A psychoacoustic test for misophonia assessment

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Misophonia is a condition where a strong arousal response is triggered when hearing specific human generated sounds, like chewing, and/or repetitive tapping noises, like pen clicking. It is diagnosed with clinical interviews and questionnaires since no psychoacoustic tools exist to assess its presence. The present study was aimed at developing and testing a new assessment tool for misophonia. The method was inspired by an approach we have recently developed for hyperacusis. It consisted of presenting subjects (n = 253) with misophonic, pleasant, and unpleasant sounds in an online experiment. The task was to rate them on a pleasant to unpleasant visual analog scale. Subjects were labeled as misophonics (n = 78) or controls (n = 55) by using self-report questions and a misophonia questionnaire, the MisoQuest. There was a significant difference between controls and misophonics in the median global rating of misophonic sounds. On the other hand, median global rating of unpleasant, and pleasant sounds did not differ significantly. We selected a subset of the misophonic sounds to form the core discriminant sounds of misophonia (CDSMiso). A metric: the CDS score, was used to quantitatively measure misophonia, both with a global score and with subscores. The latter could specifically quantify aversion towards different sound sources/events, i.e., mouth, breathing/nose, throat, and repetitive sounds. A receiver operating characteristic analysis showed that the method accurately classified subjects with and without misophonia (accuracy = 91%). The present study suggests that the psychoacoustic test we have developed can be used to assess misophonia reliably and quickly.
1%. Misophonia has a significant impact on the quality of life\(^2\) and causes daily stress because of anticipation of encounters with misophonic triggers\(^3\).

An fMRI study showed greater activation of the anterior insular cortex (AIC) in misophonics compared to controls when presented with trigger sounds\(^4\). The AIC is involved in the “salience network” which is critical in interoceptive signals and emotion processing (including anger). Increased functional connectivity of the AIC with core parts of the DMN (Default Mode Network), hippocampus, and amygdala, were also found in response to trigger sounds\(^5\). Two later trigger-exposure fMRI studies further supported involvement of the “salience network” in misophonia\(^6,7\). One of them also showed an increased synchronization of the premotor, mid-cingulate, and orbitofrontal cortices in subjects with misophonia\(^8\).

Misophonia is most commonly diagnosed through clinical psychological interviews and/or with questionnaires\(^9\). Schröder et al.\(^3\) described what criteria should be present to diagnose misophonia and they suggested the A-MISO-S questionnaire to assess them. These have later been reviewed by the same group\(^9\), and form the basis of the revised version of the A-MISO-S: the AMISOS-R. Diagnostic criteria include: Feelings of irritation, anger, and/or disgust towards specific oral or nasal human generated sounds, loss of self-control (due to impulsive physical reactions), avoidance behaviors, significant impact on the quality of life, and indications that these behaviors are not better explained by other disorders (e.g., autism or attention deficit hyperactivity disorder). Other questionnaires include the Misophonia Questionnaire\(^9\) and the MisoQuest\(^10\). The latter is the only one that has been fully validated. To date, none of these have been translated and validated in French.

To our knowledge, no psychoacoustic test exists for misophonia. While questionnaires’ performance in diagnosing misophonia and its associated distress is reasonably good, they are based on the subjects’ recollection of their experience when faced with misophonic sounds. The true lived experience of the misophonic sounds is missing. We believe that measuring this subjective experience is important in estimating the aversion of subjects when faced with triggers. Such a test would also reveal for what kind of sounds a patient presents strong feelings and/or reactions. Moreover, estimates of the unpleasantness of misophonic sounds could be used as in situ outcome measures when evaluating potential misophonia treatments.

In a previous study\(^11\), we designed a psychoacoustic test for the diagnosis of hyperacusis by using the ratings of natural sounds on a pleasant to unpleasant VAS (Visual Analog Scale). In this study, we propose using a similar approach but adapted to misophonia using misophonic sounds. The task was completed online by 253 subjects. Our goals were to: (i) Identify which trigger sounds were rated as most unpleasant, (ii) select an optimal subset of these to create a new assessment tool for misophonia, and (iii) further validate the use of ratings of natural sounds as a novel approach for sound-based pathologies assessment and diagnosis.

**Methods**

**Subjects.** Subjects were recruited through mailing lists and social networks. Notable Facebook groups were “Misophonia/Misokinésie—1er groupe de France”, “Misophonia/Misokinésie—2ème groupe de France”, “Misophonia without Borders”, “Misophonia Treatment and Management”, “Misophonia International Support Group”, “Western and Pacific Misophonia Support Group”, “CAA tinnitus and hyperacusis Special Interest group”, and “Orthophonie et Audiologie Québec”. 253 subjects took part in the study (median age = 33 years; Median Absolute Deviation (MAD) = 7 years). The only inclusion criterion was to be at least 18 years old.

The ethics committee of Aix-Marseille University approved this study (reference number: 2020-10-08-001). The study was performed in accordance with institutional guidelines and the Declaration of Helsinki, and complied with national regulations. Informed consent was obtained from all participants.

**Online task.** The first page included a detailed description of the task, our contact information, and a request to do the experiment in a calm environment. No identifying information was collected, only the age. A list of questions, with explanations (shown here in brackets), was asked: (1) Do you have hearing issues (you ask others to repeat, you have problems understanding speech in noise)? (2) Do you have tinnitus (ear whistling)? (3) Do you have auditory hypersensitivity (are some sounds loud or painful at modest intensities for you when they do not cause any reaction in others)? (4) How disabled are you by this hypersensitivity? (5) Are there any particular sounds that trigger very intense reactions in you such as anger, disgust…? Those that responded “yes” to the last question, were asked to name what sounds trigger these reactions. Explanations could be seen by hovering the mouse over an information bubble. Questions 1, 2, 3, and 5 could be answered with “yes”, “no”, or “I don’t know”. Question 4 could be answered with “not at all”, “a little”, “moderately”, or “a lot”. For the remaining of the paper, questions 1, 2, 3, and 5 will be referred to as self-report questions for hearing issues, tinnitus, hyperacusis, and misophonia, respectively. Caution should be taken when examining our results on the self-report of hyperacusis. Reasons for this will be addressed in the discussion.

