



## Conquering Pedaphobia: A Case Study of Counselling Interventions

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### ABSTRACT

This paper presents a case study of a 22-year-old female client who came for counselling sessions for the purpose of overcoming her pedaphobia. Symptoms, such as, dizziness, nausea, arousal, sweating palm and body shaking were noticed to be visible not only by the presence of a real child, but also by pictures, stories and imaginations of infants. Systematic desensitization technique, a form of Exposure Therapy, was applied to treat the client. It involved relaxation and breathing techniques, and supported by the application of live modelling guided participation. Along with the interventions, Rational Emotive Behaviour Therapy techniques were also applied, such as, thought recording, irrational thoughts identification and disputation, Rational Emotive Imagery (REI), coping self-statement, and forceful self-statement. By the end of the therapy, the client reported to have experienced a decline in the occurrences of symptoms and demonstrated the ability to overcome her phobia.

*Keywords:* phobia; pedaphobia; systematic desensitization; counselling intervention; rational emotive behaviour therapy

### INTRODUCTION

Fear can be described as an unpleasant and distressing emotion which we usually experience when we believe that we are at risk. This emotion exists for survival purposes as it helps us to steer away from danger by activating our fight and flight responses. However, the fact that it can also be set off by false beliefs and imaginations,

our daily activities and quality of life might be affected even when there is no real danger.

A phobia is a type of fear based on a misdiagnosis of a threat and a persistent irrational aversion to phobic stimulus, which causes the sufferer to feel compelled to avoid at all costs (Furness-Smith, 2014). The earliest reference to phobia was by Hippocrates in fourth century. The term of 'phobia' was coined after a Greek God known as Phobus. Phobus was believed to

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be able to make victory in battle by reducing the enemy to a state of abject terror (Wright, 2014). The modern usage of the term started in 1786 when phobia was defined as “a fear of an imaginary evil, or an undue fear of a real one” by Oxford English Dictionary (Furness-Smith, 2014).

Phobia is usually a learned response, although some phobias might be caused by nature or genetic. It can be divided into various categories, and under Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-V) phobias are classified into three groups, namely, specific phobia (animal, natural environment, blood-injection-injury, situational and other), social phobia, and Agoraphobia.

### **Pedaphobia**

On January 14, 2013, ABC News reported a case of a high school teacher in Ohio, United States who claimed discrimination over her rare phobia – pedaphobia. Waltherr-Willard who was transferred to a position teaching Spanish at a junior high school asserted to experience anxiety when she was around young children. Her lawsuit stated that her health suffered tremendously once transferred, where her blood pressure rose and she was at risk for a stroke.

Like any other unusual phobia, such as, selenophobia (fear of the moon), euphobia (fear of hearing good news), and plutophobia (fear of wealth), pedaphobia is not recorded in DSM-V, but the sufferers showing the symptoms of phobia, which are related closely to anxiety and caused the individuals to avoid phobic stimulus.

Pedaphobia (alternatively called “paedophobia” or “pedophobia”) basically means fear of infants or children, where by the word *peda* comes from the Greek word for child. It is related to age-focused

fears, such as, ephebiphobia – the fear of youth, and gerontophobia – the fear of the elderly (Schwartz, Houlihan, Krueger, & Simon, 1997). Besides, previous studies also identified the fear of child as a factor affecting conception and pregnancy (Kometer & Fiegl, 1998) which might lead to tokophobia – fear of getting pregnant and giving birth.

Research related to pedaphobia is very limited, hence, the causes of the phobia are not clearly defined. Some authors suggest fear towards children is due to adults’ distinct awareness of the capacity of children (Coiner & Geroge, 1998), as the modern age has created a culture of pedaphobia by highlighting about toddlers unable to sit still and running amok in nurseries causing chaos (Grigg, 2015). Others believe it may be caused by childhood experiences, such as, sexual and physical abuses. Besides, there is also research on the influence of horror films that instilled the idea of children being rather nastier than innocent, which vacillated between ‘twin extremes of protectiveness and pedaphobia’ (Coghlan & O’Sullivan, 2011).

