

Phenomenology of Misophonia in the Iranian Population: A Grounded Theory Study

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Article Info

Article type:

Original Research

Section:

Rehabilitation Counseling

How to cite this article:

Abbasi, H., Mohammadi, S., & Hassani, F. (2026). Phenomenology of Misophonia in the Iranian Population: A Grounded Theory Study. *KMAN Counseling and Psychology Nexus*, 4, 1-17.

<http://doi.org/10.61838/kman.rc.psynexus.6408>



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ABSTRACT

The present study aimed to explore the lived experiences of individuals with misophonia in Iran and to develop a data-grounded theory of the phenomenon. This qualitative study employed grounded theory using the systematic approach of Strauss and Corbin. The participants comprised 14 individuals, including 12 individuals with misophonia, one clinical psychology specialist, and one family member of an individual with misophonia, who were selected from among students at universities in Zanzan through purposive and theoretical sampling. Data were collected through in-depth semi-structured interviews and analyzed using MAXQDA software through open, axial, and selective coding. The findings led to the identification of the core phenomenon of “internal explosion in response to violated expectations,” comprising three interrelated layers: sensory–physiological, cognitive, and meaning–identity. Causal conditions included conditioning in the context of chronic stress, including military service, irregular work shifts, and experiences of war; adverse early relationships and childhood trauma, including bullying; and personality predisposition and perfectionism. Contextual conditions included private versus public environments, close relationships versus interactions with strangers, and the sleep–wake boundary. Intervening conditions included the perceived justifiability of the sound, the natural entitlement associated with time, the emotional relationship with the sound-producing individual, and psychological state and stress. Coping strategies were identified at four levels: environmental control, situational management, internal management, and long-term attitudinal change. Consequences emerged across three dimensions: individual consequences, including persistent psychological distress, sleep disturbance, and changes in worldview; interpersonal consequences, including tension in close relationships and stigmatizing labels; and behavioral consequences, including avoidance and dependence on sound-blocking devices. In addition, nine novel concepts emerged from the data: acquired hypervigilance, the day/night sleep paradox, threefold sound justifiability, a triadic vicious cycle, compulsive sound checking, the association between misophonia and childhood bullying trauma, cognition–affect conflict or a quasi-delusional experience, the bipolarity of auditory experience, and the effects of loneliness and warm social interactions.

Keywords: *misophonia, grounded theory, lived experience, paradigm model, Iranian population*

1. Introduction

Misophonia has emerged over the past decade as a clinically significant and increasingly investigated condition characterized by markedly decreased tolerance to specific sounds or associated sensory cues. Although everyday sounds such as chewing, lip smacking, breathing, sniffing, tapping, clicking, or repetitive movements are typically innocuous for most people, individuals with misophonia may experience intense affective, cognitive, physiological, and behavioral reactions when exposed to them. These reactions commonly include anger, disgust, irritation, anxiety, autonomic arousal, urges to escape, difficulty concentrating, and disruption of interpersonal functioning. The contemporary conceptualization of misophonia has moved beyond the notion of a simple dislike of sound toward recognition of a complex disorder of decreased sound tolerance in which the meaning, source, context, predictability, and perceived controllability of triggers interact with individual psychological characteristics. The Delphi consensus definition proposed by an international multidisciplinary group was an important step toward clarifying the construct, emphasizing that misophonia involves reduced tolerance to specific sounds or associated stimuli that elicit strong negative emotional, physiological, and behavioral responses and may result in clinically meaningful impairment (Swedo et al., 2022). Systematic reviews similarly indicate that, despite considerable progress in conceptualization and assessment, major uncertainties remain regarding its etiology, boundaries, underlying mechanisms, and optimal treatment (Ferrer-Torres & Giménez-Llort, 2022).

Epidemiological research suggests that misophonia-related symptoms are not confined to a small clinical subgroup. Population studies have demonstrated that different degrees of sound intolerance occur across community samples, although prevalence estimates depend substantially on assessment instruments, diagnostic thresholds, and operational definitions. Using the S-Five in a representative United Kingdom sample, Vitoratou et al. showed that misophonic experiences occur along a continuum and that a meaningful proportion of the general population experiences symptoms associated with substantial burden and functional interference (Vitoratou et al., 2023). More recently, a representative population-based investigation in Germany further demonstrated that clinically relevant misophonia is present within the broader population and highlighted the importance of distinguishing

ordinary sound annoyance from persistent symptom patterns associated with distress and impairment (Pfeiffer et al., 2025). Recognition of this dimensional distribution has important implications because individuals whose symptoms do not conform to narrowly defined clinical presentations may nevertheless experience significant occupational, academic, relational, and psychological consequences. Historical and conceptual discussions have even raised the possibility that descriptions resembling misophonic responses can be identified retrospectively in accounts of prominent historical figures, underscoring that the phenomenon itself may predate its contemporary scientific terminology (Norena, 2024).

The clinical expression of misophonia is heterogeneous. Trigger stimuli are often repetitive and human-generated, yet the same acoustic event may produce dramatically different responses depending on who produces it and under what circumstances. Research examining the source of human-generated triggers has demonstrated that the identity and interpersonal significance of the sound source can meaningfully influence the misophonic response (Müfrefze et al., 2025). Experimental evidence likewise suggests that affective responses are not determined exclusively by the acoustic properties of sounds; identification and interpretation of a sound as a personally relevant trigger may fundamentally alter its emotional impact (Savard et al., 2022). Recent work on social context has extended this perspective by examining the reciprocal relationship between misophonia and social judgments, suggesting that perceptions of other people can influence misophonic reactions while misophonic sensitivity itself may shape evaluations of those producing the triggering sounds (Humolli et al., 2026). These findings are particularly important for understanding why sounds produced by family members, spouses, coworkers, or other frequently encountered individuals may become more distressing than physically similar sounds occurring in impersonal or less meaningful contexts.

Growing evidence therefore supports cognitive and contextual models in which the response to a trigger is shaped not only by bottom-up auditory processing but also by top-down interpretation, attention, expectation, memory, and learned associations. Contemporary cognitive models emphasize that threat-related appraisal, attentional capture, expectancy, beliefs concerning the sound producer, and difficulty disengaging from triggering stimuli may participate in the development and maintenance of misophonia (Savard & Coffey, 2025). Neurophysiological,

perceptual, and cognitive research has similarly suggested that atypical processing in misophonia cannot be reduced to hearing acuity alone but may involve distinctive interactions between sensory detection, salience attribution, autonomic activation, attention, and higher-order cognitive processes (Patro et al., 2025). In particular, recent findings indicate that greater misophonia severity is associated with impaired psychological or cognitive flexibility and increased rumination, suggesting that difficulty shifting attention or perspective once a trigger has been detected may intensify and prolong the emotional response (Black et al., 2026). Such mechanisms may help explain clinical descriptions in which affected individuals report becoming mentally “locked” onto a sound, anticipating its recurrence, or continuing to monitor the environment even after the triggering stimulus has ceased.