Subjects were requested to complete the MisoQuest\(^10\). We chose this questionnaire as it is, to the best of our knowledge, the only fully validated misophonia questionnaire. It contains 14 items. Each item is given a score from 1 to 5: (1) I completely disagree, (2) I disagree, (3) Neither agree nor disagree, (4) I agree, (5) I completely agree. The total score is obtained by summing the scores for each item, it ranges from 14 to 70. A total score above (or equal to) 61 suggests misophonia diagnosis\(^10\). Siepsiaik et al.\(^12\) chose this cut-off by subtracting one standard deviation (SD = 4.3) from the mean total score of misophonics (mean = 65.72). To verify this cut-off, we performed a Receiver Operating Characteristic (ROC)\(^13\) analysis of data from Siepsiaik et al.\(^12\) (Supplementary Data “raw_data2.csv”) and found that a cut-off of 61 was optimal (highest overall classification accuracy) in separating MisoQuest total scores of controls (n = 254) from scores of misophonics (n = 61).

Subjects were first presented with white noise and were asked to adjust a volume slider until sound was at a comfortable listening level. Subjects then trained with the rating of test sounds that are not part of the experimental sounds (“marimba” and “squeaking door”). This was also the opportunity to readjust the volume if necessary.
Once the training phase finished, subjects were asked not to change their system sound level for the remainder of the experiment. All subsequent sounds were thus presented at individual comfortable levels.

Twenty-eight sounds were repeated three times at random and each sound had to be assessed on a VAS ranging from “very pleasant” (far left) to “very unpleasant” (far right). The words “very pleasant” and “very unpleasant” were coloured respectively in green and red to avoid any confusion. Subjects were instructed that sounds are not necessarily very pleasant or very unpleasant and that the pleasantness/unpleasantness of sounds are variable. As such, they were requested to use the full length of the scale. If the sounds were neither pleasant nor unpleasant, then the subject was instructed to respond in the middle of the scale (“neutral”). Subjects could replay the sound as many times as necessary before finalizing the answer with a button.

The test was available in English or in French and was accessible via a computer or a smartphone. It took about 20 min to complete. The MisoQuest was translated into French by the authors.

**Labeling subjects.** Subjects were labeled as misophonics (n = 78; median age = 32, MAD = 8) if they self-reported misophonia and if their MisoQuest score was above (or equal to) 61. Subjects were labeled as controls (n = 55; median age = 33, MAD = 5) if they had a MisoQuest score below 61, did not self-report hearing issues, tinnitus, hyperacusis and misophonia (answered “no” or “I don’t know”), and indicated no impact of hyperacusis on their lives (answered “not at all”).

**Sounds.** Sixteen misophonic sounds were selected based on previous reports of misophonia triggers in the literature. We selected mouth, breathing, nasal, and throat sounds as well as repetitive sounds (keyboard typing and pen clicking). Six unpleasant and six pleasant sounds were also selected. These were rated as such by controls in a previous study.

Sound files were retrieved from publications, and from online sources. These are detailed in Table 1. Sound duration ranged from 0.9 s to 2.8 s (mean = 2.1 s, SD = 0.4 s). All sounds had the same root-mean-square sound pressure.

**Statistical analysis.** Sound ratings’ analysis was first attempted with a linear mixed-effects model. However, the distribution of its residuals did not fulfill assumptions of linearity or homosedasticity. Together with observations of sound ratings’ distributions, it was clear that our data did not show gaussian distributions (this was also confirmed with Lilliefors tests). We thus used non-parametric tests. When testing the null hypothesis that two samples were equal, we used the Wilcoxon non-parametric two-tailed rank test. When multiple comparisons were performed, α was corrected with the Bonferroni correction. Intraclass Correlation Coefficient (ICC) estimates and their 95% confidence intervals were calculated based on a mean-rating (across repetitions, k = 3), absolute agreement, 2-way mixed-effects model (i.e. ICC(2,3)). ICC values range between 0 and 1. Values below 0.5, between 0.5 and 0.75, between 0.75 and 0.9, and above 0.9 indicate poor, moderate, good, and excellent reliability, respectively. Statements on ICC reliability were made with respect to 95% confidence intervals. To compute effect sizes between median sound ratings for two groups, we used the r effect size. Values of r near 0.5, 0.3 or 0.1 indicate, respectively, large, medium, and small effect sizes. To compare the performance of classifiers, we used ROC curves. These allow comparison of specificity (proportion of negatives (e.g., controls) correctly identified as negatives) and sensitivity (proportion of positives (e.g., misophonics) correctly identified as positives) of classifiers for different cut-off values. The higher the AUC (Area Under Curve) of these curves, the better the classifier. The maximum possible AUC is 1, which would indicate a perfect classifier. The Wilson score with continuity correction was used to estimate 95% confidence intervals for accuracy, specificity, and sensitivity results. For correlations, Spearman’s ρ (rho) was used. To test the effect of repetition on sound ratings, we built a zero–one inflated beta model using R (R Core Team 2021) and the brms package. All other above computations and following figures were done with MATLAB 2019a.

### Table 1. List of sounds. and indicate where sounds were retrieved: Enzler et al.17, Fan et al.20, www.fesliyanstudios.com, www.freesound.org, and www.youtube.com, respectively. “Chewing 2” was self-created and recorded in the same session than sounds from Enzler et al.17, but it was not used in the final list of that publication.

| Misophonic trigger sounds | Unpleasant sounds | Pleasant sounds |
|---------------------------|------------------|-----------------|
| Blowing nose FrS | Pen clicking FrS | Clapping E | Birds E |
| Breath Running E | Slurping E | Distorted Guitar Dissonance E | Fountain E |
| Chewing 1 E | Sniffing FrS | Fork Scratch Plate E | Harp E |
| Chewing 2 | Snoring FrS | Knife Hit Glass E | Laugh E |
| Cough FrS | Swallowing E | Throat Clearing FrS | Scream E |
| Gargling FrS | | | Underwater E |
| Hard Breathing FrS | | | |
| Keyboard E | | | |

Once the training phase finished, subjects were asked not to change their system sound level for the remainder of the experiment. All subsequent sounds were thus presented at individual comfortable levels.