### **Systematic Desensitization**

Systematic desensitization technique is a well-known approach and widely used for phobia treatment. It was developed by Joseph Wolpe, a South African Psychiatrist, in 1950s (Furness-Smith, 2014). This approach applies a fixed planned process and involves gradual exposures of phobic stimulus to a person, which slowly brings gradual reduction of the person’s level of sensitivity or fear intensity. It works by reversing learned behaviours and applying principles of classical conditioning (Furness-Smith, 2014).

Wolpe (1958) explains that systematic desensitization helps to remove

fear arousal through repeated pairing of imaginal representations of threatening situations with deep relaxation. The intervention is known as counter-conditioning. Biologically, it is impossible for a person to be in a state of acute arousal while being in a state of relaxation. Thus, when the person encounters the phobic stimulus, he will become calmer in which this is called an adapted response (Furness-Smith, 2014). The effect of systematic desensitization treatment in terms of reciprocally inhibitory process is occurring at the level of the autonomic nervous system (Bandura, Blanchard & Ritter, 1969).

### **Live Modelling Guided Participation**

This method was originally applied by Brunhilde Ritter in 1965 and further developed as contact desensitization (Bandura, Blanchard & Ritter, 1969). The procedure starts with a model (usually a therapist) demonstrates the desired behaviour before the subject (client) is aided through further demonstration and joint conditions. Subject is assisted physically by enacting the activities concurrent with the model. The physical guidance is then gradually reduced until the subject is able to perform the desired behaviour without assistance.

### **CASE DESCRIPTION**

In order to respect privacy and anonymity, the name of the person described in this case study has been changed. Fiza, a 22-year-old female client, reported to have symptoms of pedaphobia when she first came for counselling. She decided to seek help after noticing the appearance of psychosomatic symptoms, such as, arousal and nausea for three weeks. She claimed that she had realized the symptoms years ago, and they were recently triggered by the content of a university course she at-

tended.

The visibility of the symptoms not only caused her worries about continuing the course, but also leading her to an anxious thought of living together with her sister-in-law who was going to give birth during the coming semester break. She also shared about her fear of being “abnormal”, as well as her concern on getting married and having children.

Symptoms faced by the client include dizziness, nausea, arousal, palm sweating and body shaking. The symptoms formed not only by the present of a real child, but also by looking at baby pictures, watching videos about toddlers, reading or listening to stories about children’s development, and imagining the face of little infants. The client expressed her feeling of disgust specifically towards children under the age of three. She described her view seeing them as cripple creatures due to the toddlers’ clumsy walking style and their drool of saliva.

The client reported no medical history, as well as, any traumatic life events related to her phobia. She was certain that her uncomfortable feeling was due to her nature and lack of exposure to children. The client is a middle child, the fifth from seven siblings. However, she was away from her family as she went to a boarding school when she was 13, and did not meet her two younger sisters that frequently when they were babies. During school break, she claimed that she often avoided herself from taking care of her little sisters. Despite her feeling of disgust, she emphasized a number of times that she did not despise babies. She also shared about her guilt over her feeling of disgust, thus, would like to work on overcoming her phobia.

## Counselling Intervention

The number of counselling sessions conducted with the client is eleven (11). The aim is to help the client conquering her fear and reducing arousal towards children. In social-learning theory, the extinction of arousal towards phobic stimulus would help reduce anxiety in other areas related to the basis of stimulus (Bandura, Blanchard & Ritter, 1969). Thus, by helping the client conquering her fear towards children, her anxiety of being “abnormal”, her meta-emotion of feeling guilt over her feeling of disgust, as well as, her concern over getting married and having children should subsequently be reduced.

The process started with an overview of the phobia and a detailed exploration of the extent of fear. Subsequently, intervention to overcome the phobia is discussed with the client before its implementation. The intervention is mainly based on systematic desensitization and live modelling guided participation. Throughout the process, the client learned how to control her anxiety over the exposure to phobic stimulus through various techniques, such as, relaxation techniques, thought recording, disputing automatic thoughts, Rational Emotive Imagery (REI), coping self-statement and forceful self-statement. Furthermore, she was required to keep a fear score journal to monitor her progress and the effectiveness of each intervention. The detail of each session is explained in the following section.