Misophonia also appears closely connected with emotion-regulation processes. Individuals with higher symptom severity frequently report difficulty modulating anger, disgust, anxiety, and physiological activation once a trigger occurs. Guetta et al. found that affective instability and difficulties in emotion regulation constitute important components of emotional functioning in misophonia (Guetta et al., 2022). Among younger populations, mindfulness and cognitive emotion-regulation processes have also been associated with symptom presentation, suggesting that differences in how individuals attend to, evaluate, and respond to internal emotional states may affect the severity and functional impact of misophonic experiences (Spencer et al., 2023). Longitudinal evidence further indicates that misophonia is associated with negative emotions and diminished quality of life over time, demonstrating that its psychological burden may persist beyond individual trigger episodes (Dibb & Golding, 2022). Consistent with this pattern, anxiety has been identified as an important explanatory mechanism linking misophonia to poorer quality of life, with evidence suggesting that heightened anxiety may partially mediate the adverse effects of misophonic symptoms on everyday well-being (Ay et al., 2024).

The functional consequences of misophonia may be substantial. Severe symptoms can interfere with education, employment, concentration, family meals, intimate relationships, social participation, sleep, leisure activities, and use of shared environments. Research examining functional impairment has indicated that symptom severity and associated psychological characteristics are central to understanding the extent to which misophonia disrupts

everyday life (Möllmann et al., 2023). Qualitative research with young people and families has illustrated the pervasive nature of this burden, showing that affected individuals may organize daily activities around escape from triggers, attempt to control the environment, withdraw from family interactions, or experience a sense of entrapment when avoidance is impossible (Guzick et al., 2025). Clinical studies of youth have similarly documented considerable impairment together with psychiatric morbidity, emphasizing that misophonia can affect developmental, educational, family, and social functioning during childhood and adolescence (Guzick et al., 2023). Developmental research has further suggested that symptom expression and associated risk factors may vary according to age and may be intertwined with psychological and psychiatric characteristics during childhood and adolescence (Siepsiak et al., 2023).

The heterogeneity of misophonia is also evident in its psychiatric and neurodevelopmental correlates. Studies have reported associations with anxiety symptoms, obsessive-compulsive phenomena, depressive symptoms, attention difficulties, sensory sensitivities, and other forms of psychopathology, although these associations do not indicate that misophonia can be reduced to any single established psychiatric diagnosis. Research directly examining its relationship with other psychiatric disorders has demonstrated a pattern of clinically relevant comorbidity while supporting the conceptual distinctiveness of the misophonic presentation (Mutlu et al., 2023). Phenotyping research has likewise identified associations between misophonia, psychiatric conditions, and medical-health variables, reinforcing the need for multidimensional clinical assessment rather than a narrowly auditory evaluation (Rosenthal et al., 2022). Network analysis has provided additional evidence that heightened sensory sensitivity may connect with broader symptom systems and clinical comorbidity through multiple pathways rather than through a single causal mechanism (Andermane et al., 2023). Moreover, research among children with attention-deficit/hyperactivity disorder has indicated an association between misophonia and cognitive disengagement symptoms, drawing attention to possible interactions between attentional functioning and sound intolerance (Gerçek et al., 2025). A systematic review of misophonia in autism has similarly emphasized sensory, behavioral, and psychiatric complexity and the need to understand how misophonia manifests within neurodevelopmental populations (Aldakhil & Shaik, 2025).

However, the relationship between adverse experiences, stress, and misophonia remains particularly complex. Patients often describe increased sensitivity during periods of psychological strain, interpersonal conflict, sleep deprivation, or chronic stress, yet it remains unclear whether trauma is a specific etiological factor or whether general stress reactivity is more relevant. Empirical evidence indicates that misophonia is related to perceived stress but is not necessarily directly associated with traumatic stress, cautioning against assuming a simple trauma-based explanation for all cases (Guetta et al., 2024). This distinction is important because individual narratives may nevertheless reveal meaningful associations between specific adverse experiences and the subsequent interpretation of particular sounds. Qualitative investigation is therefore especially useful for exploring whether participants themselves perceive links between chronic stress, interpersonal adversity, childhood experiences, learned vigilance, and the emergence or escalation of sound-triggered responses without presupposing a universal traumatic etiology.

Another increasingly important issue concerns individual variability. Misophonia is unlikely to represent a completely uniform phenotype. Person-centered research using symptom-based subgrouping has identified meaningful variability across individuals, supporting the possibility that different constellations of sensory, emotional, cognitive, and behavioral symptoms may characterize distinct subgroups (Woolley et al., 2025). Mixed-method research has likewise demonstrated that the subjective misophonic experience includes dimensions that may not be captured adequately through symptom scores alone, reinforcing the value of combining quantitative measurement with detailed accounts of lived experience (Ozuer et al., 2025). Such findings are particularly relevant to theory development because apparently contradictory observations—for example, tolerance of a sound in one context but extreme distress in another—may become understandable when personal meanings, interpersonal relationships, expectations, and coping histories are considered.

Cultural context may further shape the phenomenology and management of misophonia. Social expectations concerning family proximity, respect, communal eating, personal boundaries, acceptable expressions of anger, obligations toward relatives, and tolerance of others' behavior can influence both exposure to triggers and the strategies available for responding to them. Yet much of the existing literature has been generated in Western or non-

Iranian settings, and relatively little is known about how misophonia is experienced and interpreted within Iranian sociocultural contexts. Emerging Iranian evidence suggests that sensory processing and attentional control may be important in explaining links between misophonia, disability severity, emotional characteristics, and disgust propensity among university students (Akbari Saneh et al., 2025). Nevertheless, quantitative association studies cannot fully reveal how Iranian individuals understand the origin of their sensitivity, attribute intention or meaning to sounds, negotiate reactions within close family relationships, or develop everyday coping strategies.

These unresolved theoretical questions are directly relevant to treatment. Cognitive-behavioral approaches have increasingly been used to address tinnitus, hyperacusis, and misophonia, with emphasis on modifying maladaptive interpretations, reducing distress, and improving coping with auditory triggers (Aazh, 2025). A pilot trial applying the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders to misophonia provided preliminary support for a transdiagnostic approach targeting emotional avoidance, maladaptive responses, and emotion-regulation difficulties (McMahon et al., 2024). A case study using metacognitive interpersonal therapy further illustrated the potential clinical relevance of interpersonal schemas, metacognition, and relational meaning in the treatment of misophonia (Natalini et al., 2024). Most recently, a randomized controlled trial in youth demonstrated the feasibility and therapeutic relevance of transdiagnostic cognitive-behavioral treatment compared with psychoeducation and relaxation training (Lewin et al., 2026). Taken together, these developments suggest that effective intervention may need to address not only exposure to sounds but also attention, cognitive appraisal, emotional regulation, behavioral avoidance, interpersonal context, and broader psychological flexibility.