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| Gargling FrS | | | Underwater E |
| Hard Breathing FrS | | | |
| Keyboard E | | | |
Results

Questionnaire data. Frequency of answers to self-report questions one to five and how they compare to each other are shown in Supplementary Table S1.

69% of recruited subjects self-reported misophonia. These had varying degrees of misophonia severity. As shown in Fig. 1, their MisoQuest scores ranged from 14 to 70. The MisoQuest diagnostic cut-off (≥ 61) is shown with a black dotted line. Histogram bins contain the upper values of bin edges (e.g., the subject with the highest score in the bottom plot had a value of 61), as such the cut-off is drawn at x = 60.

Frequencies of diagnoses with the MisoQuest and the self-report question on misophonia are shown with respect to other self-report questions (hearing issues, tinnitus, hyperacusis, and hyperacusis impact) in Table 2. 22%, 19%, and 71% of misophonics self-reported hearing issues, tinnitus, and hyperacusis, respectively. Median MisoQuest scores for misophonics and controls were 65 (MAD = 2; range: 61—70) and 27 (MAD = 9; range: 14—52), respectively.

Answers by misophonics on the open question of what sounds they considered as triggers are shown in Fig. 2. Sounds were arbitrarily separated in categories. Some sounds were assigned to repetitive or high-pitched sounds.

Table 2. Frequency of misophonia diagnoses using the MisoQuest and self-report of misophonia and how they compare to self-report of hearing issues, tinnitus, hyperacusis, and hyperacusis impact. "Misophonia?", "Hearing Issues?", "Tinnitus?", "Hyperacusis?", and "Hyperacusis Impact?" refer to questions 5, 1, 2, 3, and 4, respectively. Subjects were labeled as misophonics if they had a MisoQuest score above (or equal to) 61, and if they self-reported misophonia (bold). Subjects were labeled as controls if they had a MisoQuest score below 61, if they answered “no” or “unknown” to questions 1, 2, 3, and 5, and if they answered “not at all” to question 4 (italics). Un. unknown = “I don’t know”, Mod. moderately.
Figure 2. Sounds reported by misophonics as triggers. The percentage of misophonics that reported a given sound, shown on the left y axis, as a trigger are indicated with bars. Each sound was assigned to one of eight categories (right y axis). Sounds are colored with respect to their assigned category. Percentages of misophonics for each category (round symbols), represent how many misophonics reported at least one sound within that category as a trigger. Misophonics could report more than one sound within each category. Unsp. Unspecified, which indicates that no specific sound was named, for instance: “any repetitive sound”. Brushing, friction, sucking, fork hitting. Apple bite, popcorn, chips. Music, motor, words (“um”, “like”). Sneezing, snorting, unspecified. Dog barking, rooster, cats, birds. Plane, church bell, keys, electronic cigarette, bones cracking, construction work, heater, washing hands, writing on table, sliding window, belt buckle, football, clapping, crowded party. Car, motorbike, horn, siren. Clothes, headphones, hands, scuffing shoes. Door slamming, cymbal. Paper compaction, turning pages, bag of chips. Leak, running, rain. Television, music. Burping, gagging, gurgling, unspecified. Breaks, guitar strings, metal scratching, winds...
because subjects specified it: for instance, "repetitive music", or "high-pitched voices". Some subjects reported several sounds within the same category. The most common trigger type reported by misophonics was mouth sounds: 91% reported at least one type of mouth sound, with 54% naming specifically chewing sounds, and 42% reporting general mouth sounds. 65% reported at least one type of repetitive sound, with 22%, 19%, and 19%, naming specifically pen click, keyboard typing, and footsteps, respectively; 45% and 31% reported at least one type of breathing/nose, and throat sound, respectively. Detailed values for each sound and category are shown in Supplementary Table S2.

Some responses were very specific, for instance: “bare feet walking on floors covered with a plastic layer, which creates a sort of suction sound”, “headphone friction on my ears”, “voice of my partner when singing”, and “repetitive words such as “um” and “like””.

Some sounds might be more associated to symptoms of hyperacusis than of misophonia, for instance loud traffic noises or high-pitched sounds26,27. Only one subject mentioned hyperacusis as a reason for the presence of two sounds: birds, and cymbal. This subject also reported high-pitched sounds like screams, squeaking sounds, and instruments (e.g., violin). (S)he did not specify if the latter were due to hyperacusis or misophonia.

Sound ratings. The VAS positions were mapped to ratings that went from 0 (highly pleasant) to 100 (highly unpleasant), where 50 was neither pleasant nor unpleasant.

For each subject and sound, we computed the standard deviation (SD) of ratings across three repetitions. For each subject, we averaged SDs across all sounds. This gives a general measure of how reliable (mean of SDs) each subject is across repetitions (low values indicate good reliability). The mean and SD of these values were 5.7 and 2.4, respectively. Subjects with their mean SDs above 10.8 (mean + 2SD) were excluded (n = 9). Three had been labeled as misophonics and one had been labeled as control. Following results on sound ratings are therefore based on 75 misophonics (median age = 32, MAD = 8) and 54 controls (median age = 33, MAD = 5).

To test the effect of repetition on sound ratings (from misophonics and controls with reliable ratings), we built a zero–one inflated beta model with group and repetition as fixed effects, and subject and sound as random effects. For the mean of ratings, the model revealed a significant effect of group (95% Credible Interval (CrI): [0.033, 0.085]), but not of repetition (95% CrI for 2nd vs 1st, 3rd vs 2nd, and 3rd vs 2nd repetitions were, respectively, [-0.0064, 0.0092], [-0.0015, 0.014], and [-0.0015, 0.014]). For each subject and sound, we thus averaged ratings across their three repetitions.

ICCs(2,3) were computed for each sound (for subjects with reliable ratings) and showed good to excellent reliability between repetitions. Mean ICC(2,3) across all sounds was 0.93. 16 sounds (out of 28) had excellent reliability. Full ICC(2,3) details are shown in Supplementary Table S3.

