

A young woman with noise intolerance

Commentary by

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Is there an explanation for this young woman's increasing intolerance of certain sounds, and how can she be helped?

Case scenario

Anastasia, a 26-year-old woman who works in a grocery store, presents to her GP saying she feels unable to continue in her employment. She has been working in the store for 18 months and was happy there until a new store manager was appointed six months ago. She feels the manager has preconceived ideas about her based on her appearance (she has a tattoo that is not completely concealed by clothing and a nose ring). She has recently noted in herself an increasing intolerance to noise – initially to the manager's voice and now to more general noise, particularly speech and noises made by people who are eating. She feels she is unable to work any longer and wants to receive a disability pension.

Anastasia has a long history of probable borderline personality disorder (problems with both family and romantic relationships, a past history of bulimia) and she lives alone. She has seen a psychologist, who, like her GP, has suspicions about whether she has another psychological disorder, and whether her noise intolerance is genuine or part of a hysteria or the borderline spectrum or paraphrenia. Anastasia does not appear to have depression or anxiety and she is taking no medications.

Is there another diagnosis for Anastasia? How should she be managed?

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Commentary

There are some sounds that many of us find annoying or irritating, such as fingernails running down a blackboard, food being slurped or loud breathing. Generally we cope with these annoying or irritating sounds without too much problem, other than perhaps to note our annoyance and to do our best to avoid such noises in the future. However, for some people such sounds trigger an intense emotional reaction, with disgust or anger that can even lead to an aggressive outburst. This reaction is the main characteristic of a newly described condition named misophonia – hatred ('miso') of sound ('phonia') – that was first described in 2000¹ and brought to popular attention in an article in *The New York Times* in 2011.² Misophonia is not included in official diagnostic systems such as the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or *International Classification of Diseases (ICD)*, but the published case series suggest it is a distressing condition that is independent from other mental disorders and not a variant of obsessive-compulsive disorder or the anxiety disorders. It may be comorbid with other conditions, such as a personality disorder, as in the case of Anastasia.

Misophonia is characterised by an aversive reaction (ranging from irritation or disgust to overt anger) that is provoked by a specific sound and which leads to a profound sense of loss of self-control (with rare but potentially aggressive outbursts). Predominantly, these are sounds made by another human being but others, such as a clock ticking or pen clicking, have been reported. The sufferer recognises the reaction as unreasonable or out of proportion to the stimulus. They will then avoid the stimulus or experience feelings of discomfort, anger or disgust that leads to significant distress. In detailed psychiatric assessments of individuals complaining of misophonia, researchers have found that although there is some symptomatic overlap with other anxiety disorders, these disorders did not account for the misophonia.³

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It has been suggested that misophonia is the result of hyperconnectivity between the auditory, limbic and autonomic systems, leading to abnormally strong reactions of the autonomic system.⁴ It needs to be differentiated from hyperacusis and phonophobia. Individuals with misophonia have been shown to have an excessive or extended physiological reaction to auditory stimuli, but not visual stimuli, when compared with individuals who do not report misophonia.¹

Anastasia's symptoms, particularly the intolerance to her manager's voice and other human sounds (especially eating noises), seem to fit the diagnostic criteria of misophonia proposed by Schröder and colleagues in 2013.³ These symptoms cannot be accounted for by depression or anxiety and are not consistent with hysteria, paraphrenia (a late-onset delusional disorder) or borderline personality disorder.

Undoubtedly, Anastasia's borderline personality disorder may be a contributing factor to her misophonia. She has negative feelings (transference) about her manager, whom she believes has 'preconceived' ideas about her. This interpersonal difficulty would exacerbate her symptoms, as she would become more focused on the manager's attitude towards her and hypervigilant such that any noises would be exaggerated. Her 'overreaction' to this in asking for a disability pension is consistent with a 'borderline' response.

Anastasia needs validation that her symptoms are 'genuine' and that misophonia does exist as a condition. She could be guided towards useful sources of patient information (e.g. <http://www.misophonia.com>). Such validation may help her to cope better with her situation at work. She may be able to find a behavioural means of reducing the sensory input from the noises (such as

wearing headphones). She could also be advised to reduce her caffeine intake, because caffeine will make the symptoms worse.

There is no specific treatment for misophonia and no evidence to suggest that medication will be of any benefit. A cognitive behavioural approach has been suggested,^{5,6} with an emphasis on graded exposure, cognitive reframing and tolerance development using mindfulness strategies. In Anastasia's case, this could be coupled with dialectical behavioural therapy for her borderline personality disorder. Tinnitus retraining therapy has also been suggested for patients with decreased sound tolerance; graded exposure is a key element in this treatment.⁷ **MT**

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COMPETING INTERESTS: None.

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