Despite these advances, a major limitation in the current literature is that mechanistic and treatment models are still developing in the absence of sufficiently rich context-sensitive theories of how individuals actually experience misophonia across time and situations. Qualitative and mixed-method findings have begun to address this gap, but many unanswered questions remain concerning the transition from an ordinary sound to a highly salient trigger, the emergence of anticipatory vigilance, the role of repeated interpersonal encounters, the meaning attributed to perceived inconsideration or intentionality, and the paradoxical use of coping strategies that provide immediate

relief while potentially maintaining long-term sensitivity. In addition, existing evidence indicates that cognitive disengagement, affective instability, rumination, sensory processing, stress, and social context may all contribute to the experience, but the way these components interact within a coherent process remains insufficiently understood (Akbari Saneh et al., 2025; Black et al., 2026; Gercek et al., 2025; Guetta et al., 2022; Guetta et al., 2024; Humolli et al., 2026).

A grounded theory approach is particularly appropriate for addressing this gap because it permits theory to emerge systematically from participants' accounts rather than imposing a predetermined clinical model on their experiences. By examining causal conditions, contextual factors, intervening conditions, coping strategies, and consequences simultaneously, such an approach can illuminate how sensory responses become embedded within cognitive interpretations, interpersonal relationships, developmental histories, and everyday behavioral patterns. This is especially important given the growing recognition that misophonia is characterized by heterogeneity, contextual dependence, psychiatric overlap, and substantial functional impairment rather than by a single uniform auditory abnormality (Möllmann et al., 2023; Rosenthal et al., 2022; Woolley et al., 2025). Developing a culturally grounded explanatory model may therefore contribute both to theoretical refinement and to the identification of clinically meaningful targets for individualized and transdiagnostic interventions.

Accordingly, the present study aimed to explore the lived experiences of individuals with misophonia in the Iranian population and to develop a grounded theory explaining the causal conditions, contextual and intervening factors, coping strategies, and individual, interpersonal, and behavioral consequences of misophonia.

2. Methods and Materials

2.1. Study Design and Participants

The present study was conducted using a qualitative approach and grounded theory methodology. By emphasizing analytic induction, this method enables an in-depth examination of phenomena within their natural contexts and facilitates the development of a conceptual framework grounded in empirical data (Corbin & Strauss, 2015). Grounded theory emphasizes the study of processes because the social world inherently involves interactions among individuals (Strauss & Corbin, 1998). Within this

approach, a process is defined as a sequence of actions and interactions among individuals and events related to a particular phenomenon. Semi-structured interviews were used for data collection. The interview protocol was developed and implemented following an extensive review of the research literature and theoretical foundations related to misophonia, as well as consultation with academic advisors.

Participants in this study consisted of students from the Islamic Azad University, Zanjan Branch, and the University of Zanjan, who were selected through purposive sampling using a theoretical sampling approach. In theoretical sampling, data collection and analysis occur simultaneously and sequentially (Charmaz, 2000). Thus, after each interview, the researcher analyzed the data and, based on that analysis, determined who should be interviewed next and what supplementary questions should be asked. This iterative process continued until theoretical saturation was reached, that is, until newly collected data no longer contributed additional information or insight regarding the emerging categories. An effort was made to achieve maximum variation in terms of age, gender, educational level, and field of study. The inclusion criterion was a score of 7 or higher on the third subscale of the Misophonia Questionnaire developed by Wu et al. (2014), which assesses overall symptom severity on a scale ranging from 1 to 15, with scores of 7 or above indicating clinically significant symptoms (Mehrabizadeh & Roshani, 2018).

2.2. Instruments

Misophonia Questionnaire by Wu et al. (2014). The Misophonia Questionnaire was developed by Wu et al. (2014) to assess the presence of misophonia symptoms, associated emotions and behaviors, and the overall severity of sound sensitivity. The instrument is a 17-item self-report measure comprising three subscales: (1) Misophonia Symptom Scale, (2) Misophonia Emotions and Behaviors Scale, and (3) an overall rating of the severity of sound sensitivity. Items are scored on a five-point Likert scale ranging from 0 to 4 (never = 0, rarely = 1, sometimes = 2, often = 3, always = 4). The total score, calculated from the first two subscales, ranges from 0 to 68. In the study by Mehrabizadeh et al. (2018), the questionnaire demonstrated satisfactory content, face, and criterion validity. Its reliability, assessed using Cronbach's alpha, was also reported to be greater than .70.

Semi-Structured Interview. Semi-structured interviews were used as the primary instrument for collecting qualitative data. This type of interview provides sufficient flexibility to facilitate an in-depth exploration of participants' experiences. Interview questions were developed according to the study objectives, the relevant research literature, including Erfanian et al. (2019) and Swedo et al. (2022), and the opinions of three clinical psychology specialists. The questions were organized into seven principal domains: (1) experiences of exposure to triggering sounds, including cognitive, emotional, physical, and behavioral dimensions; (2) consequences of exposure in social, family, occupational, and academic relationships; (3) factors that intensified or reduced reactions, including time, place, and psychological state; (4) characteristics of the home and workplace environments; (5) experiences that had led to changes in reactions; (6) coping strategies, including behavioral, cognitive, and emotional strategies; and (7) outcomes and consequences of using these strategies. Interviews began with general questions concerning age at onset, types of distressing sounds, and the history of the problem. Each interview lasted approximately 45–60 minutes. All interviews were conducted and audio-recorded by the principal researcher and transcribed immediately following completion.

2.3. Data analysis

After written informed consent was obtained from the participants, the interviews were audio-recorded and transcribed verbatim immediately after each interview. Data collection and analysis proceeded simultaneously and cyclically; that is, each interview was followed by data analysis, and the emerging findings guided subsequent interviews. During this process, as preliminary categories became clearer and certain codes reached saturation, such as types of misophonic triggers and avoidance strategies, repetitive questions were removed from subsequent interviews. Based on findings from earlier interviews, new questions were added to the interview guide to allow deeper exploration of emerging categories, such as the role of adverse early relationships and experiences of childhood bullying. Technical memos were also used to document ideas and insights emerging from the data and categories (Charmaz, 2000). These memos provided an opportunity for an ongoing internal dialogue by the researcher regarding the developing theory and played an important role in conceptualization and in tracing ideas from the raw data

through the coding process. Data analysis followed the systematic method proposed by Strauss and Corbin (1998), consisting of three stages: open coding, axial coding, and selective coding. Constant comparative analysis was employed throughout these stages (Glaser, 1978). Accordingly, the researcher continuously compared events, indicators, codes, and categories with one another. Following analysis, raw data were transformed into indicators representing small units of information obtained from different individuals and sources. These indicators were classified using multiple codes and subsequently organized into increasingly abstract categories. This process reduced redundancy and extraneous material and generated the evidentiary basis necessary for category development.