Figure 3 compares the median ratings of each sound for the controls and misophonics. For each subject, we computed the median of their sound ratings for each category. The median for each sound category was then calculated across subjects for each group (control and misophonic). The difference of medians between the misophonic and control groups (i.e., y–x coordinates of diamond symbols in Fig. 3) was markedly larger for misophonic sounds (difference = 18.3) than for unpleasant (difference = 1) or pleasant sounds (difference = 5.5). Rank tests were used to evaluate the null hypothesis that median ratings for sounds with the same category were the same for the two groups. Misophonic sounds’ medians were significantly different between both groups (p = 5.3 · 10^-10; r = 0.51). Unpleasant and pleasant sounds’ medians did not show significant differences (p = 0.75, and p = 0.50, respectively; r = −0.03, and −0.06, respectively).
Misophonic sounds were separated in four subcategories based on categories described in the literature\textsuperscript{2,3}, and those observed in Fig. 2: mouth, breathing/nose, throat and repetitive sounds. Figure 4 shows the ratings of controls and misophonics, and the effect size, for each sound. The effect size allows us to determine the most discriminant sounds, i.e., those that can best separate control from misophonic ratings. In accordance with Fig. 3, misophonic sounds had the highest effect sizes, while unpleasant and pleasant sounds had low effect sizes. Mouth and repetitive sounds had the highest mean effect size: 0.66 and 0.52, respectively. “Chewing 1”, “Chewing 2”, “Slurping”, “Sniffing”, “Throat Clearing”, and “Pen Click”, had large effect sizes (r > 0.5): 0.74, 0.73, 0.53, 0.62, and 0.57, respectively. “Vomit” had a low effect size (− 0.08) and was rated as very unpleasant for both groups. This suggests that it was wrongfully categorized as a misophonic trigger sound.

Core discriminant sounds.

To create a new assessment tool, we wanted to select the sounds with the most discriminative power whilst keeping in mind clinical practicalities. This tool should not be too time-consuming (not too many sounds), and it should capture the main complaints of misophonics. As shown in Fig. 2, several categories of sounds were considered as triggers. Moreover, some subjects would report mouth sounds as triggers, and not mention any repetitive sounds. The contrary was seen too. Hence, the final choice of sounds should assess these putative dimensions of misophonia. As in Enzler et al.\textsuperscript{17} for hyperacusis, the optimal subset of sounds to assess misophonia were called Core Discriminant Sounds (CDS). For clarity, the first will be referred to as CDS\textsubscript{hyp} and the latter as CDS\textsubscript{mis}. As seen in Figs. 3 and 4, misophonic sounds discriminate best misophonic from control ratings. As such, the CDS\textsubscript{mis} were selected within these. We wanted to keep sounds from each subcategory of misophonic sounds, to assess the unpleasantness of each in the CDS\textsubscript{mis}. To identify what sounds were the most important in discriminating controls from misophonics in each subcategory, we first defined a metric that could measure this: the CDS score. Second, we computed this metric for different choices of CDS and compared their performance using ROC curves\textsuperscript{19}.

To compute the CDS score, we took an approach similar to the definition of dB HL, where 0 dB HL is defined as a normalized value i.e., a value that represents the behavior of a control population. Positive values are deemed different than normal when crossing a chosen threshold (usually 20 dB HL). Our goal was to create a metric that evaluates how different subjects' ratings are from a given threshold. We set a threshold for each sound at the 75% quantile of the control group's distribution. For a given subject, a given sound \((s \in \textit{CDS} = \{1, 2, 3, \ldots, |\textit{CDS}|\})\) where each index represents one of the CDS and \(|\textit{CDS}|\) is the number of elements within this set, we compute the distance, in percentage, of this sound's rating \((\text{Rating}_s)\) from its respective 75% quantile \((\text{Quantile}_{75,s})\):
with \( \text{Rating}_s - \text{Quantile}_{75.5} = 0 \) if \( \text{Rating}_s < \text{Quantile}_{75.5} \) (we only want to evaluate positive differences) and \( \text{Distance}_s = 0 \) if \( \text{Quantile}_{75.5} = 100 \) (to avoid division by 0). \( 100 - \text{Quantile}_{75.5} \) is the maximum possible distance of a rating from its respective quantile. The CDS score expresses how high a given subject's ratings are relative to the quantiles. For a given set of sounds (the CDS), the CDS score is computed by averaging the distances of sound ratings within that set and whose quantiles are below 100. This subset of sounds is defined as:

\[
s_{\text{valid}} = \{ s \in \text{CDS} | \text{Quantile}_{75.5} < 100 \}
\]

Indeed, for sounds with a 75% quantile (\( \text{Quantile}_{75.5} \)) equal to 100, their \( \text{Distances}_s \) becomes zero. However, we do not want to include this null distance in our average. In this study, no sound had their 75% quantile of control ratings equal to 100. The CDS score is defined as:

\[
\text{CDS Score} = \frac{1}{|s_{\text{valid}}|} \sum_{x \in s_{\text{valid}}} \text{Distance}_x
\]

where \( |s_{\text{valid}}| \) is the number of sounds in the CDS with a 75% quantile below 100.

For each CDS score, we computed the cut-off value that best separates misophonic scores from control scores i.e. the value where scores above (or equal to) this cut-off indicate misophoria and scores below this cut-off indicate no misophoria. The cut-off values were obtained by maximizing classification accuracy. Accuracy was calculated by dividing the sum of true positives (misophonics with a score above (or equal to) the cut-off) and true negatives (controls with a score below the cut-off) by the total number of subjects (75 misophonics + 54 controls = 129 subjects).

For each subcategory, we tested every combination of \( k \) sounds possible, with \( k \) ranging from 1 to \( n \), where \( n \) is the number of sounds within that subcategory. In other words, we tested CDS that contained 1 to \( n \) sounds, and for each number of sounds \( (k) \), we tested all the possible ways we could select \( k \) sounds from \( n \) sounds.

For each \( k \), we selected the combinations of CDS that gave the highest accuracy. Figure 5 shows the highest accuracy, for each \( k \), and for each subcategory. The best subset of sounds for mouth sounds, CDS\text{Mouth}, were “Chewing 1”, “Chewing 2”, and “Slurping”. For breathing/nose sounds, maximum accuracy was the same for \( k = 2, 3, \) and 4. Maximum AUC for these were 0.870, 0.873, and 0.860, respectively. As such, the most accurate combination of three sounds was chosen for CDS\text{Breathing/Nose}. They contained one breathing sound and two nose sounds: “Breath Running”, “Sniffing”, and “Snoring”. The CDS\text{Repetitive} were “Pen Click”, and “Keyboard”. The CDS\text{Throat} were “Throat Clearing”, and “Swallowing”. These sounds form the CDS\text{Miso} (\( n = 10 \)).

