Essential safety expectations remained. What changed was the route by which Sam encountered expectations. Staff reduced nonessential direct commands, repeated prompting, close evaluative attention, and conventional praise. They allowed observation before participation, offered genuine choices, divided tasks into smaller units, and returned to activities after conversation, humor, movement, visual attention shifts, or brief rest. The teacher's role shifted from a person who obtained compliance to a collaborative partner who helped Sam retain access to an activity.

Table 2. *Case-specific reformulation of demand delivery*

Formulation target	How it was implemented	Early observed response
Reduce evaluative salience	Repeated prompts, close watching, and verbal praise were minimized; feedback was neutral and sometimes limited to a shared smile.	Sam was less likely to stop immediately after success and remained available for further participation.
Route requests through play	Teacher and child initially wore animal masks; later, instructions were spoken by fictional characters such as a wolf and the school cat Milo.	Task engagement increased while the masks could gradually be faded.
Use indirect/nonverbal choice	Rather than requiring an oral color response, the teacher first offered two finger choices; later Sam could touch the required pencil for the teacher to retrieve.	The educational target remained while verbal-performance pressure decreased.
Build recovery into work	Worksheet items were separated by conversation, looking through a window, checking on a preferred cat, or a brief pause.	He returned to tasks more often instead of progressing directly from refusal to freezing and crying.
Share control of sequence	In physical education, Sam helped arrange equipment and initiate the order of activities.	Participation increased when he influenced how the demand unfolded.
Use symbolic mediation for self-care	Dolls and pretend reactions to taste were used during meals.	Food participation and emerging independent eating at school improved.
Permit different forms of participation	Sam could watch, point, answer through a role, or begin with one item before conventional performance was expected.	Access to the group and task was preserved while participation expanded gradually.

4. Outcomes

4.1 Early school response

Teacher records described a visible reduction in freezing and crying within approximately two to

three weeks of the first systematic demand-sensitive adjustments. Improvement first appeared as greater access to activities rather than disappearance of avoidance. During pencil-and-paper work, Sam moved from watching the teacher, drawing one line, or placing a few dots to making more task-relevant marks and completing additional items when the same activity was embedded in role play and separated by recovery periods. In physical education, he progressed from not following the sequence to participating after helping organize it. At mealtimes, pretend play supported tasting and the beginning of more independent eating at school.

Communication became more spontaneous. Sam increasingly asked adults about preferred animals, approached peers, and remained in shared activities for longer. These changes were naturalistic observations rather than blinded or standardized outcome data. They were also not linear. School staff described renewed difficulty during periods of greater cumulative demand across the micro-school and external intervention. The association cannot show that group ABA caused deterioration; fatigue, novelty, inconsistent expectations, or other unmeasured variables could have contributed.

4.2 Caregiver perspective

In a written account provided in April 2025, after the primary case window, Sam's mother retrospectively described broader conversation with peers and relatives, increased persistence after unsuccessful attempts, better participation in individual and group activities, wider food variety, eating with other people, and greater tolerance of changes in setting. She also reported continuing difficulty with toileting, sleep and waking routines, and eating without conversation or interest-based distraction. Her account therefore described meaningful change without implying complete resolution and was not treated as an independent prospective outcome measure.

A direct narrative from Sam was not obtained because of his young age and the retrospective design. His preferences, refusals, requests for pauses, and observable willingness were represented through contemporaneous records and adult reports; the caregiver account should not be interpreted as the child's own perspective.

4.3 Concurrent influences

Fluoxetine was initiated between January and March 2025; the accessible retrospective record did not contain sufficient dosing information for analysis. External group ABA continued during most of the early school reformulation and was subsequently discontinued in March following the school's request. Medication, service discontinuation, increasing familiarity, and caregiver learning therefore overlapped with the observed changes, and the early improvement cannot be attributed to the micro-school adaptations alone.

4.4 Case-derived recognition pattern

Across the case record, the clinically informative pattern was not poor intervention response

alone, but a discrepancy between demonstrated ability and performance under different demand conditions. Despite autism being supported across multiple independent professional assessments, Sam's progress under direct, adult-led intervention remained markedly below that expected from abilities demonstrated in familiar and self-initiated contexts. Access to the same or comparable skills improved when demands were presented indirectly, with lower interpersonal pressure, or through self-initiated and role-mediated activities. This demand-sensitive competence–performance discrepancy became the principal case-derived signal prompting reconsideration of the existing formulation and subsequent PDA-focused assessment.