Open Coding. At this stage, the raw data obtained from interviews and memos were examined line by line, and initial concepts were extracted. In vivo codes were used in naming categories, meaning that participants' own wording and expressions were retained whenever possible to ensure that the emerging concepts remained closely grounded in the original data.

Axial Coding. Following category development, one category was selected as the focal category, or central phenomenon, for theory development. This selection was based on several criteria, including the relationship of the category to other categories, its frequency of occurrence, the ease and speed with which it reached saturation, and its clear implications for theory development (Glaser, 1978). In accordance with the criteria proposed by Strauss and Corbin (1998), the remaining categories, including causal conditions, strategies, contextual conditions, intervening conditions, and consequences, were organized around this focal category.

Selective Coding. At this stage, the categories were integrated and a coherent storyline was developed, resulting in the final grounded theory. All analytic efforts were directed toward the development of a middle-range theory (Charmaz, 2000) that was grounded in the data and provided an explanation of the fundamental phenomenon of misophonia. MAXQDA software was used to facilitate the coding and data-analysis process.

In qualitative research, the concept of trustworthiness is used in place of the quantitative concepts of validity and reliability (Lincoln & Guba, 1985). To establish the trustworthiness of the findings, the four criteria proposed by Lincoln and Guba (1985) were considered.

(1) **Credibility** was established through member checking of the findings by three participants and through continuous comparative analysis.

(2) **Dependability** was established through detailed documentation of the research procedures and external auditing by the academic supervisors.

(3) **Confirmability** was ensured by maintaining an audit trail of evidence, including direct quotations, and by using in vivo coding.

(4) **Transferability** was facilitated through the provision of thick descriptions of the participants and the research context.

3. Findings and Results

This study involved 14 participants, including 12 individuals with misophonia who obtained a score of 7 or higher on the third scale of the Misophonia Questionnaire developed by Wu et al. (2014), together with two individuals without misophonia. One of the latter was a clinical psychology specialist experienced in the treatment of anxiety disorders, and the other was a family member of an individual with misophonia. Descriptive information regarding the participants is presented in Table 1.

Table 1

Demographic Characteristics and Misophonia Scores of Participants With and Without Misophonia

Participant	Age	Gender	Marital Status	Education	Third Scale Score
No. 1	40	Male	Married	Undergraduate student	7–9
No. 2	32	Female	Married	Undergraduate student	7–9
No. 3	20	Female	Single	Undergraduate student	10–12
No. 4	34	Male	Single	Master's student	7–9
No. 5	39	Male	Single	Doctoral student	7–9
No. 6	37	Male	Married	Bachelor's degree	10–12
No. 7	39	Male	Married – unaffected	Bachelor's degree	—
No. 8	35	Female	Married	High school diploma	7–9
No. 9	26	Female	Married	Associate degree	7–9
No. 10	19	Female	Single	Undergraduate student	7–9
No. 11	65	Male	Married	Less than high school diploma	10–12
No. 12	45	Male	Married – specialist	Doctorate in Clinical Psychology	—
No. 13	27	Male	Single	Associate degree	7–9
No. 14	28	Male	Single	Bachelor's degree	7–9

This section presents the findings derived from the analysis of the in-depth interviews. Based on the systematic approach of Strauss and Corbin (1998), the data were analyzed through open, axial, and selective coding, resulting in the identification of one focal category and five additional major categories within a paradigm model.

Core Phenomenon: Internal Explosion in Response to Violated Expectations

The central core of the misophonia experience identified in this study was a multilayered and involuntary reaction referred to as an “internal explosion.” This phenomenon consisted of three interconnected layers: a sensory–physiological reaction, including hatred, disgust, nausea, somatic anger, and hand tremors; a cognitive reaction, including attentional fixation on the sound, active searching, and compulsive checking; and a meaning–identity reaction,

involving interpretation of the sound as a violation of moral, social, or functional expectations.

One participant described the experience as follows:

“In that state, my mind immediately ignores everything else and focuses on that sound. No, I can't ignore it. In fact, my brain locks onto that sound. Even after the annoying sound stops, my mind keeps searching for it for several minutes to make sure it is no longer there.” (Participant No. 5)

Another participant with a history of childhood bullying provided a more intense description:

“Even now, when I hear that repetitive sound, I feel like I'm going crazy. I clench my fists, and even then my hands shake from anger. I feel as though the purpose of this constant repetition is to drive me crazy and make me angry, and then laugh at my anger.” (Participant No. 14)

Causal Conditions: Predisposing Factors

Analysis of the data identified three groups of factors that appeared to contribute to the development and consolidation of misophonia.

Conditioning in the Context of Chronic Stress

Many participants attributed the onset or exacerbation of their sensitivity to periods of chronic stress, particularly when accompanied by sleep disturbance. Military service, irregular work shifts, prolonged emotional stress, and experiences of war were among the reported contexts.

An older participant referred to his experience of war as follows:

“I have been like this since I came back from the front. ... Right now, we are in a state of war. This situation itself has made us constantly alert. We are always waiting to hear an explosion. Whenever we hear any sound, we think it may be a bombing, and this situation keeps us under continuous stress.” (Participant No. 11)

Adverse Early Relationships and Childhood Trauma

Participants referred to emotionally cold relationships with parents, perceived discrimination, rejection, unresolved bereavement, and experiences of childhood bullying as early developmental contexts associated with their sensitivity.

One participant explicitly linked childhood bullying to his current sound sensitivity:

“I remember that when I was a child, one of my classmates bullied me and bothered me. That boy mostly hurt me with his words, and he kept doing it repeatedly. I feel that this repetitive quality of sounds is connected to that period. I feel that the sound creates the same feeling in me that that boy used to create.” (Participant No. 14)

Personality Predisposition and Perfectionism

Some participants reported having been sensitive to sounds since childhood or described personality characteristics such as excessive orderliness and perfectionism.

“You become a real perfectionist, where anything less than 100 feels like zero to you; and then these ridiculous sounds seem to be telling you that some things are not in order.” (Participant No. 5)

Contextual Conditions

Misophonia was not experienced in the same way across all situations. Three principal contextual conditions were identified in the data.

Private Versus Public Environments. Homes and other private environments represented the primary contexts in which severe reactions occurred. An older participant referred to changes following retirement: “Now that there

are fewer people around me, my nerves have become more fragile.”

Close Relationships Versus Strangers. Sounds produced by close others, including family members and spouses, were more distressing than those produced by strangers. One participant commented: “I think it mostly depends on who is making the sound. A sound made by someone you see every day is more annoying than the same sound made by a stranger on the street.”

Sleep–Wake Boundary. For most participants, the period of transition into sleep was the most sensitive time. “Even when I’m asleep, I hear the sounds around me, and they bother me a lot.” (Participant No. 9)

Intervening Conditions: Moderating Factors

Several factors reduced or intensified the severity of reactions.

Justifiability of the Sound

Sounds for which there was a reasonable explanation, such as illness or a medical condition, were more tolerable.