Ratings of the CDS\text{Miso} for both groups are shown in Fig. 6. Two example subjects (one control and one misophonic) are also shown with their respective CDS scores. For each subcategory, we computed their CDS score. We also computed a global score, CDS\text{ScoreTotal}, which is computed by including all sounds from the CDS\text{Miso}. Optimal cut-off values, computed with ROC analysis, are indicated next to each score in brackets. Hence, for each score, we can assess if subject's ratings are abnormal. For instance, a CDS\text{ScoreMouth} above (or equal to) 37.67 suggests that a subject was abnormally annoyed by mouth sounds. More generally, a CDS\text{ScoreTotal} above
Scores for misophonic subject 107 were above respective cut-off values for CDS ScoreMouth, CDS ScoreBreathing/nose, CDS ScoreThroat, and CDS ScoreTotal. This suggests that this subject’s misophonia was specific to mouth, breathing/nose, and throat sounds, but not to repetitive sounds. Subject 107 was 40 years old and self-reported misophonia and hyperacusis, the latter with no impact on her/his life. (S)he did not self-report tinnitus or hearing issues and had a MisoQuest score of 62. This subject reported chewing, breathing, and gagging as trigger sounds.

Control subject 103 was 29 years old, did not self-report misophonia, hyperacusis, tinnitus and hearing issues, and had a MisoQuest score of 14.

Across all recruited subjects (with reliable sound ratings), each CDS score correlated positively with the MisoQuest score ($\rho = 0.67, 0.53, 0.54, 0.53, \text{and} 0.71$, for mouth, breathing/nose, throat, repetitive, and total, respectively; $p = 2.1 \cdot 10^{-33}, 9.3 \cdot 10^{-19}, 8.7 \cdot 10^{-20}, 3.6 \cdot 10^{-19}, \text{and} 5.4 \cdot 10^{-39}$, respectively). Classification performances of each CDS score in separating controls from misophonics are shown in Table 3.

With each subcategory of CDSMiso, we could identify different behaviors from one subject to another. For instance, for misophonic subject 107 in Fig. 6, repetitive sounds were not more unpleasant than controls, but other subcategories were. In Table 4, we identified such patterns by counting misophonic subjects that had the same subcategories’ CDS score above (or equal to) their respective cut-offs. Most misophonics (55%) had all subcategories above their respective cut-offs. 15% showed no abnormality for repetitive sounds, while they did...
for all other subcategories. Conversely, 3% showed abnormality for repetitive sounds, while they did not for all other subcategories.

| Mouth | Breathing/noise | Throat | Repetitive | N  |
|-------|----------------|--------|------------|----|
| Yes   | Yes            | Yes    | Yes        | 41 |
| Yes   | Yes            | Yes    | No         | 11 |
| Yes   | Yes            | No     | Yes        | 5  |
| Yes   | Yes            | No     | No         | 6  |
| Yes   | No             | Yes    | Yes        | 4  |
| Yes   | No             | No     | Yes        | 2  |
| Yes   | No             | No     | No         | 1  |
| No    | Yes            | Yes    | Yes        | 1  |
| No    | No             | Yes    | Yes        | 2  |
| No    | No             | No     | No         | 1  |

Table 4. Frequency of misophonic subject’s subcategory profiles. “Yes” indicates that the CDS score of the given subcategory is above (or equal to) its cut-off. “No” indicates that the CDS score is below its respective cut-off.

Discussion

Summary of the findings. With this study we wanted to create a tool that could assess misophonia by directly confronting subjects with trigger sounds. First, we found that misophonics’ unpleasantness towards sounds was specifically higher for misophonic sounds, while general pleasant or unpleasant sounds were not different from control ratings. Second, we identified a subset of sounds, the CDSMiso, that could be used to assess misophonia. They could also evaluate potential subcategories of misophonia. A metric, the CDS score, was used to quantify misophonia and its subcategories.

Questionnaire data on hearing. Previous studies have found audiological problems to be rare in misophonics. In our study, 22% of misophonics self-reported hearing issues. It is unclear whether our findings suggest that hearing issues are missed by clinical measures in misophonics, or if the validity of online questionnaire data is to be questioned. Jager et al. had 109 misophonics (randomly selected from 575 misophonics) perform an audiogram (air and bone conduction thresholds from 0.25 to 8 kHz, and from 0.25 to 2 kHz, respectively, both in octave steps). 97% (n = 106) had bilateral normal hearing. However, they did not perform speech discrimination measures. Schröder et al. had only five subjects (out of 42) undergo hearing tests (pure tone, speech audiometry, and loudness discomfort levels). One patient showed conductive hearing loss. The other four showed no audiological abnormalities. Findings might have been different if the remaining 37 subjects had been tested. Our question on hearing issues indicates two examples in its explanation: “you ask others to repeat” (eventually hearing loss), and “you have problems understanding speech in noise” (speech in noise issues). Given results on
71% of misophonics reported hyperacusis. This prevalence is much higher than the 1% found by Jager et al.²
or of the 25% found by Sanchez and Silva.¹⁸ We believe the high prevalence of hyperacusis in misophonics in our
study should be taken with caution. Indeed, no diagnostic measure of hyperacusis was used, only one self-report
question. Most importantly, the question on hyperacusis (“do you have auditory hypersensitivity?”) might have
been wrongfully interpreted as positive for misophonics, even though no hyperacusis was present. Explanation
(i.e., definition of hyperacusis) for that question (“are some sounds loud or painful at modest intensities for you
when they do not cause any reaction in others”) was only shown when hovering over an information bubble.
Subjects might have missed this. For future online studies, better care should be taken to word this question.
19% of misophonics reported tinnitus. Our results are higher than those by Jager et al.,² where only 2% of
misophonics had tinnitus. However, the latter had only been diagnosed as such prior to the study. It is not stated
whether all subjects had undergone screening for tinnitus (and hyperacusis) prior to the study or not. On the
other hand, Sanchez and Silva reported that 50% of misophonics self-reported tinnitus. Furthermore, with our
data, we cannot be sure that tinnitus was chronic.
Result discrepancies indicate that a putative link between tinnitus, hyperacusis, hearing loss, and misophonia
is unclear.