### Session 1 and 2

Session 1 started with the client coming to the counselling session with the purpose of overcoming her pedaphobia. Exploration on client’s fear was done in detail, and the overview of her phobia is as described in the Case Description section.

During session 2, the counsellor proceeded with designing a fear hierarchy, whereby the client was asked to rank her phobic stimulus which includes pictures of a baby, stories about children, movies or videos regarding babies, baby dolls, and real babies. Besides, she was also asked to score her fear from 1 – not afraid/comfortable, to 5-very afraid/very uncomfortable. In this session, she ranked pictures of a baby as the least-anxiety provoking stimulus, followed by stories of children development, movies or videos related to babies, baby dolls, and real babies as the most frightening stimulus. She also scored each phobic stimulus with 5.

The counsellor later explained to the client about her conditions and proposed a suitable treatment plan. She was informed that she would be exposed gradually to each phobic stimulus following the least frightening to the most frightening phobic stimulus. Bandura, Blanchard and Ritter (1969) mentioned that avoidance responses can be eliminated if persons are exposed to a graduated sequence of modelling activities beginning with displays that have low arousal value. Scott and Stradling (2006) stated similar idea, highlighting that clients who are suffering from phobia will benefit greatly from a therapeutic task that gradually reset collecting experiential data on the harmless of what they have been avoiding, and help client to practice tackling in ascending order of difficulty those situations they have been avoiding.

At the end of the session, client was assigned with homework whereby she needed to find a picture of a baby and look at the picture as long as she can. She was also told to record how long she can stand looking at the picture, as well as her physical sensations, behaviours and thoughts after exposing herself to the stimulus.

### Session 3

The client came with the picture she had selected and a notebook, which contained her thought records and her reactions towards the exposure to phobic stimulus (which at this stage, it was the picture of a baby). She reported that she was only able to take a glance at the picture for the first two days, but the length of time staring at the picture began to increase from 1 minute, to 3 minutes and 5 minutes for the subsequent days.

The client's physical reactions when looking at the picture were also discussed. She mentioned symptoms, such as, dizziness and nausea were dominating, besides arousal and sweating palm. The reactions were discussed together with her thoughts records whereby mostly she described her thoughts with "geli" (a Malay word which describes the feeling of disgust). According to Hood and Anthony (2012):

*Disgust and sensitivity to disgust play a prominent role in some specific phobias, including emetophobia, BII phobias, and certain animal phobias, such as, those of spiders and snakes. Disgust sensitivity has been found to mediate the relationship between contamination fear and avoidance as well as, between contamination beliefs and self-reported fear during a behavioral approach test, suggesting that avoidance is motivated by a desire to alleviate the sensation of disgust rather than to prevent harm (pg. 22).*

At this stage, the counsellor helped the client to identify her phobic triggers by differentiating her feeling – which is disgusting, from her real thoughts. The counsellor pointed out what she wrote as thoughts might actually her feelings, and client would need to identify her real thoughts that guided her feeling. The client then reported that her feeling of disgusting might due to her beliefs that children's saliva is dirty, their body parts are fragile, and their body movement looks crippled. These beliefs made her feel anxious to deal with children.

In this session, the client learned about two types of phobic thinking, which are overestimation and catastrophic thinking (Antony, Craske & Barlow, 2006). The counsellor also explained how the errors in thinking can contribute to unnecessary fear, and gave examples related to client's situation. Catastrophic thinking for instance, led client to think children's saliva is germy. Furthermore, overestimation thinking led her to think that the children's body is breakable and looks crippled.

The client was informed by the counsellor that changing of thoughts would help her to learn about dealing with her fear healthily and reconceptualise her phobia so that she would be more relax and rational when encountering phobic stimulus. The counsellor used Socratic questions to help the client changed her thoughts and guide her to discriminate between rational and irrational thoughts. Besides, the client was taught on how to debate with her irrational thoughts and controlling her physical sensations using breathing techniques for relaxation.