“If someone makes mouth sounds and I know that they have a particular medical condition, those mouth sounds do not bother me.” (Participant No. 4)

Natural Entitlement Associated With Time

The day/night sleep paradox was one of the notable findings of the study.

“The sound of the television at noon can actually help me take a nap comfortably, but the same sound at night when I’m trying to sleep is unbearable. I think the difference is that at night everyone is supposed to be asleep and there should be no sound, so the expectation of silence is that person’s natural right.” (Participant No. 5)

Emotional Relationship With the Sound-Producing Individual

When the individual producing the sound was loved or respected, the sound was experienced as more tolerable.

“If my grandfather smacks his lips while eating, it bothers me less.” (Participant No. 4)

Psychological State and Stress

Stress, cognitive preoccupation, and low mood intensified sound sensitivity.

“When I’m very worried and I think that I haven’t achieved my dreams, I become irritable, and somehow everything starts to get on my nerves.” (Participant No. 13)

Coping Strategies

Participants employed a wide range of strategies to manage distressing situations. These strategies could be classified into four levels.

Level 1: Environmental Control

Physical avoidance, including leaving the environment or avoiding social gatherings, was frequently used.

Removal of the sound source, such as taking the battery out of a clock, was another strategy.

Complaining or asking others to stop the sound was also used, depending on the person's social position and the context.

"I try to avoid that environment, and most importantly, I try to make myself feel better by going into nature." (Participant No. 11)

Level 2: Situational Management

Forced tolerance was commonly reported, particularly at parties and formal gatherings.

Attentional diversion, such as talking with others or playing with children, was also used.

Participants frequently relied on sound-blocking or sound-masking devices, including AirPods, cotton, podcasts, and earplugs.

"My only solution for these situations is AirPods. That's why I always have my AirPods with me. Even when I'm going to sleep, they have to stay in my ears until I have actually fallen asleep." (Participant No. 3)

Level 3: Internal Management

Participants described internalizing their anger and distress rather than expressing them.

Motivational self-talk was also used.

Compulsive checking of sounds, resembling obsessive-compulsive behavior, was another internal strategy.

One participant with a comorbid disorder described the mechanism of compulsive checking as follows:

"If I hear a quiet sound, I keep trying to check whether it is continuing. Sometimes I do this so much that I start making perceptual errors. For example, once I waited so intensely for a sound to stop that even after it had stopped, I thought it was still continuing at a lower volume." (Participant No. 13)

Level 4: Long-Term Attitudinal Change

Participants described internalizing responsibility by concluding that the problem was within themselves and that they therefore needed to change themselves.

Acceptance and adaptation were also reported.

"In recent years, I've come to the conclusion that I should work more on myself than on other people. I should change myself more than trying to change others." (Participant No. 4)

Consequences

Misophonia had extensive consequences across individual, interpersonal, and behavioral domains.

Individual Consequences

Participants experienced persistent psychological distress, including feelings of internal suffocation and suppressed anger.

Sleep and daily functioning were impaired.

Some participants described a shift in worldview from optimism toward pessimism.

Feelings of being trapped and unsuccessful in managing the problem were also reported.

"I get so angry inside. It feels like I'm suffocating." (Participant No. 2)

Interpersonal Consequences

Participants experienced tension in close relationships with spouses, children, and parents.

Social relationships became more restricted.

Some reported relational breakdowns with particular family members.

Participants also reported being labeled by others as selfish, arrogant, isolated, or depressed.

"Unfortunately, because of this issue, people around me call me selfish, arrogant, isolated, and depressed." (Participant No. 9)

Behavioral Consequences

Participants avoided social situations.

Dependence on sound-blocking devices progressively increased.

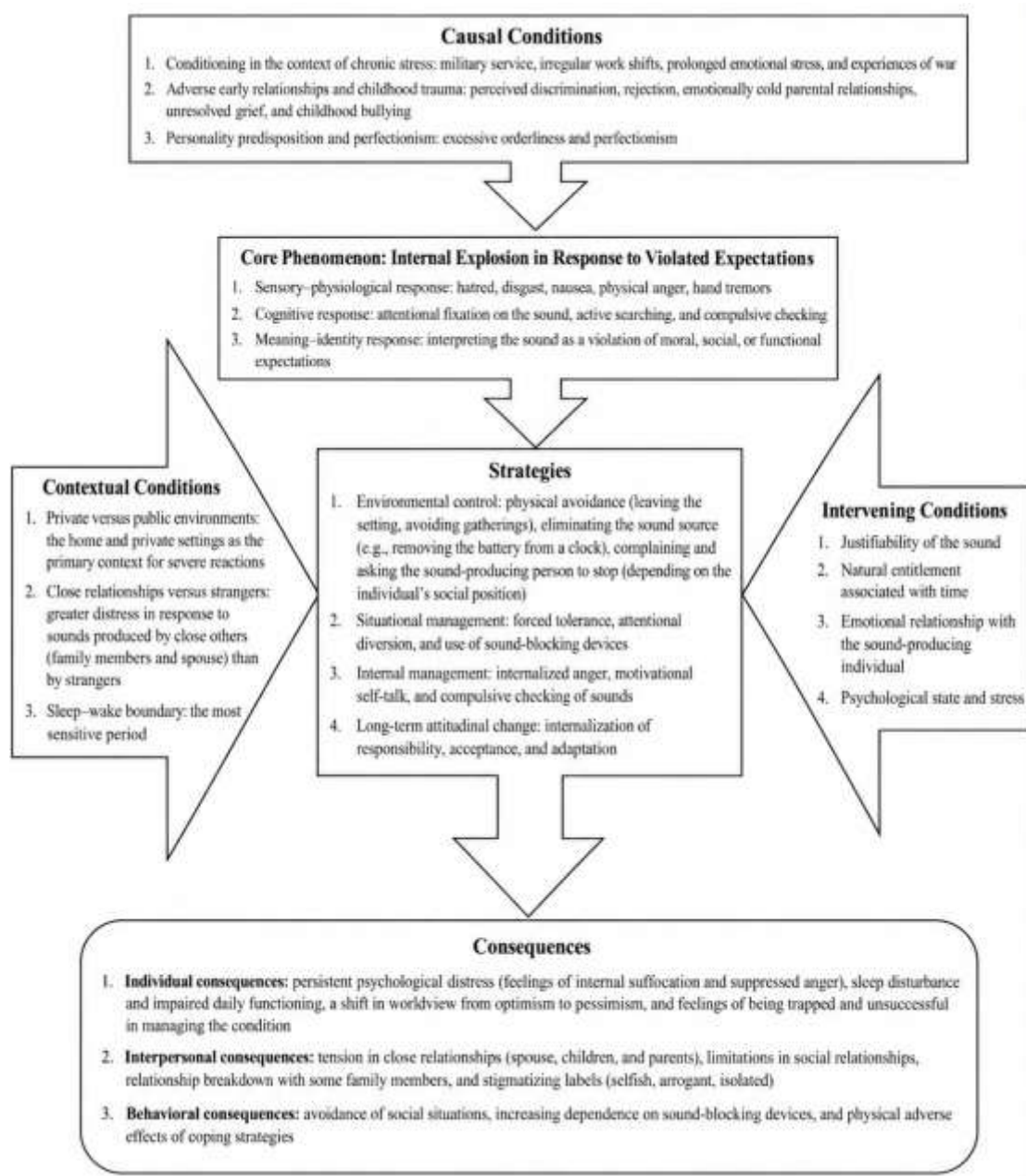
Some coping strategies were associated with physical adverse effects.