The MisoQuest and misophonic sounds. Siepsia et al.¹⁸ found that the MisoQuest was very specific
and not very sensitive: 96% and 66%, respectively. They compared MisoQuest scores to face-to-face interview
diagnosis using the diagnostic criteria by Schröder et al.³ We found similar results: 99% specificity and 45%
sensitivity, when comparing MisoQuest scores with self-diagnosis. 55% of subjects self-diagnosing misophonia
were not diagnosed as such by the MisoQuest. This highlights the putative variability in misophonia diagnosis
(and severity). This echoes the rather high prevalence rates of misophonia found by Wu et al.² (20%) and Nay-
lor et al.¹⁰ (49.1%). The latter have stated that only 0.3% had severe cases of misophonia, and that misophonia
seemed to affect many people mildly, but only a few severely. As discussed by Edelstein et al.,²³ controls and
misophonics find similar sounds to be aversive, but the degree of aversion experienced by misophonics is higher,
which is in broad agreement with our findings (Fig. 4). The line between slightly abnormal annoyance towards
specific sounds and its significant impact on the quality of life is what makes misophonia a serious condition.
91%, 65%, 44%, and 31% of misophonics reported at least one mouth, repetitive, breathing/nose, and throat
sound, respectively, as a trigger (Fig. 2). These are similar proportions to those shown by Jager et al.²: 96%, 74%, 85%,
and 69% for eating, repetitive tapping, breathing/nose, and mouth/throat sounds, respectively. Inquiring
trigger sounds with an open question might explain lower percentages in our study. Indeed, subjects might
not have taken the time to think of every sound that could be considered as a trigger, and rather focused on
the first, and probably main, ones that came to mind. One subject wrote: "so many I can't even think of more
right now but mostly human related noises...". In Jager et al.,² a readymade list of trigger sounds was prepared.
Nevertheless, chewing and mouth sounds were the most reported both in this study and in previous ones²,³,²⁹.

Besides, differences in category percentages also depend on how sounds are attributed. For instance, we
attributed "Swallowing" as a throat sound (focusing on the location of the sound source), whereas Jager et al.,²
had it in the eating category. Also, we could have eventually assigned some animal sounds to "Repetitive sounds"
instead of "Environmental". However, from subjects' descriptions it was not clear if it was the repetitive nature of
the sound (e.g., continuous dog barking) that was the trigger or not. It would be of interest to have misophon-
ics categorize sounds, instead of researchers. Also, it could be interesting for future research to have a large set
analysis, empirical categories of misophonic triggers.

Sound ratings and misophonia. Misophonics had significantly higher ratings than controls for misopho-
nic sounds, while pleasant and unpleasant sounds did not show significant differences (Figs. 3 and 4). As
expected, misophonics show high levels of unpleasantness towards specific human generated sounds²⁻⁴, even at
comfortable listening levels. The latter supports previous suggestions that physical characteristics of sounds are
less detrimental in sound aversion, rather that it is the previous experiences and associations with triggers that
make them unpleasant.¹⁶ These results emphasize the differences between misophonia and hyperacusis.

In this study, subjects could decide when the next sound would play. They were given more control than what
they usually have over daily situations. Indeed, the context in which sounds are experienced makes the triggers
more, or less, uncomfortable. For instance, Edelstein et al.⁴ reported that discomfort was worse when subjects
felt they could not escape the situation (e.g. plane trip), which is their main coping mechanism.²⁴ Besides, lack
of control of neighborhood sounds makes them more unpleasant, even in the case of non-misophonic sounds.⁶⁴
Hence, even in a controlled situation, ratings by misophonics were higher than for controls. This suggests that context
is not solely necessary for misophonic aversion, and that underlying emotional and memory associations with
sound are sufficient to generate abnormal aversion. Still, as shown recently by Edelstein et al., context may modulate the severity of such aversion.

Our VAS might measure a mixture of emotion and memory associations related to sounds. For instance, keyboard typing and pen clicking sounds were rated as high even though the sound stimuli were short. This could be explained by two possibilities: a short repetitive stimulus is sufficient to directly induce aversion, and/ or it is the memory associations with this type of sound that influenced the rating. These sounds are thought to be annoying because of their repetitive and unpredictable nature, and because of the context in which they are experienced: misophonics do not understand why the originators of the sound do not stop making these rude sounds.¹ In the task, the repetitions (e.g., number of pen clicks) were limited because of the short stimulus...
misophonia has been suggested to be a psychiatric disorder.29. Misophonic complaints. “Moderate” or “Severe” to accurately define cut-offs for each severity, for instance using the AMISOS-R2. Moderate cases of misophonia. Would be of interest to test such an approach on another cohort of subjects. Interestingly, cut-off values were cut-offs. This is not surprising as cut-offs were selected to maximize classification accuracy of our subjects. It is of the CDSMiso can be used to have a detailed assessment of misophonia and could potentially be used to identify subtypes of misophonia. The core discriminant sounds as a diagnostic tool for misophonia. With the CDSMiso, we selected the most discriminant misophonic triggers, while maintaining sounds from four main subcategories (mouth, breathing/nose, throat, and repetitive sounds), each of which were often reported as triggers in Fig. 2. This suggests that the ratings collected in the task and the method used to select the CDSMiso accurately represent misophonic complaints.

We showed that the CDS Score Total classified misophonics and controls with 91% accuracy. Each subcategory of the CDSMiso can be used to have a detailed assessment of misophonia and could potentially be used to identify subtypes of misophonia. CDS Score Mouth had the highest classification accuracy of all subscores (Table 3). This highlights the strong specificity that misophonia has with chewing and eating sounds, which are the most often reported as triggers.3-4

In Table 4, we attempted to identify potential subtypes of misophonia by using the CDS scores of each subcategory of the CDSMiso. Most subjects (55%) had scores from each subcategory above (or equal to) their respective cut-offs. This is not surprising as cut-offs were selected to maximize classification accuracy of our subjects. It would be of interest to test such an approach on another cohort of subjects. Interestingly, cut-off values were computed with rather severe cases of misophonia (high MisoQuest scores). Patterns might emerge in mild to moderate cases of misophonia.