At the end of the session, the client was assigned with a homework to choose a new baby picture and change to another new picture every day. She was required to record her fear score for each exposure, her physical sensations when looking at

the pictures, the length of time staring at the picture, her irrational thoughts, and her debates with the irrational thoughts along with relaxation techniques. Besides, the client was asked to find information regarding the function of saliva and how breakable the baby's body is. The purpose of this homework is to help client to debate with her irrational thoughts and unnecessary fear.

#### Session 4

The client reported that she started to get control over her fear when looking at the babies pictures. She reported to score 2 out of 5 of her fear score. She also informed that she had a great support from her roommates, whereby they helped her to choose pictures and gave positive encouragement. Moreover, she shared the information she found via the internet regarding saliva and fragility of baby's body. Two facts in article phrases that helped her to fight her irrational thoughts were "*saliva fights germs in your mouth and prevent bad breath*" and "*babies are not easily "breakable" if you do things in a gentle and caring manner*". The counsellor encouraged her to continue with this intervention until she scored 1 out of 5.

In this session, the counsellor told the client that the treatment would move to the next stage whereby the client would learned about rational-emotive imagery (REI) technique. Rational-emotive imagery technique is a technique used for client to practice at changing their unhealthy negative emotions to healthy ones while maintaining a vivid image of the negative event (Ellis & Dryden, 2007). The client was asked to close her eyes and imagine herself playing, hugging, and carrying a baby. At the same time, she would also need to work on making herself feel calm and rational by identifying her unhealthy

emotions and thoughts, as well as, using coping self-statement to overcome her fear.

The imagery was done in 5 minutes, and the client said that she initially felt anxious (which she described as "a feeling I do not like") and described her fear score as 3 because she knew that was only an imagination, so she felt safer. The counsellor however explained to the client that it was important for her to regard the imagining activity as real experience as it helped her to prepare for real life exposure. The client repeated this activity for three times with the assistance from the counsellor.

At the end of the session, the client was asked to practise the REI at least three times each day. The purpose of this homework is to develop automatic healthy feelings when confronting worst things or situations (Ellis & Dryden, 2007). The client was also informed that during the next session, she would be watching videos about babies and toddlers together with the counsellor.

#### Session 5 and 6

The client reported that REI activity was quite hard for her to regard as real experience, but she somehow tried her best to put herself into the situation. The counsellor informed that the client needed to engage with this activity continuously so that she would have enough preparation before being exposed to real stimulus. Ellis and Dryden (2007) mentioned that a client needs to practice for 30 or more days in a row to set automatic changes and healthy habit.

As planned, the counsellor had prepared three short videos taken from YouTube website to be used in this session. The videos were basically related to the development of babies and toddlers. The client was asked to observe the babies or

toddlers in the videos and orally reveal her thoughts at the same time, while the counsellor jotted down all her stated thoughts. This activity triggered client's anxiety feeling whereby she closed her eyes and put her hands over her face once in a while. The counsellor constantly encouraged her to talk about her feelings and thoughts, while reminded her to use relaxation and coping self-statement techniques.

After the video session, the discussion was carried out concerning the client's negative thoughts, as well as, the strategies to dispute and overcome those irrational thoughts and feelings. The client reported rating 4.5 out of 5 for her fear score. At this stage, the counsellor taught the client about forceful self-statements technique, whereby this technique serves to convince oneself that the situation he or she is facing is not awful (Ellis & Dryden, 2007). It is almost similar to coping self-statements but coping self-statements technique is about helping the client to internalize healthy perspectives by repeating the helpful coping statements to herself several times a day, while forceful self-statement is to doctrine the idea of non-awful situations and developing confidence in the client to overcome her situation. Later, the counsellor and the client discussed on creating related coping self-statements and forceful self-statements for the client to practice. The client was asked to write those statements on small cards and to use those cards when practicing REI. She was also told to watch videos related to infants, which could help with her imaginary activity.

The intervention using videos exposure was continued in session 6. The counsellor guided the client to conquer her phobia with the aid of coping self-statements and forceful self-statements cards. Besides, she was assisted and encouraged to continue becoming more aware of her

irrational thoughts that came to her mind every time her fear was triggered. The client was asked to continue with REI and watch related videos as her homework.

### **Session 7**

The session started with the counsellor asking about the client's progress by referring to the fear score. Scoring had showed declination, whereby the score for REI and videos exposures was 3.