"Once, I used my AirPods so much that my ears started bleeding." (Participant No. 3)

Based on the findings of the study, the paradigm model of misophonia is presented in Figure 1.

Figure 1

Paradigm model of “internal explosion in response to violated expectations” based on grounded theory and derived from the study findings



Based on the extracted paradigm model, the grounded theory developed in the present study can be described as follows. Individuals with misophonia gradually develop a multilayered and involuntary reaction as a result of the combined effects of conditioning in the context of chronic stress, including experiences of war, military service, irregular work shifts, and prolonged emotional stress; adverse early relationships and childhood trauma, including bullying, rejection, emotionally cold parental relationships, and unresolved bereavement; and personality predisposition and perfectionism. This reaction, conceptualized as an

“internal explosion,” consists of three interconnected layers: a sensory–physiological reaction, including hatred, disgust, and hand tremors; a cognitive reaction, including attentional fixation on the sound, active searching, and compulsive checking; and a meaning–identity reaction, involving interpretation of the sound as a violation of moral, social, or functional expectations. The reaction intensifies within specific contexts, including private environments, close relationships with family members and spouses, and the sleep–wake boundary. Its intensity is also influenced by intervening factors that may either reduce or amplify the

response, including the perceived justifiability of the sound, such as illness or controllability; natural entitlement associated with time, as reflected in the day/night sleep paradox; the emotional relationship with the sound-producing person, including affection toward that person; and the individual's psychological state and level of stress. To manage these experiences, affected individuals employ coping strategies at four levels: environmental control, including avoidance and removal of the sound source; situational management, including forced tolerance and use of sound-blocking devices; internal management, including internalized anger, motivational self-talk, and compulsive checking; and long-term attitudinal change, including internalization of responsibility and acceptance. Nevertheless, these strategies often result in unintended consequences across three domains: individual consequences, including persistent psychological distress, sleep disturbance, and changes in worldview; interpersonal consequences, including family conflict and stigmatizing labels; and behavioral consequences, including avoidance of social situations and increasing dependence on sound-blocking devices. Overall, the grounded theory developed in this study indicates that misophonia extends beyond simple sensory sensitivity and represents a multilayered, relational, and meaning-laden phenomenon rooted in developmental contexts, chronic stress, and maladaptive cognitive patterns.

In addition to the principal categories, several novel concepts emerged from the present study.

Acquired Hypervigilance. Heightened alertness and active searching for sounds develop in response to repeated inconsiderate behavior by others or prolonged exposure to chronically stressful conditions, such as war.

Day/Night Sleep Paradox. A sound that is tolerable during the daytime may become intolerable at night because nighttime is cognitively defined as a period in which one is naturally entitled to silence.

Threefold Justifiability. Sounds are evaluated according to three criteria: intentionality, controllability, and the presence of a legitimate justification, such as illness.

Triadic Vicious Cycle. Anxiety, obsessive-compulsive tendencies, and sound sensitivity interact bidirectionally and mutually intensify one another.

Compulsive Sound Checking. This OCD-like behavior involves repeatedly monitoring the continuation and persistence of a sound and may result in perceptual errors even after the sound has ceased.

Association Between Misophonia and Childhood Bullying Trauma. Repetitive sounds in adulthood may

reactivate or reproduce the experiential pattern of repeated verbal harassment by a childhood bully.

Cognition–Affect Conflict (Quasi-Delusional Experience). The individual cognitively understands that the sound is not intentionally intended to cause harm, yet affectively experiences it as though the sound producer is deliberately trying to provoke or harm them.

Bipolarity of Auditory Experience. Auditory experiences are divided into “bad sounds,” perceived as toxic, bullying, or mocking, and “good sounds,” experienced as warm, kind, accepting, and nonjudgmental.

Effects of Loneliness and Warm Social Interactions. Loneliness appears to intensify sound sensitivity, whereas warm and supportive social interactions appear to reduce it.

4. Discussion

The present study aimed to explore the lived experiences of individuals with misophonia in the Iranian population and to develop a grounded theory explaining the conditions under which misophonic reactions emerge, intensify, and are managed. The findings indicated that the central phenomenon of misophonia could be conceptualized as an “internal explosion in response to violated expectations,” comprising three interconnected layers: sensory–physiological, cognitive, and meaning–identity responses. This core phenomenon was embedded within a broader paradigm involving causal conditions, contextual conditions, intervening conditions, coping strategies, and consequences. The results further showed that misophonia was not experienced merely as heightened sensitivity to specific acoustic features; rather, participants interpreted trigger sounds through relational, moral, contextual, and expectancy-based meanings. This finding is consistent with the contemporary consensus definition of misophonia, which conceptualizes the condition as decreased tolerance to specific sounds or associated cues accompanied by strong emotional, physiological, and behavioral responses and meaningful functional impairment (Swedo et al., 2022). It also supports recent theoretical approaches proposing that misophonia should be understood as a multidimensional phenomenon involving interactions between sensory processing, cognition, emotion, and context rather than as an isolated auditory abnormality (Patro et al., 2025; Savard & Coffey, 2025).

The first major finding concerned the sensory–physiological layer of the core phenomenon, characterized by intense disgust, hatred, nausea, physical anger, and

somatic arousal such as hand tremors. These reactions were described as rapid, involuntary, and difficult to control. This pattern is consistent with evidence showing that misophonia involves highly specific affective and autonomic responses to trigger stimuli. Savard et al. demonstrated that affective reactions in misophonia are strongly influenced by whether a sound is identified as a personally meaningful trigger, indicating that the emotional response is not determined by sound intensity or acoustic structure alone (Savard et al., 2022). Similarly, studies of emotional functioning have shown that affective instability and difficulties in regulating emotional responses are prominent among individuals with misophonia (Guetta et al., 2022). The present findings extend this literature by showing that participants experienced bodily arousal and emotional aversion as part of a unified subjective reaction, suggesting that physiological activation may be closely integrated with cognitive appraisal and interpersonal meaning.