It would also be of interest to correlate CDS scores with precise severity scales of misophonia (e.g., “Mild”, “Moderate”, or “Severe”) to accurately define cut-offs for each severity, for instance using the AMISOS-R². The CDSMiso were selected based on misophonics identified by the MisoQuest. It would be interesting to verify that correlation found between the CDS Scores and the MisoQuest, is also found with other measures of misophonia, like the MQ² and the AMISOS-R².

Other limits. Identification of sound seems to influence pleasantness-unpleasantness ratings.35 In this study, sounds were presented without any text or image identification. Most misophonic sounds are easy to identify with sound alone. However, this might not have been the case for other sounds. Several misophonics mentioned nail sounds as triggers (Fig. 2). In our task, “Fingernails on Chalkboard” was not rated higher by misophonics than controls. This could be because the sound was not recognized and therefore not associated with a visual or tactile perception, or with a past experience. It could be of interest to add information from other sensory modalities, like vision, to the stimuli. Besides, having a subpart of the experiment solely with visual stimuli (e.g., leg rocking) could potentially be used to measure cases of misokinesia.

Cut-offs for each of the CDS scores might have to be reassessed by future studies. Indeed, those shown in Table 3, were computed to optimally classify “clean” subjects. The distribution of CDS scores might not be the same for other cohorts, especially if severity of misophonia is different. This should also be considered if the task is used in a different setting than an online task. It is possible that ratings may slightly differ in a clinical setting than in an online situation. Besides, further validation of the task in a clinical setting, where potential psychiatric and/or audiologic comorbidities may be evaluated by the clinician, is important. Furthermore, having a psychoacoustic test only with triggers (e.g., the CDSMiso), might change the dynamic of VAS responses, as such cut-offs might also have to be reassessed for this reason.

Future assessment of test–retest reliability of the CDSMiso is important to confirm its viability as a novel assessment tool for misophonia.

The VAS measures the pleasantness-unpleasantness of sound. However, misophonics may experience a variety of emotions that could potentially modulate rated unpleasantness, for instance anger, disgust, stress, or anxiety.1 It might be of interest to have the CDSMiso evaluated with VAS for each of these.
Finally, gender data was not collected in our study and our French version of the MisoQuest has not been previously validated.

Conclusions and perspectives
A new assessment tool for misophonia was developed and tested. We further validated a method previously used for hyperacusis assessment\(^\text{10}\), and successfully applied it to another condition (misophonia) and setting (online). We showed that misophonics had higher ratings than controls for misophonic triggers, and not for pleasant or unpleasant sounds, thus further showing that misophonia is specific to certain sounds. The CDS scores can be used to assess misophonia globally, but also to identify potential subcategories of misophonia with a score for each subcategory of the CDS\(_{miso}\).

This psychoacoustic tool, the first that has been developed to assess misophonia, could motivate other studies on conditions where relation to sound is abnormal. For instance, decreased sound tolerance (mainly hyperacusis, but also misophonia) is present in autism\(^\text{16,37}\). A different set of CDS could be more adequate to assess hyperacusis and misophonia in such population.

Using the CDS\(_{hyp}\) and the CDS\(_{miso}\), together in one experiment, with controlled levels, could potentially serve as a novel tool to assess both conditions at once. Tyler et al.\(^\text{38}\) suggested four main types of hyperacusis: loudness, annoyance, fear, and pain. The CDS\(_{hyp}\) probably measure loudness-, and eventually pain- hyperacusis\(^\text{17}\). The CDS\(_{miso}\) most probably measure annoyance hyperacusis, at least annoyance that is specific to the definition of misophonia.

The CDS\(_{miso}\) could potentially be used as an outcome measure over the course of misophonia management. It offers the advantage of directly assessing aversion to triggers at the time they are presented, unlike questionnaires that may not have the proper temporal resolution to assess quick and subtle changes in the lived experience. On the other hand, questionnaires may be more adequate to assess the impact of misophonia on the quality of life, which typically requires extended time to realize if any progress or worsening has been achieved.

Data availability
All data generated or analyzed during this study are included in this published article's supplementary information files.