The counsellor prepared two articles regarding babies' development from parenting magazines and read the articles together with the client. The client was asked about her feelings and thoughts when reading those articles. She scored herself 2.5 out of 5 for fear score. During the intervention, she mentioned that she became aware of her irrational thoughts yet tried her best to combat the thoughts with coping self-statements and forceful self-statements she had been practicing. However, she also said that she tended to read the articles without trying to understand the content as she was trying to reduce her anxiousness.

The counsellor reminded the client not to continue with her self-defence, which was avoiding her from understanding the articles as it would not help her to learn on conquering her fear. The counsellor also highlighted this self-defence with her previous defence during the imagination activity in session 4, whereby she kept telling herself that the intervention was only an imagination, while she was supposed to regard the imagination as real, so that she would be prepared for real exposure.

At the end of the session, the client was asked to continue her intervention by exposing herself to relevant videos and articles, as well as, REI. The client was also being informed that her intervention would

move to the next level, whereby exposure to dolls would be implemented in the next session once the client reached the score of at least 1.5 out of 5.

### Session 8 and 9

In these sessions, the intervention involved the use of a doll to help the client overcoming her phobia. The counsellor believed that this intervention would be helpful for the client as the selected doll was able to laugh and cry, imitating a real baby. Before the intervention began, the client was asked about her progress on using videos and articles as exposure elements. The client reported to have more control over her fear and scored 1 out of 5 for fear score.

The use of doll is part of modelling intervention and was used to help the client getting prepared for her real exposure to children. The client expressed her thrill to participate in this modelling process though she realized that the phobic stimulus she was exposed to has an increasing arousal value.

During this intervention, the counsellor modelled the way of preferred behaviour, such as, holding the baby, hugging, feeding and changing diaper. The client was encouraged to imitate the actions and alert with her thoughts while performing the behaviour.

Similar intervention was conducted for session 8, except that a different doll was used. The doll portrays the toddler's characteristics, whereby it is able to laugh, cry and talk. The client performed preferred actions, such as, feeding the baby and walk with the baby.

The client's initial fear score during this intervention was 5. She was allowed to bring the dolls home to continue her intervention so that she would get used to the dolls. Intervention with the two dolls took about three weeks before the client



**Figure 1: The doll representing a baby** was exposed to live modelling guided participation.

### Session 10

At this stage, the counsellor believed that the client was ready to be exposed to live modelling guided participation. The intervention took place at a playground. During the first visit, the counsellor sat and played with toddlers while the client observed from a distance. The client was encouraged to imitate the actions of counsellor whenever she was ready.



**Figure 2: The doll representing a toddler**

The second visit took place a week after the first visit. Between the first and second visit, the client was encouraged to go to places whereby she can meet with children, such as, restaurants, shopping malls and



playgrounds. For instance, if she went to a restaurant, the client was asked to sit near to parents with children. She was required to do the observations and recorded her irrational thoughts, disturbed emotions, and physical sensations, while exercising her skills of relaxation and disputing thoughts using techniques learned during the previous sessions.

The client showed good progress during the second visit, whereby she was able to stand near to the children although initially she was stiffed. The counsellor encouraged the client to continue using self-statement cards and relaxation techniques. The intervention continued with the third visit, whereby the client was able to sit and play with the children.

### **Session 11**

This is the termination session. During this stage, the client was asked to list down the important lessons she had learned throughout the whole counselling process. The counsellor also briefed the client about the possible precipitants of relapse and encouraged her to not hesitate or be afraid of reengage with therapy and get help again in the future. The client was informed that a follow up session would be conducted a month after the termination session.

### **Follow up session**

The client was contacted via telephone and she reported to be able to help her sister-in-law in taking care of her nephew. She sounded happy and mentioned that she was glad to be able to overcome her anxiety. She also told that the exercises given during counselling session were very helpful.

### **DISCUSSION**

The counselling intervention for pedophobia being referred to in this case can be framed as a model shown in Figure 3.