The cognitive layer of the central phenomenon involved attentional fixation on trigger sounds, active searching for the sound, and compulsive monitoring of whether the sound had stopped or might recur. Participants described their minds as becoming “locked” onto sounds and continuing to search for them even after the external stimulus had ceased. This finding aligns closely with recent evidence linking greater misophonia severity with impaired flexibility and heightened rumination (Black et al., 2026). Difficulty disengaging from a salient auditory stimulus may prolong the emotional response beyond the actual duration of the sound and contribute to anticipatory vigilance. Cognitive models of misophonia similarly emphasize attentional capture, expectancy, threat-related interpretation, and reduced cognitive flexibility as mechanisms that may maintain symptoms over time (Savard & Coffey, 2025). The findings are also compatible with research suggesting that perceptual and cognitive processing in misophonia involves interactions among salience detection, attention, and higher-order interpretation (Patro et al., 2025). Therefore, the compulsive sound checking observed in the present study may represent a clinically important maintenance mechanism through which attention becomes increasingly organized around detecting, monitoring, and anticipating potential triggers.

A particularly novel finding was the meaning–identity layer of the response, in which participants interpreted sounds as violations of moral, social, or functional expectations. In other words, distress was not simply caused by the presence of a sound but by what the sound was

perceived to signify, such as disrespect, inconsideration, disorder, or a breach of the expectation that a particular environment should remain quiet. This finding is strongly supported by studies showing that social context and source characteristics influence misophonic responses. Müfreze et al. found that the source of human-generated trigger sounds plays an important role in determining the severity of the response (Müfreze et al., 2025). Humolli et al. similarly showed that social judgments and misophonic reactions may influence one another reciprocally, emphasizing the interpersonal nature of the condition (Humolli et al., 2026). The present study adds a further interpretive dimension by suggesting that trigger sounds can become symbols of violated expectations. This may help explain why identical sounds can be tolerated in one setting but experienced as intolerable in another.

The findings regarding causal conditions suggested that chronic stress may contribute to the formation or intensification of misophonia. Participants linked symptom onset or worsening to prolonged stressors such as military service, irregular work shifts, emotional strain, sleep disruption, and experiences of war. This finding is broadly consistent with evidence indicating that misophonia is associated with elevated perceived stress (Guetta et al., 2024). However, Guetta et al. also found that misophonia was not directly associated with traumatic stress, indicating that stress-related mechanisms should not automatically be interpreted as evidence of trauma causation (Guetta et al., 2024). The current results support this distinction. Chronic stress may increase vigilance, irritability, physiological arousal, and sensitivity to environmental stimulation without necessarily implying that misophonia is a post-traumatic condition. The concept of acquired hypervigilance that emerged in this study may therefore represent one pathway through which prolonged stress increases anticipatory monitoring of sound.

Adverse early relationships and childhood trauma, including bullying, perceived rejection, cold parental relationships, and unresolved grief, were also identified as possible background factors. Some participants explicitly connected repetitive adult triggers to earlier experiences of verbal harassment or emotional injury. This finding should be interpreted cautiously because current evidence does not establish childhood trauma as a universal etiological pathway for misophonia. Nevertheless, it is compatible with the broader observation that misophonic experiences can become strongly linked to personal meaning, memory, and interpersonal context. The symptom-network perspective

proposed by Andermane et al. is useful in this regard because it suggests that sensory sensitivity may connect with affective, cognitive, and psychiatric symptoms through multiple pathways rather than a single causal mechanism (Andermane et al., 2023). The present findings suggest that, for some individuals, early interpersonal experiences may influence the meaning assigned to repetitive or intrusive sounds, thereby amplifying emotional responses to them.

Personality predisposition and perfectionism were another causal category identified in the present study. Participants described excessive orderliness, rigid standards, and discomfort when environmental conditions deviated from expectations. This finding is consistent with recent evidence implicating reduced flexibility and repetitive cognition in greater symptom severity (Black et al., 2026). It may also complement broader cognitive models in which rigid expectations and difficulty adapting to unwanted sensory input contribute to distress (Savard & Coffey, 2025). In the present model, perfectionistic tendencies appeared especially relevant when participants interpreted sound as evidence that the environment was “not as it should be.” Thus, perfectionism may operate not only as a general personality trait but also as a cognitive lens through which environmental irregularity becomes emotionally salient.

Contextual conditions were highly influential. Participants reported that symptoms were often more intense in private environments, in close relationships, and around the transition to sleep. Greater reactivity toward close family members or spouses than toward strangers is consistent with findings showing that social proximity and source identity affect misophonic reactions (Humolli et al., 2026; Müfreze et al., 2025). Qualitative work with young people and families has similarly shown that misophonia can substantially disrupt household functioning and close relationships because triggers are often produced repeatedly by people with whom the affected individual has frequent contact (Guzick et al., 2025). The present results extend these observations by indicating that familiarity may intensify not only exposure frequency but also perceived expectation, emotional significance, and judgments concerning whether the sound “should” occur.

The sleep–wake boundary was another important contextual factor. Participants described increased sensitivity at night, particularly when attempting to fall asleep. The “day/night sleep paradox” identified in this study suggests that identical sounds may be tolerated during daytime rest but become intolerable during nighttime sleep because silence is perceived as a legitimate expectation at

night. This finding further supports the role of appraisal and context in misophonia. It also has clear functional implications because sleep disturbance can contribute to irritability, reduced emotion regulation, impaired concentration, and heightened sensory sensitivity the following day. Consistent with this, previous research has shown that misophonia can affect daily functioning and quality of life substantially (Dibb & Golding, 2022; Möllmann et al., 2023). Therefore, sleep-related sensitivity may operate both as a consequence of misophonia and as a factor that further intensifies symptoms.

The intervening conditions identified in this study also underscore the importance of cognitive and interpersonal appraisal. Sounds were perceived as more tolerable when participants believed that the producer had a medical reason, lacked control over the sound, or was someone they loved or respected. This threefold justifiability—intentionality, controllability, and justification—offers a useful extension of previous findings demonstrating that trigger identification and source characteristics shape emotional responses (Müfreze et al., 2025; Savard et al., 2022). It suggests that misophonic reactions may be reduced when the individual can generate a benign explanation for the sound. This mechanism may be particularly relevant for cognitive interventions, because reappraisal of intention and controllability could potentially reduce anger, disgust, or perceived interpersonal threat.

Psychological state and stress also moderated symptom intensity. Participants reported greater sensitivity when worried, emotionally distressed, or preoccupied. This result is consistent with studies linking misophonia to stress, anxiety, and emotion-regulation difficulties (Ay et al., 2024; Guetta et al., 2022; Guetta et al., 2024). Anxiety has been shown to mediate the association between misophonia and poorer quality of life, suggesting that general emotional arousal may magnify the impact of trigger exposure (Ay et al., 2024). Findings among children and adolescents also indicate that mindfulness and cognitive emotion-regulation processes are associated with misophonic symptomatology (Spencer et al., 2023). Taken together, these findings suggest that misophonia severity is partly state-dependent, increasing when an individual’s capacity to regulate emotion or redirect attention is already compromised.