Received: 31 January 2021; Accepted: 4 May 2021
Published online: 26 May 2021

References
1. Jastreboff, M. M. & Jastreboff, P. J. Components of decreased sound tolerance: Hyperacusis, Misophonia, Phonophobia. JTHS News Lett. 2, 5–7 (2001).
2. Jager, I., de Koning, P., Bost, T., Denys, D. & Vulink, N. Misophonia: Phenomenology, comorbidity and demographics in a large sample. PLoS ONE 15, e0231390 (2020).
3. Schröder, A., Vulink, N. & Denys, D. Misophonia: Diagnostic criteria for a new psychiatric disorder. PLoS ONE 8, e54706 (2013).
4. Edelstein, M., Brang, D., Rouw, R. & Ramachandran, V. S. Misophonia: Physiological investigations and case descriptions. Front. Hum. Neurosci. 7, 296–296 (2013).
5. Kumar, S. et al. The brain basis for Misophonia. Curr. Biol. 27, 527–533 (2017).
6. Jastreboff, P. J. & Jastreboff, M. M. Decreased sound tolerance: Hyperacusis, misophonia, diphasophobia, and polycacusis. Handb. Clin. Neurol. 129, 375–387 (2015).
7. Edelstein, M., Monk, B., Ramachandran, V. S. & Rouw, R. Context influences how individuals with misophonia respond to sounds. bioRxiv https://doi.org/10.1101/2020.09.12.292391 (2020).
8. Wu, M. S., Lewin, A. B., Murphy, T. K. & Storch, E. A. Misophonia: Incidence, phenomenology, and clinical correlates in an undergraduate student sample: Misophonia. J. Clin. Psychol. 70, 994–1007 (2014).
9. Zhou, X., Wu, M. S. & Storch, E. A. Misophonia symptoms among Chinese University students: Incidence, associated impairment, and clinical correlates. J. Obsessive-Compuls. Relat. Disord. 14, 7–12 (2017).
10. Naylor, J., Caimino, C., Scutt, P., Hoare, D. J. & Baguley, D. M. The prevalence and severity of Misophonia in a UK undergraduate medical student population and validation of the Amsterdam Misophonia Scale. Psychiatr. Q. https://doi.org/10.1007/s11126-020-09825-3 (2020).
11. Cassiello-Robbins, C. et al. A preliminary investigation of the association between misophonia and symptoms of psychopathology and personality disorders. Front. Psychol. 11, 3842 (2021).
12. Cassiello-Robbins, C. et al. The mediating role of emotion regulation within the relationship between neuroticism and Misophonia: A preliminary investigation. Front. Psychiatry 11, 847 (2020).
13. Schröder, A. et al. Misophonia is associated with altered brain activity in the auditory cortex and salience network. Sci. Rep. 9, 75452 (2019).
14. Cerlami, L. & Rouw, R. Increased orbitofrontal connectivity in misophonia. bioRxiv https://doi.org/10.1101/2020.10.29.346650 (2020).
15. Potgieter, I. et al. Misophonia: A scoping review of research. J. Clin. Psychol. 75, 1203–1218 (2019).
16. Stepsiak, M., Sliwerski, A. & Łukasz Dragan, W. Development and psychometric properties of MisoQuest: A New self-report questionnaire for Misophonia. Int. J. Environ. Res. Public. Health 17, 1797 (2020).
17. Enzler, F., Fournier, P. & Norriza, A. J. A psychoacoustic test for diagnosing hyperacusis based on ratings of natural sounds. Hear. Res. 400, 108124 (2021).
18. Stepsiak, M., Sobczak, A. M., Bohaterewicz, B., Cichocki, Ł & Dragan, W. L. Prevalence of misophonia and correlates of its symptoms among inpatients with depression. Int. J. Environ. Res. Public. Health 17, 5464 (2020).
19. Delacour, H., Servonnet, A., Perriot, A., Vigezzi, J. F. & La Ramirez, J. M. coarse ROC (receiver operating characteristic): Principes et principales applications en biologie clinique. Ann. Biol. Clin. 63, 11 (2005).
20. Fan, J., Thorogood, M. & Pasquier, P. Emo-Soundscapes: A Dataset for Soundscape Emotion Recognition. https://doi.org/10.1109/ACII.2017.8273600. (2017).
21. Koo, T. K. & Li, M. Y. A guideline of selecting and reporting intraclass correlation coefficients for reliability research. J. Chiropr. Med. 15, 155–163 (2016).
22. Fritz, C. O., Morris, P. E. & Richler, J. J. Effect size estimates: Current use, calculations, and interpretation. *J. Exp. Psychol. Gen.* 141, 2–18 (2012).
23. Newcombe, R. G. Two-sided confidence intervals for the single proportion: Comparison of seven methods. *Stat. Med.* 17, 857–872 (1998).
24. Bürkner, P.-C. brms: An R Package for Bayesian Multilevel Models Using Stan. *J. Stat. Softw.* 80, 1–28 (2017).
25. Bürkner, P.-C. Advanced Bayesian multilevel modeling with the R Package brms. *R J.* 10, 395–411 (2018).
26. Anati, M., Axelsson, A., Eliasson, A. & Magnusson, L. Hypersensitivity to sound—questionnaire data, audiometry and classification. *Scand. Audiol.* 28, 219–230 (1999).
27. Littwin, R. Hyperacusis management: A Patient's perspective. In *Hyperacusis and Disorders of Sound Intolerance: Clinical and Research Perspectives* 241–264 (Plural Publishing, San Diego, 2018).
28. Sanchez, T. G. & da Silva, F. E. Familial misophonia or selective sound sensitivity syndrome: Evidence for autosomal dominant inheritance?. *Braz. J. Otorhinolaryngol.* 84, 553–559 (2018).
29. Schröder, A. E., Vulink, N. C., van Loon, A. J. & Denys, D. A. Cognitive behavioral therapy is effective in misophonia: An open trial. *J. Affect. Disord.* 217, 289–294 (2017).
30. Levy-Leboyer, C. & Naturel, V. Neighbourhood noise annoyance. *J. Environ. Psychol.* 11, 75–86 (1991).
31. Clasesen, C. The odor of the other: Olfactory symbolism and cultural categories. *Ethos* 20, 133–166 (1992).
32. DeLoach, A. G., Carter, J. P. & Braasch, J. Tuning the cognitive environment: Sound masking with "natural" sounds in open-plan offices. *J. Acoust. Soc. Am.* 137, 2291–2291 (2015).
33. Poulain, J.-P. Towards a sociological theory of eating: A review of Alan Ward's the practice of eating. *Anthropol. Food* 20, 20. https://doi.org/10.4000/aof.4773 (2020).
34. Wiggins, S. Moments of pleasure: A preliminary classification of gustatory moments and the enactment of enjoyment during infant mealtimes. *Front. Psychol.* 10, 1404 (2019).
35. Shimi, S. Emotion and identification of environmental sounds and electroencephalographic activity [abstract]. *Fukushima J. Med. Sci.* 38, 43–56 (1992).
36. Khalifa, S. et al. Increased perception of loudness in autism. *Hear. Res.* 198, 87–92 (2004).
37. Williams, Z. J., He, J. L., Cascio, C. J. & Woynaroski, T. G. A review of decreased sound tolerance in autism: Definitions, phenomenology, and potential mechanisms. *Neurosci. Biobehav. Rev.* 121, 1–17 (2021).
38. Tyler, R. S. et al. A review of hyperacusis and future directions: Part I. Definitions and manifestations. *Am. J. Audiol.* 23, 402–419 (2014).

Acknowledgements

We thank Benoit Ruiz for coding the online experiment. We thank Marta Siepsia for her help in analyzing raw data from the first MisoQuest study16. We would like to thank the two anonymous reviewers for their constructive suggestions and comments.

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Funding

This project has received funding from the European Union’s Horizon 2020 research and innovation programme under the Marie Sklodowska-Curie grant agreement No 764604. The project leading to this publication has received funding from the Excellence Initiative of Aix-Marseille University—A*Midex, a French “Investissements d’Avenir programme”. The corresponding author (AN) is supported by “La Fondation Pour l’Audition”. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Competing interests

The authors declare no competing interests.

Additional information

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1038/s41598-021-90355-8.

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