5. Case-Derived PDA Screening Checklist

5.1 Why a separate recognition step was needed

This case suggests that a confirmed autism diagnosis can create a recognition blind spot. When progress is poor, clinicians may reasonably focus on autism severity, skill deficit, treatment dose, or reinforcement. Yet none of those explanations alone captured Sam's ability to perform under low-pressure conditions and lose the same performance when the social demand became explicit. If that contrast is not recorded, services may intensify direct procedures before asking whether directness is part of the problem.

At least one PDA-specific screening measure should therefore be considered when three conditions coincide: autism is suspected or established; intervention outcomes are markedly below what the child's demonstrated abilities would predict; and direct, repeated, monitored, or evaluative demands are associated with deterioration. The EDA-Q and EDA-8 are important caregiver-report measures and may be used where linguistically and clinically appropriate. Across the literature reviewed for this report, we identified no Persian, multi-source workflow that begins with a treatment-response discrepancy and guides a centre or school from initial concern to further assessment; this gap is consistent with broader reports of limited assessment guidance and variable professional approaches to EDA/PDA (Haire et al., 2023, 2024; Kamp-Becker et al., 2023).

5.2 Proposed checklist and intended use

The Persian development version was derived from the recognition questions raised by this case and mapped to foundational PDA descriptions, EDA-Q/EDA-8 research, DISCO-based work, clinical overviews, systematic and scoping reviews, and critical accounts of alternative explanations (Green et al., 2018; Haire et al., 2024; Kamp-Becker et al., 2023; Kildahl et al., 2021; Newson et al., 2003; O'Nions & Eaton, 2020; O'Nions et al., 2014a, 2016, 2018, 2021). Ten professionals with relevant clinical, educational, developmental, or rehabilitation expertise reviewed item necessity, relevance, and clarity. This review was used to refine the development version; it is not presented as psychometric validation.

The checklist is targeted rather than universal. It is intended for children in autism assessment, education, or intervention services who show severe demand avoidance, pressure-linked escalation, or progress substantially below demonstrated ability. Its five domains assess direct demand-avoidant features; competence-performance discrepancy and reversibility; temporal

course; variation across settings and people; and variation by the type or delivery of demands. Information may be supplied by a parent, teacher, therapist, records, and direct observation, with multi-informant completion preferred whenever feasible.

No total score or diagnostic cut-off is recommended. The checklist guides one of three provisional actions: continue the usual pathway with monitoring when evidence is insufficient; obtain additional multi-source information and broader clinical assessment when a PDA profile remains plausible; or avoid escalating pressure and temporarily review the intervention plan while assessment is completed. It does not diagnose PDA, override an autism diagnosis, replace the EDA-Q/EDA-8, or justify stopping an otherwise indicated intervention. The checklist remains an unpublished, development-stage instrument and is not currently available for public use.

6. Discussion

6.1 Principal clinical finding

The principal finding is not that a failed intervention reveals PDA. It is that an established autism diagnosis should not close further formulation when outcomes are markedly lower than expected. In Sam's case, the informative signal was the conjunction of three observations: demonstrated competence outside direct teaching, systematic loss of performance as interpersonal pressure increased, and partial restoration of participation when demand delivery changed. That conjunction justified PDA-specific screening and reformulation. Poor progress without this pattern would not support the same inference.

This distinction protects the argument from two errors. The first is diagnostic overshadowing: attributing every treatment difficulty to autism severity or deficient motivation. The second is PDA over-attribution: using the label to explain any refusal while overlooking pain, anxiety, sensory overload, language or executive demands, trauma, fatigue, unrealistic goals, poor treatment fidelity, or adverse environmental contingencies. Anxiety and intolerance of uncertainty are plausible contributors to demand avoidance, but available findings do not reduce EDA/PDA to a single mechanism (O'Nions & Eaton, 2020; Stuart et al., 2020; White et al., 2023). A screening result should widen formulation, not prematurely narrow it.

6.2 Why direct-demand intervention mattered

The report does not evaluate ABA as a general treatment category. The external service used the term ABA, but a treatment manual, fidelity data, trial-level outcomes, and supervision records were unavailable. Causal or general claims about ABA are therefore unwarranted. What can be stated is narrower: in this child, adult-led requesting, repetition, monitoring, praise, and contingencies were repeatedly associated with reduced access to known skills. Changing those interpersonal variables at school was followed by early improvement. The clinically relevant unit was not the treatment label but the functional relation between demand delivery and performance.

The within-child contrast is consistent with the transactional emphasis recommended in critical PDA literature: avoidance is produced within an interaction between the child, the demand, the adult, and the wider environment, rather than residing solely as a fixed trait inside the child (Green et al., 2018; Haire et al., 2023; Kildahl et al., 2021; O’Nions & Eaton, 2020). Educational studies report high levels of school difficulty and placement disruption in children described as having PDA/EDA, while greater flexibility and adaptation of the educational context are repeatedly identified as important in parent and practitioner accounts (Gore Langton & Frederickson, 2016, 2018; Truman et al., 2024). Published case-based literature remains sparse and includes four case descriptions from a population-based epilepsy cohort (Reilly et al., 2014) and a school case in which commonly used autism strategies were ineffective until an EDA-informed, flexible educational plan was adopted (Lyle & Leatherland, 2018). The present report adds an early-childhood case from a non-UK context and makes the treatment-response discrepancy the entry point for screening.