Participants used coping strategies across four levels: environmental control, situational management, internal management, and long-term attitudinal change. Avoidance, leaving the environment, removing sound sources, using earphones or earplugs, and attempting to distract attention

provided immediate relief but often restricted daily activities. This pattern is consistent with qualitative evidence showing that individuals with misophonia frequently organize their environments and routines to escape or prevent trigger exposure (Guzick et al., 2025). However, repeated avoidance may also reduce opportunities for adaptive learning and increase dependence on environmental control. The high degree of functional impairment associated with symptom severity reported in previous research supports the clinical importance of such behavioral adaptations (Möllmann et al., 2023). The current findings therefore suggest that coping strategies can be simultaneously protective in the short term and potentially maintaining in the longer term.

The identification of compulsive sound checking as an internal coping strategy is especially noteworthy. Participants repeatedly monitored whether sounds continued, anticipated recurrence, and in some cases reported perceived continuation even after the external sound had stopped. This phenomenon resembles obsessive-compulsive checking in its repetitive, uncertainty-reducing function, although it should not necessarily be equated with obsessive-compulsive disorder. Misophonia has been associated with psychiatric comorbidity, including obsessive-compulsive symptoms, but remains conceptually distinct from established psychiatric disorders (Mutlu et al., 2023; Rosenthal et al., 2022). The present data suggest that checking behavior may be a transdiagnostic process rather than evidence of diagnostic equivalence. This interpretation is also consistent with studies emphasizing heterogeneity and the existence of symptom-based subgroups within misophonia (Woolley et al., 2025).

The long-term coping strategy of internalizing responsibility and attempting to change oneself rather than others may represent a potentially adaptive shift toward acceptance and self-regulation. This finding is consistent with therapeutic approaches that focus on psychological flexibility, emotion regulation, cognitive restructuring, and reducing maladaptive avoidance. Cognitive-behavioral approaches have shown clinical value in the management of misophonia and related sound-tolerance difficulties (Aazh, 2025). Transdiagnostic treatment approaches, including the Unified Protocol, have also shown promise in targeting emotional avoidance, inflexible responses, and difficulties regulating distress (McMahon et al., 2024). Similarly, a randomized controlled trial in youth has demonstrated the clinical potential of transdiagnostic cognitive-behavioral treatment compared with psychoeducation and relaxation

training (Lewin et al., 2026). Metacognitive interpersonal therapy may also be relevant where trigger responses are strongly embedded in interpersonal beliefs, relational expectations, and self-other representations (Natalini et al., 2024).

The consequences identified in the present study were extensive and occurred at individual, interpersonal, and behavioral levels. Participants reported persistent psychological distress, sleep disturbance, impaired daily functioning, pessimistic changes in worldview, family conflict, social restriction, stigmatizing labels, avoidance, and increasing dependence on sound-blocking devices. These findings are consistent with longitudinal evidence showing that misophonia is associated with negative affect and impaired quality of life (Dibb & Golding, 2022). They also align with evidence of substantial functional impairment in adults and youth (Guzick et al., 2023; Möllmann et al., 2023). The interpersonal consequences are especially important because misophonia may produce reciprocal cycles in which the affected person experiences others as inconsiderate, while family members may interpret avoidance or irritability as rejection, arrogance, or hostility. Such cycles may intensify social isolation and reinforce trigger-related vigilance.

5. Conclusion

The study identified the influence of loneliness and warm social interaction on symptom severity. Participants described greater sensitivity when isolated and reduced distress during supportive, emotionally warm interaction. This finding is compatible with emerging evidence that social context is closely involved in the misophonic experience (Humolli et al., 2026). It also suggests that symptom management should not focus exclusively on sound exposure but should consider social connectedness, interpersonal security, and relational regulation. The overall pattern is consistent with a growing view that misophonia is heterogeneous and context dependent, with different combinations of sensory sensitivity, emotional dysregulation, attentional capture, cognitive rigidity, social appraisal, and psychiatric comorbidity contributing to symptom expression (Anderman et al., 2023; Woolley et al., 2025). The present grounded theory therefore extends previous research by integrating these processes into a culturally situated model in which misophonia is understood as a multilayered sensory, cognitive, affective, relational, and meaning-based phenomenon.

The present study had several limitations. First, the sample size was relatively small and was primarily drawn from university-related populations in Zanjan, which may limit the transferability of the findings to other age groups, occupational groups, socioeconomic backgrounds, or cultural regions of Iran. Second, the study relied primarily on retrospective self-report and interview narratives, making the findings potentially vulnerable to recall bias and participants' subjective interpretations of symptom onset and causal experiences. Third, although maximum variation sampling was used, the sample did not include a sufficiently broad range of clinical severity levels or formally diagnosed psychiatric and neurodevelopmental subgroups. Fourth, the inclusion of one clinical specialist and one family member provided useful external perspectives but was insufficient to fully represent family and clinician experiences. Finally, because the design was qualitative and theory-generating, causal relationships among chronic stress, childhood experiences, perfectionism, compulsive checking, and misophonia cannot be established.

Future research should test the proposed grounded theory quantitatively using larger and more diverse Iranian samples and examine whether the identified categories and pathways can be replicated across different cultural settings. Longitudinal studies are particularly needed to clarify the temporal relationships among chronic stress, sleep disruption, acquired hypervigilance, attentional fixation, compulsive sound checking, and symptom progression. Future investigations should also examine whether perfectionism, cognitive inflexibility, intolerance of uncertainty, emotion-regulation difficulties, and interpersonal appraisal mediate or moderate the relationship between trigger exposure and functional impairment. Experimental studies could investigate the effects of perceived intentionality, controllability, and justifiability of trigger sounds under controlled conditions. It would also be valuable to explore the day/night sleep paradox objectively using ecological momentary assessment and sleep-related monitoring. Additional qualitative work with family members, children, adolescents, older adults, and individuals with psychiatric or neurodevelopmental comorbidities could further refine the model and identify clinically meaningful subtypes.

Clinical assessment of misophonia should extend beyond identifying trigger sounds and should systematically examine the meaning attributed to those sounds, interpersonal context, perceived intentionality and controllability, chronic stress, sleep disturbance,

perfectionistic expectations, attentional fixation, compulsive checking, and avoidance patterns. Treatment programs may benefit from a transdiagnostic framework integrating emotion-regulation training, cognitive restructuring, attentional flexibility, reduction of compulsive monitoring, gradual modification of avoidance, acceptance-based strategies, and work on perfectionistic or rigid expectations. Clinicians should also assess whether trigger reactions are embedded in unresolved interpersonal experiences or recurring family conflict and, where appropriate, incorporate family-based or interpersonal components. Psychoeducation for relatives may reduce stigmatizing interpretations of the individual's behavior and facilitate more constructive responses to trigger situations. Finally, treatment should aim not only to reduce immediate distress but also to improve sleep, social participation, relationship functioning, autonomy from sound-blocking devices, and the individual's capacity to remain psychologically flexible in the presence of unavoidable sensory triggers.

Authors' Contributions

Authors equally contributed to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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