A Young Woman with Misophonia Leading to Unwanted Sexual Arousal with Comorbid Obsessive–Compulsive Disorder

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Abstract

Misophonia is a disorder characterized by an aversion to selective sounds, leading to a reflexive, aversive emotional response such as disgust, anger or an urge to lash out, or an unwanted physical sensation. We report here the case of a young woman presenting with unwanted sexual arousal in response to specific sounds, who also developed a comorbid obsessive–compulsive disorder.

Keywords: Misophonia, obsessive–compulsive disorder, sexual arousal

Introduction

Misophonia, first described by Pawel Jastreboff, is a phenomenon characterized by aversion to selective sounds.[1] Few authors have tried to propose criteria to define misophonia, for example, Schröder *et al*.[2] and Dozier *et al*.[3] As per the criteria given by Dozier *et al*.[3] , the presence or anticipation of a specific sensory experience (such as sound or sight) provokes an impulsive, aversive physical and emotional response, typically beginning with disgust which escalates to anger. The stimulus elicits an immediate physical reflex response which could be skeletal or internal muscle action, sexual response, or other physical sensation. The negative emotional experience is later recognized as excessively unreasonable to the provoking stressor. As a result, the individual then tends to avoid the misophonic situation – if he/she does not avoid it; it is endured with distress, leading to significant interference in the person's life. At present, it has not been defined and studied enough to be included in any diagnostic classification.

A study on university students reported 16% having clinically significant symptoms, while 6.6% were found to have significant impairment as a result.[4] Another study of 483 undergraduate students found a 20% prevalence of misophonia with clinically significant symptoms.[5] It has been found to be associated with various other psychiatric conditions such as obsessive–compulsive disorder (Schroder, Wu), depression,[5] generalized anxiety disorder, attention deficit hyperactivity disorder, posttraumatic stress disorder, Tourette's syndrome, and eating disorders.[2,5,6,7] We report here the case of a young female who reported to a tertiary care teaching hospital in Mumbai.

Case Report

Miss X, a 25-year-old unmarried female from Mumbai, a Bachelor of Mass Media working in a private company, presented to the outpatient department with chief complaints of (1) sexual response repeatedly elicited by certain sounds over the last 8–10 years, (2) repetitive and intrusive thoughts about genitals of gods and goddesses and (3) a fear that she might harm her parents for the last 2–3 years.

As per history, at around 13 years of age, she began to experience a stimulating sensation in her vagina accompanied by sexual excitement in response to hearing her sister's breathing during sleep or the clicking sounds she made to call a puppy. Subsequently, it further extended to the chewing sounds of her father, sister, and younger brother when they would

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together have meals at the table. She would feel extremely anxious and distressed due to the symptoms, which lead to frequent anger outbursts toward family members. She started avoiding meals with family members and would eat alone in her bedroom. She would not let her sister sleep along with her or would use headphones while sleeping to avoid hearing her breath sounds. She reported that each time she heard these sounds, she felt relief from her distress only when she masturbated. If she wouldn't, she would continue feeling anxious, restless, and irritable. This led to a compulsive urge to masturbate. She also reported feeling disgusted about herself due to the same.

For the last 2–3 years, she began to experience unwanted sexual arousal at her office in response to the chewing sounds of her colleagues while eating. She also developed a fear that she might focus on the genitals of male colleagues. Hence, she would avoid interacting with them and isolate herself during lunch breaks, leading to functional impairment at work.

On further inquiry, Ms. X reported to have repeated thoughts of the genitals of gods/goddesses whenever she would offer prayers to idols. These were her own thoughts but were intrusive and out of control. She would feel anxious and disgusted at herself for getting these thoughts and would constantly apologize to God. Over a period, she stopped worshipping altogether. She also repeatedly experienced fear that she might lose her virginity and would be preoccupied in protecting it. With this fear, she stopped traveling in a taxi to avoid being around males. If things were not placed in a certain order, she would have thoughts that something ill might happen to her parents. Finally, she would also check 2–3 times if her pants were zipped each time she came out from the washroom. There was no disturbance in biological functions. She did not express suicidal ideation. She denied the use of any substances. There was no history of any abnormal involuntary movements. She had been diagnosed with hypothyroidism a few years back and was on treatment for the same, with recent reports being normal.

