

Misophonia: A connection between sounds and emotions?

By Cindy Poore-Pariseau, Ph.D.

Misophonia, which literally means “hatred of sounds,” has been in existence for longer than anyone knows, but was first “officially” named by Dr. Pawel J. Jastreboff when he noticed a connection between certain “soft” noises (chewing, tapping, ticking, etc.) and a rise in stress levels and emotions that seemed over the top (anger, anxiety, panic). A question to be addressed is why are we now seeing a rise in accommodation requests for this disorder? One possibility is that, due to the nature of the disorder, individuals with this disorder are often isolated, seemingly angry and intolerant, and unaware that this condition is not just a “me quirk.”

As is the case for other disabilities, the advent of the internet has allowed individuals and professionals to search symptoms, become diagnosed, and receive support. With information access from sources such as the internet, it is now much easier for individuals and professionals to understand the condition is beyond quirky behaviors or off-putting personalities.

The following is my own experience with misophonia, written to provide insight into the discovery process.

At a very early age, I cried when it was time to get my hair cut. I have wildly curly hair, and the assumption was that the cutting and pulling on the curls caused the crying. At that time, what I did not know how to express was that the problem was the hairdresser; while she was a very nice person who always did a great job, she was also a gum chewer who continuously cracked bubbles in my ear. For many people with misophonia, gum is “the enemy,” so getting my hair cut felt like pure torture. As a child, how could I tell an adult to stop doing something, especially when I did not have the knowledge to explain what the issue was?

As I became older and more self-aware, I developed coping systems that included having an excuse and/or way out of a room or situation in which there was gum or ice chewing, clocks ticking, and other repetitive “soft” sounds that most people can filter out. Until my mid-30s, I thought this was just a strange “me quirk” and I did my best to deal with it all alone. This resulted in a good amount of isolation and avoidance of most social activities.

And then one day I received a call from my daughter’s elementary school teacher. She related

to me an incident in which my daughter very angrily approached another student and told him to stop chewing. That was the first time it ever occurred to me that this “sound issue” was not just a “me thing.” The lightbulb went off, and I began researching this sensitivity to sound. At the same time, I felt a great sadness at the thought that someone I loved might spend her life enduring this emotionally painful reaction to noise.

Over the years, the name has evolved. The first time I searched the symptoms (about 20 years ago), the term *hyperacusis* popped up. Hyperacusis is defined as “a highly debilitating hearing disorder characterized by an increased sensitivity to certain frequencies and volume ranges of sound.” Although that didn’t seem quite right, it was all I could find. It was a start. A few years later, my search of the symptoms revealed the term *selective sound sensitivity syndrome*, but this seemed to be just another name for hyperacusis.

Then, about seven years ago, I came across the term *misophonia*. While hyperacusis and SSSS are related to physical pain in the ear, misophonia is related to the emotional provocation of a variety of responses, including anger, overwhelming anxiety, and/or panic. Finally ... a definition. No longer was this a “Cindy quirk”; I shared this information with family and friends and co-workers, anyone and everyone I came across who would accept the information. I have shared as much information as I can in a variety of online forums to raise awareness.

Although I was in my mid-40s when I discovered this term *misophonia*, it was not until I turned 50 that I felt comfortable enough to do something about it. My office and home became “no gum” zones. I request that batteries be removed from clocks or that meetings be moved. I close my office door when keyboard clicking becomes too much. I

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turn down social and professional events that include eating. And I ask that meetings not include working lunches. I am now much more comfortable explaining to others why the door was closed, why I could not attend certain functions, etc. However, when doing each of these, I know I impact others and there is always a bit of guilt associated with each request. (I know the feeling of guilt is wrong ... I'm working on it.)

Recently, there have been more and more students requesting accommodations for misophonia. I have mixed feelings about this. I am thrilled that people are becoming more aware of this impairment at a much younger age than I did. At the same time, I am saddened to find that so many people live with this day to day.

For those in our field, many challenges exist in regard to accommodating students diagnosed with misophonia.

➤ **First, what is it?** Literally, misophonia means “hatred of sounds.” This can be a misnomer, as sounds in general are not “hated.” Trigger sounds are certainly intolerable and can result in anger, anxiety, and/or panic attacks. In addition, for some, the “sight” of certain sounds can trigger the same fight-or-flight response. By this I mean that watching someone chew, for example, can be as big a trigger as the actual sounds.

➤ **Second, what causes misophonia?** There have been different theories over the years. A recent study detailed in *Current Biology* states “that brain scans of misophonia sufferers show that particular sounds, like eating and drinking, cause the part of their brain that processes emotions, the anterior insular cortex, to go into overdrive [and this region is] connected differently, compared to normal brains, to the amygdala and the hippocampus, areas that are

involved in recalling past experiences” (see <http://bit.ly/2ZOqkNs>).

➤ **Third, who is qualified to make a diagnosis?** Misophonia is not in the DSM or ICD. Who is qualified to diagnose an impairment that does not officially exist? Misophonia International has a resource called The Misophonia Network. Among those recommended through the network for diagnosing misophonia are professionals from the following fields: audiologists, counselors, medical doctors, music therapists, occupational therapists, psychiatrists, and psychologists. Of course, not everyone in each of these professions can make a diagnosis. At this point, however, there are no “expert” fields.

➤ **Finally, what accommodations are appropriate?** As with all disabilities, accommodations must be assessed on a case-by-case basis. Generally, the following accommodations may be considered:

- **Testing:** Noise-canceling headsets and/or earplugs and a reduced-distraction testing location. NOTE: Because wearing headsets/earplugs all day, every day can cause ear/ear canal pain, students may request environmental controls such as a room with no ticking clocks, food-/drink-/gum-free environments, and proctor awareness.

- **Classroom:** Ability to leave the classroom when necessary; seating preferences (e.g., near the door and/or in the area where most of the class is not in the student’s visual field); recording of lectures; elimination of food/gum from classroom, unless such is medically necessary; and use of an FM system.

- **Housing:** Single bedroom may be requested, as the student will need to decompress and control sounds in that space.

For more information about misophonia, see <https://misophonainstitute.org/>. ■

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