6.3 Contribution and limits of the proposed checklist

The authors’ development-stage checklist (Farshchi et al., 2025) is a preliminary, non-diagnostic aid for investigating cases in which intervention performance is unexpectedly inconsistent with demonstrated competence. It prompts clinicians to examine whether performance varies systematically with demand characteristics, context, time, and interpersonal delivery. Unlike caregiver-report measures such as the EDA-Q and EDA-8, which assess characteristics associated with PDA/EDA (O’Nions et al., 2014a, 2021), it structures initial recognition; it neither establishes PDA/EDA nor replaces comprehensive clinical assessment. It also informs provisional decisions about monitoring, further assessment, and caution before increasing pressure. Its provisional status accords with literature emphasizing limited diagnostic consensus and methodological uncertainty in PDA assessment (Haire et al., 2024; Kamp-Becker et al., 2023; Kildahl et al., 2021).

The checklist must remain a development-stage aid until tested prospectively. Necessary studies include Persian cognitive interviewing, feasibility in routine autism services, inter-rater and test-retest reliability, factor structure, convergence with EDA-Q/EDA-8, discrimination from anxiety and other causes of avoidance, diagnostic-accuracy studies against an independently defined reference process, and examination of whether checklist use improves decisions without increasing over-identification or delaying other assessment. No score-based classification should be introduced before such evidence exists.

6.4 Strengths and limitations

Strengths include a clinically consequential contradiction documented across home, school, assessment, and external intervention contexts; chronological description of both deterioration and early improvement; explicit separation of demonstrated ability from demanded performance; and operational detail about how the school changed its approach. The Iranian setting is also important because almost all published child and adolescent PDA studies have been conducted in or recruited predominantly from the United Kingdom (Haire et al., 2024).

Limitations are substantial. This is a retrospective single case without experimental control, blinded assessment, stable quantitative baseline, or standardized implementation. The external ABA protocol and fidelity were not available. The GARS record came from a locally modified form, and the EDA questionnaires were orally translated without formal Persian validation. Fluoxetine, discontinuation of group ABA, caregiver learning, increasing familiarity, natural maturation, fatigue, expectancy, and other contextual variables overlapped with the observed improvement. A direct child narrative was unavailable, and adult reports cannot substitute for the child's perspective. Medical, sensory, anxiety, communication, and learning contributors were not documented with equal depth. The report therefore supports clinical plausibility and a screening hypothesis, not treatment efficacy, PDA diagnostic validity, or checklist accuracy.

An earlier Persian-language web article described aspects of the family's experience. That account was not peer reviewed and contained retrospective attributions that were corrected against the service chronology for this report. The current manuscript should be disclosed to the journal as a substantially expanded, clinically structured, and analytically distinct case report. Finally, this paper ends in March 2025 and deliberately excludes the subsequent longitudinal trajectory, later quantitative monitoring, and durability of change.

7. Conclusion

This case illustrates that a well-established autism diagnosis does not necessarily provide a complete clinical formulation when a child's response to intervention is markedly inconsistent with their demonstrated abilities. Despite autism having been supported by multiple independent professional assessments, the child showed a striking discrepancy between poor progress under direct, adult-led demands and substantially better access to the same or comparable skills when demands were presented indirectly and with less interpersonal pressure. This pattern prompted reconsideration of the existing formulation and a PDA-focused assessment.

These findings suggest that unexpectedly poor progress under direct intervention should prompt clinical reconsideration when it is disproportionate to the child's demonstrated competence, particularly when performance improves as demands become less direct or less salient. In such cases, increasing intervention intensity without first examining the nature of this discrepancy may overlook a clinically meaningful demand-sensitive pattern.

Data Availability

The checklist remains an unpublished, development-stage instrument and is not currently available for public use. Descriptive information regarding its purpose, conceptual basis, intended use, and limitations is provided in this manuscript. Child-level records are not publicly available because residual re-identification risk cannot be eliminated in a single-case report. De-identified information may be considered upon reasonable request, subject to maternal consent and applicable institutional requirements.

Conflict of Interest

Two authors were professionally involved in the micro-school from which part of the case information originated and participated in developing the proposed checklist. This positional relationship is acknowledged as a potential source of interpretive bias. The authors report no financial conflict of interest.

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