



# Intensive cognitive-behavioral therapy for comorbid misophonic and obsessive-compulsive symptoms: A systematic case study

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## ABSTRACT

This case report describes the treatment of an adolescent who presented for intensive treatment of severe co-occurring misophonic and obsessive-compulsive symptoms. The presenting misophonic symptoms involved a strong anger and anxiety response to pen clicking, throat clearing, and squeaky noises. Cognitive-behavioral therapy was utilized to treat misophonic symptoms in the context of intensive treatment for obsessive-compulsive symptoms. Systematic data collection revealed that misophonic symptoms only reduced when exposures to misophonic specific stimuli were conducted. In addition to a substantial reduction in obsessive-compulsive symptom severity across treatment, misophonic symptoms reduced by 59% (from severe to mild severity) after only two sessions targeting these symptoms. At three months post-treatment, misophonic symptoms had reduced an additional 18% to subclinical severity. Results suggest cognitive-behavioral therapy may provide an effective treatment for adolescents with misophonia. A discussion of how to implement exposures for misophonic symptoms is provided in addition to other research and clinical recommendations.

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## 1. Theoretical and research basis for the treatment

One challenge for therapists conducting cognitive-behavioral therapy with exposure and response prevention (CBT-ERP) for obsessive-compulsive disorder (OCD) consists of navigating the variety of psychopathology that often co-occurs with the disorder (Ruscio, Stein, Chiu, & Kessler, 2010). Strategies to manage comorbid symptoms may differ according to their type. For example, depressive symptoms are frequently comorbid with OCD; yet, research has found that unless depressive symptoms are highly severe, they generally will remit as obsessive-compulsive symptoms reduce (Meyer et al., 2014). However, other symptoms, such as oppositionality, are much more likely to interfere with CBT-ERP implementation and often require some form of treatment augmentation (Peris & Piacentini, 2014; Storch et al., 2008). During a recent intensive treatment of a youth with severe OCD, the authors were presented with a comorbid condition called misophonia that to date has received little attention in the literature. This case study outlines the rationale for treatment choice and

implementation (i.e., the use of exposure techniques for both symptoms), the effectiveness of this treatment approach, and a detailed discussion of how treatment was tailored to misophonic symptoms.

Misophonic symptoms are characterized by high levels of anxiety, irritation, disgust, anger (or "rage"; Bernstein, Angell, & Dehle, 2013), and distress in response to specific sounds frequently encountered in daily life (Edelstein, Brang, Rouw, & Ramachandran, 2013). These sounds are phenomenologically heterogeneous, although they are often related to eating/chewing/crunching, lip smacking, pen clicking, and clock ticking sounds in one's environment (Edelstein et al., 2013). While research suggests misophonic symptoms present across a range of severity levels, a consensus has not been reached regarding a definition for "clinically severe" misophonic symptoms. Modeled after the National Institute of Mental Health Global Obsessive Compulsive Scale, some have proposed that clinically severe misophonic symptoms involve moderately distressing sound sensitivities that cause significant interference (Wu, Lewin, Murphy, & Storch, 2014). The nosology of misophonia is currently debated in the literature. Misophonia may constitute a free-standing psychiatric diagnosis (Schröder, Vulink, & Denys, 2013). Others have identified misophonic symptoms as a type of sensory intolerance syndrome or sensory over-responsivity (Rogers & Luby, 2011).

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There is preliminary support that this condition may be related to OCD and Tourette syndrome, as they are highly comorbid (Bernstein et al., 2013; Ferreira, Harrison, & Fontenelle, 2013; Hazen et al., 2008; Johnson et al., 2013; McGuire, Wu, & Storch, 2015; Taylor, Conelea, McKay, Crowe, & Abramowitz, 2014; Webber, Johnson, & Storch, 2014) and possibly share similar neurobiological or genetic underpinnings (Giorgi, 2015; Van Hulle, Schmidt, & Goldsmith, 2012). For example, amygdala hyperactivation during presentation of symptom-related stimuli has separately been shown to occur in those with misophonia and OCD aggression/checking and sexual/religious symptom dimensions (Giorgi, 2015; Via et al., 2014). That being said, misophonic symptoms have been observed to be comorbid with other psychiatric problems like eating disorders and childhood behavior problems (Klockow, Telfer, & Abraham, 2014; Taylor et al., 2014; Van Hulle et al., 2012) and as a stand-alone condition (Carter, Ben-Sasson, & Briggs-Gowan, 2011; Van Hulle et al., 2012).