Her mother is diagnosed case of schizophrenia and on treatment, with a history of hospital admission and receiving electroconvulsive therapy. She also reported a history suggestive of psychotic symptoms and substance abuse in her elder brother, who had never been evaluated for the same. There was a history of impulsivity in the younger sister with self-injurious behavior following breakup of a romantic relationship. Her father was under treatment for diabetes, mellitus, and hypertension.

Her birth and developmental history were within the normal limits. She was average in academics during her school and college days. Her menstrual cycle was regular. She was never sexually active with a partner. Physical examination was within normal limits.

On Mental Status Examination, Ms. X was an averagely built young female and was well kempt. She was cooperative and attentive throughout the interview. Rapport was established with ease, and she maintained eye contact. She reported her mood as being anxious and had a distressing affect. Thoughts contained obsessive beliefs in the form of sexual obsessions, obsessive fear of acting on unwanted impulses, for example, stabbing her mother or focusing on the genitals of male colleagues and blasphemous obsessions. Ideas of guilt and magical thinking were also present. She denied any perceptual abnormality. Her concepts, intelligence, and judgment were found to be adequate on clinical assessment. She had good insight into her illness.

Based on psychiatric evaluation, the patient was diagnosed with misophonia and obsessive–compulsive disorder (OCD). Her baseline Yale-Brown Obsessive Compulsive Scale (YBOCS) score was 28 (severe) and her Amsterdam Misophonia Scale (AMISOS) score was 17.[2] For treatment, she has started on escitalopram 10 mg, which was optimized to 20 mg on further follow-ups. The patient was psychoeducated about the illness. Exposure therapy was commenced, and she was advised to gradually expose herself to trigger sounds instead of avoiding them. She was advised lifestyle modification in the form of daily physical exercise. At the end of 8 weeks, YBOCS score reduced to 9 (mild) and the AMISOS score to 8. She reported 70%–80% overall improvement and had resumed having dinner with family members and traveling alone by taxi. She also had improved functioning at her workplace.

Discussion

Our patient fulfilled the criteria proposed by Dozier *et al*.[3] The positive findings were an impulsive, aversive physical and emotional response that began with irritation/disgust that frequently escalated to anger in response to the presence or anticipation of stimuli such as chewing sounds of family members and colleagues and sister's breathing sounds. The physical response was in the form of sexual arousal. Dysregulation of thoughts leads to occasional aggressive outbursts. She would later experience the emotional response to have been excessive and unreasonable. She avoided misophonic situations. All this led to significant socioоccupational impairment.

To our knowledge, this is one of the few cases with a physical response being sexual arousal. Context influences how individuals with misophonia respond to sounds.[8] It has been noted to be triggered specifically by sounds produced by specific individuals. In this case, it was triggered by sounds of the father and siblings but not of the mother. Such findings have provided a foundation for cognitive behavioral therapy as part of the treatment of misophonia.

It is interesting to note that in this case, the patient had only symptoms of misophonia for the first 5–6 years and later developed symptoms of OCD along with it. Studies have shown diminished mean peak amplitude of the Auditory N1 component in response to oddball tones in patients with misophonia.[8] Several studies have shown abnormalities of

N1 as an endophenotype for patients with schizophrenia. A previous study has even found the occurrence of psychotic symptoms in patients with misophonia.[9] In a study based on Danish registers, prior diagnosis of OCD was associated with an increased risk of developing schizophrenia and schizophrenia spectrum disorders later in life.[10] In this case, there is a strong family history of schizophrenia; thus, it would be intriguing to study if misophonia could be a precursor in the progression of OCD to schizophrenia.

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Conflicts of interest

There are no conflicts of interest.

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