General Hospital Psychiatry xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

General Hospital Psychiatry

journal homepage: http://www.ghpjournal.com

Letter to the editor: Potential treatment targets for misophonia

To the Editor,

Misophonia, a condition characterized by extreme sensitivity to select sounds, has recently been proposed for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) [1]. Individuals with this disorder respond with irritation, disgust, anger and distress when exposed to auditory cues ranging from eating sounds (e.g., lip smacking, chewing or swallowing) to breathing sounds or other repetitive sounds (e.g., foot or pen tapping [2]). Individuals with misophonia typically employ several coping strategies, although the primary response is avoidance, including leaving the room, wearing headphones or rearranging schedules to avoid known triggers [2]. Individuals also report that mimicking the trigger sounds can temporarily relieve some of the discomfort [2]. Misophonia was first identified by audiologists [3] but has recently begun to find its way into the clinical psychology literature. However, although case studies [4] and clinical descriptions [5] are beginning to emerge, to our knowledge, there have been no efforts to explore treatment options beyond using tinnitus retraining therapy, which uses psychoeducation and sound therapy to promote habituation [3]. Since the white noise generators used in sound therapy can be seen as more sophisticated avoidance techniques that minimally reduce distress, it is crucial that we find ways to treat the underlying condition.

Schroder et al. (2013) [1] proposed a set of diagnostic criteria and suggested that misophonia best fits in the obsessive–compulsive (OCD) and related disorders category of the *DSM, Fifth Edition*. We agree with this conceptualization but caution against assuming that misophonia should be treated similarly to OCD. In OCD, obsessions cause distress, *anxiety* and sometimes disgust, which are relieved through compulsions. In misophonia, the primary response when confronted with the offending stimulus is *anger* (along with disgust), which is relieved through removal of the trigger. While fear decreases with repeated exposure to the threatening stimulus, disgust does not habituate to exposure in the same way [6]. Although similar studies have not yet been conducted on anger habituation, disgust and anger share several features [7]. For example, evidence from event-recall research suggests that thinking of disgust often brings up anger-related themes, while anger-eliciting situations often bring up feelings of disgust [7]. Therefore, it is possible that exposing a person with misophonia to eating sounds may not result in the same learning as occurs in exposure and response prevention within the context of OCD.

Instead, researchers might look to the emerging literature on cognitive restructuring and stress inoculation training for anger [8]. Primary components of these treatments include identifying triggers, cognitive reframing and relaxation training. We propose that enhancing perspective taking and compassion towards others may also be useful treatment targets [9]. Compassion training, for example, reduces biopsychological responses to stress- and anger-evoking situations [10]. Putting oneself in the shoes of the person eating popcorn in the movie theater and cultivating compassion for them, for example, might decrease the anger directed at that person.

In addition, therapists may need to focus on increasing distress tolerance, as targeted in mindfulness- and acceptance-based therapies such as acceptance and commitment therapy and dialectical behavior therapy. Rather than attempting to reduce or eliminate the anger and disgust that are triggered, it may be more effective to change one's relationship with these emotions and improve one's ability to engage in meaningful activities even in the face of them. When the goal is to improve the capacity to tolerate or accept the emotional arousal, decreasing or eliminating it becomes less important. Since misophonia involves emotions that are difficult to habituate to through exposure, distress-tolerance and acceptance-based approaches to treatment may be particularly well suited.

As research on the existence and phenomenology of misophonia continues to mount, we believe that it will become increasingly evident that misophonia is a disorder worthy of inclusion in the *DSM*. Currently, clinicians must rely on instincts and on trial and error to treat patients presenting with symptoms of misophonia. Although instincts and case studies are valid starting points when dealing with any new disorder, as misophonia becomes more firmly established, it will be important to conduct more rigorous and standardized research on the best ways to help this understudied and thus underserved population.

Acknowledgments

The authors would like to thank Dr. Vijay Mittal for his comments on earlier drafts of this letter.

Rebecca L. Schneider BA*
Joanna J. Arch PhD
Department of Psychology and Neuroscience
University of Colorado Boulder, Boulder, CO, USA
*Corresponding author at: 345 UCB Muenzinger Boulder CO 80309-0345, USA. Tel.: +1 404 402 3377
E-mail-address: Rebecca.L.Schneider@colorado.edu

Available online xxxx

References

[1] Schröder A, Vulink N, Denys D. Misophonia: diagnostic criteria for a new psychiatric disorder. PLoS One 2013;8(1):e54706.
[2] Edelstein M, Brang D, Rouw R, Ramachandran V. Misophonia: physiological investigations and case descriptions. Front Hum Neurosci 2013;7.
[3] Jastreboff MM, Jastreboff PJ. Decreased sound tolerance and tinnitus retraining therapy (TRT). Aust N Z J Audiol 2002;24(2):74–84.
[4] Webber TA, Johnson PL, Storch EA. Pediatric misophonia with comorbid obsessive–compulsive spectrum disorders. Gen Hosp Psychiatry 2014;36(2):231.e1–2.

http://dx.doi.org/10.1016/j.genhosppsych.2015.03.020

[5] Wu MS, Lewin AB, Murphy TK, Storch EA. Misophonia: incidence, phenomenology, and clinical correlates in an undergraduate student sample. J Clin Psychol 2014; 70(10):994–1007.
[6] Olatunji BO, Wolitzky-Taylor KB, Willems J, Lohr JM, Armstrong T. Differential habituation of fear and disgust during repeated exposure to threat-relevant stimuli in contamination-based OCD: an analogue study. J Anxiety Disord 2009;23(1):118–23.
[7] Nabi RL. The theoretical versus the lay meaning of disgust: implications for emotion research. Cognit Emot 2002;16(5):695–703.
[8] Beck R, Fernandez E. Cognitive–behavioral therapy in the treatment of anger: a meta-analysis. Cogn Ther Res 1998;22(1):63–74.
[9] Hofmann SG, Grossman P, Hinton DE. Loving-kindness and compassion meditation: potential for psychological interventions. Clin Psychol Rev 2011;31(7): 1126–32.
[10] Arch JJ, Brown KW, Dean DJ, Landy LN, Brown KD, Laudenslager ML. Self-compassion training modulates alpha-amylase, heart rate variability, and subjective responses to social evaluative threat in women. Psychoneuroendocrinology 2014;42:49–58.

Please cite this article as: Schneider R.L., Arch JJ, Letter to the Editor: potential treatment targets for misophonia, Gen Hosp Psychiatry (2015), http://dx.doi.org/10.1016/j.genhosppsych.2015.03.020