Although little is known about the epidemiology of this condition, one study found that 20% of an undergraduate sample had clinically significant misophonic symptoms (Wu et al., 2014) and others have suggested an average age of onset at 13 years old (Schröder et al., 2013). Misophonic symptoms are thought to be chronic and have a familial association (Edelstein et al., 2013), although more research is needed to understand the course and etiology of misophonia. Due to the need to avoid specific stimuli and the emotional reactions the stimuli produce, it is not surprising that misophonic symptoms are associated with impairment in academic, professional, and interpersonal functioning (Edelstein et al., 2013; Wu et al., 2014). Considering the distress and impairment caused by these symptoms (Carter et al., 2011; Van Hulle et al., 2012), it is imperative that research identify effective psychological and pharmacologic treatments for misophonia.

Two case studies provide some evidence that CBT-ERP may be an appropriate treatment for misophonia (Bernstein et al., 2013; McGuire et al., 2015). However, others have found this approach ineffective (Hadjipavlou, Baer, Lau, & Howard, 2008) or have suggested alternative treatments based on counter-conditioning (Dozier, 2015). Bernstein et al. (2013) successfully implemented CBT-ERP over six sessions to treat misophonia, though in-session exposures were not conducted (in vivo exposures were implemented outside of the session). The treatment provided emphasized cognitive restructuring, behavioral modification, and physiological recalibration through exercise. The exact outcomes of their treatment protocol is unknown due to the lack of symptom measurement to track treatment response. McGuire et al. (2015) also recently provided a brief description of CBT-ERP for two youths with misophonia. Treatment for these patients lasted six and 13 sessions respectively, and both followed a more traditional CBT-ERP approach to treatment, including a heavy emphasis on in vivo exposure during and outside of the session. Measurements of misophonic symptoms were administered before and after treatment, showing a 20% and 42% reduction in symptoms for these two youths.

The current case study builds upon the work of McGuire et al. (2015) in several ways. The adolescent described below received treatment for misophonia within the context of intensive CBT-ERP for severe OCD. Due to a similar cognitive-behavioral conceptualization (see below), the clinical team integrated the treatment of these two conditions into a uniform approach that helped both the clinicians and patient work on symptoms interchangeably, as if misophonia was just another dimension of OCD. More so, treatment techniques specifically tailored to treat misophonia (e.g., exposures with misophonic stimuli) were only provided during two consecutive sessions of the intensive treatment to identify the utility of exposures with misophonic related

stimuli. This comparison was possible due to the use repeated measurements of obsessive-compulsive and misophonic symptoms throughout treatment. Additionally, this case study is the first to provide an in-depth discussion of how we designed and implemented exposures for misophonic symptoms. The authors hope this discussion will help spur additional research into potentially effective methods for exposures targeting misophonic symptoms and consequently provide therapists with a clinical tool for treating these impairing symptoms. Finally, this case study included a 3-month follow-up assessment to provide the first data on the durability of treatment gains.

## 2. Case introduction

Julia (pseudonym), a 14-year-old female, presented to our clinic to begin three weeks of intensive CBT-ERP for OCD (see Lewin et al., (2005) for a description of the treatment protocol). The patient presented with current OCD, major depressive disorder (severe, recurrent), specific phobia (needles), and attention deficit hyperactivity disorder (combined type). When treatment began, Julia was taking 20 mg of fluoxetine, 1 mg of clonazepam, and 10 mg of aripiprazole daily, which was prescribed by her outpatient psychiatrist.

Julia was referred to our intensive program for treatment of her obsessive-compulsive and depressive symptoms. Her obsessions included intrusive disturbing images, fears of embarrassing herself, distressing thoughts about lying or not saying the “right” thing, obsessions with even numbers, difficulty deciding whether she should throw things away, and worries about separation from her parents. Her OCD was brought further to her parents' attention by recently increased overt compulsions such as counting, needing to tell/ask/confess to her parents, doing things in even numbers, checking behaviors, and needing to touch/tap/rub.

Of note, she also reported being “annoyed” and anxious as a result of certain noises, especially pen-clicking, squeaky noises like markers against a white board, and certain throat noises her brother made. Her presentation was consistent with research indicating children with OCD frequently have elevated sensory sensitivity, especially when they have comorbid depression and externalizing disorders (Lewin, Wu, Murphy, & Storch, 2014). As treatment progressed, she indicated that the noises were significantly interfering with her ability to function in school because of the strong affect they caused and the subsequent maladaptive behaviors that were needed to cope with the affective response. Specifically, in one episode, a classmate was clicking her pen during an in-class activity. After a few minutes, Julia shouted “I’m done with this [expletive]” and walked out of the classroom. Julia described several negative automatic thoughts that occur in the presence of misophonic triggers. In the example given above, Julia described that she was thinking that the student was intentionally clicking their pen to annoy others and was fearful that she may end up in a physical altercation with the student if she did not leave the room.

## 3. Assessment

Julia completed two semi-structured interviews at various treatment sessions to assess treatment progress and outcomes. The interview measures provided a clinician-rated assessment of obsessive-compulsive and misophonic symptoms, respectively. They were administered by two trained members of the research staff who were not involved in Julia's treatment or this case study.

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