Saavedra and Silverman (2002): Button phobia

Lesson 1.3.3 | Concepts and methods

1. Psychology and background

Specific phobia: persistent fear/avoidance of a particular object or situation, interfering with life. **Fear** concerns perceived threat; **disgust** is revulsion. Both can contribute to avoidance.

Classical conditioning: associations change the response to a stimulus. **Expectancy learning:** the object signals a feared negative outcome. **Evaluative learning:** the object itself becomes negatively evaluated, without requiring an expectation of objective danger.

Operant links: escaping buttons can remove distress and negatively reinforce avoidance. Rewarding contact can positively reinforce approach. Improved approach does not automatically mean disgust has disappeared.

2. Aim and case

Examine the role of disgust and evaluative learning in one child's button phobia and treatment. Longitudinal clinical case study of a nine-year-old Hispanic American boy referred with his mother to a university child-anxiety programme in Miami.

Avoidance had lasted about four years. At age five, a bowl of buttons reportedly spilled over him during a school art task. He later avoided buttoned clothing and contact, affecting uniform use and concentration. This retrospective history suggests a possible learning event, not a demonstrated cause.

3. Assessment and first treatment phase

Child/parent anxiety interviews, observed approach, a ranked distress hierarchy and the **Feelings Thermometer (0-8)** supplied different data. Sessions included about 30 minutes with the child and 20 with the child/mother.

Gradual real-life exposure progressed from easier to harder button tasks; his mother reinforced successful completion. After early behavioural improvement, persistent disgust prompted further imagery and cognitive work.

> A case study is an in-depth investigation of one participant. It is not a controlled experiment with a randomly assigned treatment and control group.

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Lesson 1.3.3 | Evidence and interpretation

1. Initial distress hierarchy

Example stimulus/task	Distress / 8
Large denim-jean buttons	2
Large coloured plastic buttons	4
Hugging mother wearing large plastic buttons	5
Medium clear plastic buttons	6
Small clear plastic buttons	8

2. Approach improved before distress did

By session four, all tasks in the hierarchy had been completed. However, ratings rose between sessions two and four, sometimes exceeding initial distress. The child could approach buttons while still evaluating them negatively.

Further questioning revealed revulsion and unpleasant smell associations. The next seven sessions incorporated progressively harder imagery, such as buttons falling on him, alongside cognitive strategies targeting negative evaluations.

3. Imagery ratings

Imagined event	Before	Midway	After
Hundreds of buttons falling on his body	8	5	3
Hugging mother in a shirt full of buttons	7	4	3

These are one child's ratings during two exposures, not group means or separate experimental conditions.

4. Outcome and conclusion

After treatment, distress was minimal and the boy no longer met the study's DSM-IV specific-phobia criteria. He wore his school shirt with clear plastic buttons daily. Gains were maintained at six- and twelve-month follow-ups.

Conclusion: disgust was important in this case. Disgust-focused work accompanied improvement, but the combined, sequential treatment does not isolate one effective mechanism.

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Lesson 1.3.3 | Evaluation and connections

1. Strengths

Depth: interviews and a detailed history illuminated an unusual phobia.
Multiple measures: observation and subjective ratings revealed that approach and distress did not initially improve together.
Longitudinal follow-up: six-/twelve-month assessments checked maintenance beyond immediate treatment.

2. Limitations

One selected case: age, background and unusual symptoms restrict generalisation.
No control: time, expectations, family involvement and earlier exposure could also affect later change.
Combined treatment: reinforcement, in-vivo exposure, imagery and cognitive work were not independently compared.
Retrospective history: remembering the onset years later may involve reconstruction.

3. Child ethics

The boy and mother gave informed consent for assessment/treatment. The mother later provided written permission for the report and publication after follow-up. The child was not named; detailed clinical information still required confidentiality.

Exposure deliberately brings contact with distressing stimuli. Initial increases in ratings show why visible compliance cannot be the only welfare measure. Monitor distress, maintain assent/withdrawal and adapt treatment carefully. A positive eventual outcome does not erase the need to assess burdens.

4. Applications and debates

Application: assess emotional experience as well as observed avoidance; disgust may matter even when approach improves.
Nature/nurture: the learning account and changing responses support experience-related influences, without excluding biological predispositions.
Individual/situational: treatment was adapted to one child's responses and family context.
Children: direct clinical research can inform age-appropriate help, but consent and privacy need special care.

> Remember: reduced avoidance, reduced disgust and absence of a diagnosis are different outcomes. Do not use them interchangeably.

Hint: Separate evidence about how a phobia began from evidence about what happened during treatment. Neither automatically identifies a single cause.