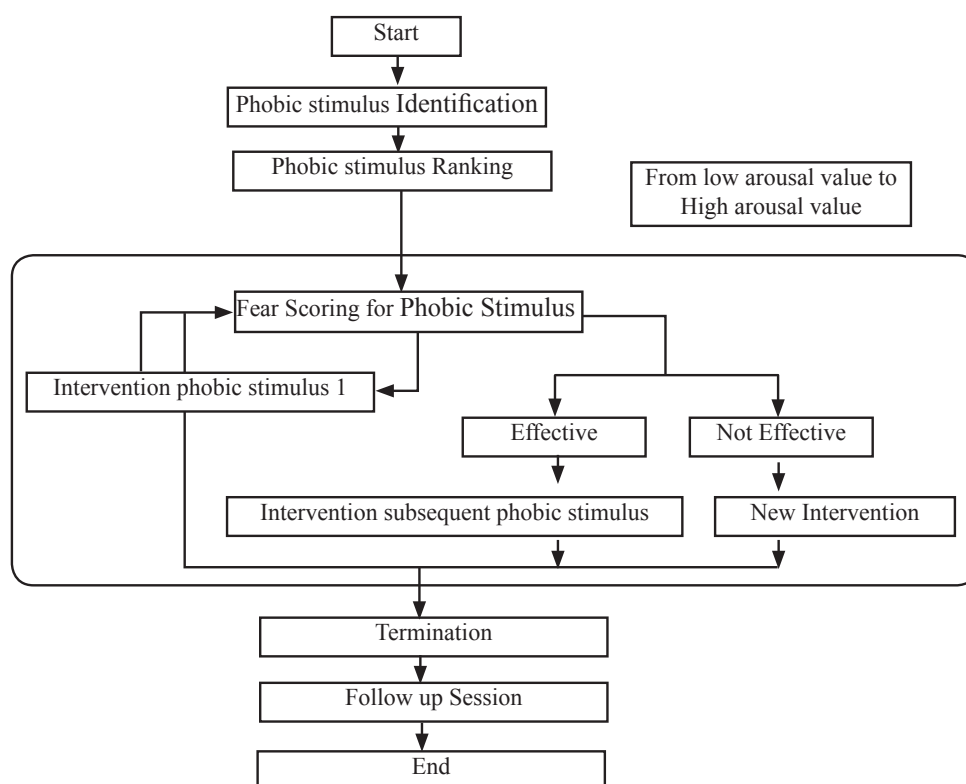
The phobia intervention model in Figure 3 illustrates the steps that can be taken by counsellors to help clients in overcoming their phobia. Phobic stimulus should first be identified, ranked and scored before each intervention took place. In this case, the phobic stimulus included pictures and videos related to infant, imagination of babies and toddlers, stories about babies, baby dolls, and the present of a real child. Each stimulus was scored from 1 – not afraid to 5 – very afraid, and ranked from the least-anxiety provoking (pictures of babies) to the most frightening (the present of a real child).

Interventions which involved the exposure to the phobic stimulus were done according to the ranking, from lowest to highest. With every implementation of the intervention, fear score was evaluated to monitor client's progress as well as the effectiveness of each intervention. Should the intervention is found ineffective, a new intervention which is considered suitable will be formed to replace the previous one.

The interventions involved in this case are the use of pictures, REI, videos and articles exposures, dolls, and exposure to environment with kids. While going through the interventions, the client learned about the errors of thinking, methods in disputing irrational thoughts, and the use of coping self-statement, forceful self-statement and relaxation techniques. The termination session is conducted after every intervention has been implemented, subsequently a follow up session before the sessions come to an end.

### **CONCLUSION**

The use of systematic desensitization to help the client in overcoming her pedophobia has proven to be effective. However, the counsellor believes that in order to defeat phobia we could not only rely



**Figure 3: Phobia Intervention Model**

merely on relaxation techniques. The use of REBT techniques to support systematic desensitization is important as they could help the client to conquer the root of her phobia which is her thoughts. It is therefore suggested that counsellors consider the use of REBT in assisting clients to overcome their phobias, as illustrated in this paper. Although the outcomes of the interventions as indicated in Figure 3 may not be conclusive or generalised, it sheds pertinent insights into the feasibility of applying techniques that correspond to systematic desensitization.

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