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ORIGINAL ARTICLE

MISOPHONIA AND THE QUALITY OF SEXUAL LIFE IN COUPLES

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Abstract

Introduction: Misophonia or selective 'hatred of sound' is a newly recognized mental disorder characterised by negative emotional reactions, feelings, and thoughts with or without impulsive behavior to specific irritating triggering sounds. The term *misophonics* has been used to refer to misophonia sufferers. A major effect reported by misophonics is a negative, or even ruinous, impact on close romantic relationships. The aim of our study was to evaluate the quality of sexual life (QoSL) in misophonics of both sexes and their close partners.

Material and methods: We enrolled 91 misophonics aged 25.1 ± 5.4 years old (24 males and 67 females) and 91 opposite-sex partners aged 27.3 ± 4.9 years old. Their misophonia was confirmed by use of the Amsterdam Misophonia Scale (A-Miso-S) questionnaire. For evaluation of the QoSL in male misophonics, we used the International Index of Erectile Function (IIEF) and the Sexual Quality of Life–Male (SQoL-M) self-report questionnaires. For female misophonics we used the self-report questionnaire Sexual Quality of Life–Female (SQoL-F) and the Female Sexual Function Index (FSFI). For comparison, the total scores from the misophonics were compared with scores from controls, who were healthy peers (91 males and 91 females who were loving couples) without misophonia.

Results: We found that the total SQoL-F scores in female misophonics were statistically lower than in controls (62.7 ± 3.5 vs 89.4 ± 4.7 in controls, $p = 0.004$). In males with misophonia, the SQoL-M total score was 38.3 ± 4.2 vs 60.7 ± 4.6 in controls ($p = 0.002$), while IIEF total scores were correspondingly 40.6 ± 5.8 and 68.1 ± 6.3 ($p = 0.001$). Erectile function score in males with misophonia was 16.3 ± 2.4 vs 27.2 ± 2.8 in controls ($p = 0.003$). Partners of misophonics of both sexes also demonstrated decreased scores in total IIEF, SQoL-M, SQoL-F, and FSFI. In female partners of misophonic males, SQoL-F total score was 71.4 ± 4.6 vs 89.4 ± 4.7 in controls ($p = 0.007$). Erectile function score in male partners of misophonic females was 20.1 ± 3.2 vs 27.2 ± 2.8 in controls ($p = 0.015$). In misophonics of both sexes who had comorbid mental disorders, the scores that characterized QoSL were even lower.

Conclusions: Misophonia decreases the quality of sexual life in sufferers of both sexes as well as their partners.

Keywords: relationships • misophonia • hyperacusis • sexual life • erectile function

MIZOFONIA A JAKOŚĆ ŻYCIA SEKSUALNEGO W PARACH MAŁŻEŃSKICH

Streszczenie

Wprowadzenie: Mizofonia lub wybiórcza „nienawiść do dźwięków" to nowo rozpoznane zaburzenie psychiczne charakteryzujące się negatywnymi reakcjami emocjonalnymi, uczuciami i myślami, z impulsywnymi zachowaniami lub bez nich, wywołanymi przez określone irytujące dźwięki. Termin „mizofonicy" jest używany w odniesieniu do osób cierpiących na mizofonię. Osoby te jako główny skutek mizofonii zgłaszają jej negatywny, a nawet destrukcyjny wpływ na relacje romantyczne z partnerami. Celem naszego badania była ocena jakości życia seksualnego (QoSL) osób cierpiących na mizofonię obu płci oraz ich partnerów.

Materiał i metody: Do badania włączyliśmy 91 osób cierpiących na mizofonię w wieku 25,1 ± 5,4 lat (24 mężczyzn i 67 kobiet) oraz ich 91 partnerów płci przeciwnej w wieku 27,3 ± 4,9 lat. Mizofonię potwierdzono za pomocą kwestionariusza *Amsterdam Misophonia Scale* (A-Miso-S). Do oceny jakości życia mężczyzn cierpiących na mizofonię wykorzystaliśmy kwestionariusze samooceny *International Index of Erectile Function* (IIEF) oraz *Sexual Quality of Life–Male* (SQoL-M). W przypadku kobiet cierpiących na mizofonię wykorzystaliśmy kwestionariusz samooceny *Sexual Quality of Life–Female* (SQoL-F) oraz *Female Sexual Function Index* (FSFI). Łączne wyniki osób cierpiących na mizofonię porównano z wynikami osób z grupy kontrolnej, które były zdrowymi osobami w podobnym wieku (91 mężczyzn i 91 kobiet pozostających w związkach partnerskich) niecierpiących na mizofonię.

Wniki: Całkowite wyniki SQoL-F u kobiet cierpiących na mizofonię były statystycznie niższe niż w grupie kontrolnej (62,7 ± 3,5 w porównaniu z 89,4 ± 4,7 w grupie kontrolnej, $p = 0{,}004$). W przypadku mężczyzn z mizofonią łączny wynik SQoL-M wyniósł 38,3 ± 4,2 w porównaniu z 60,7 ± 4,6 w grupie kontrolnej ($p = 0{,}002$), natomiast łączne wyniki IIEF wyniosły odpowiednio 40,6 ± 5,8 i 68,1 ± 6,3 ($p = 0{,}001$). Wynik funkcji erekcji u mężczyzn z mizofonią wyniósł 16,3 ± 2,4 w porównaniu z 27,2 ± 2,8 w grupie kontrolnej ($p = 0{,}003$). Wyniki partnerów i partnerek osób cierpiących na mizofonię obu płci również były obniżone wyniki w skalach IIEF, SQoL-M, SQoL-F i FSFI. W przypadku kobiet będących partnerkami mężczyzn cierpiących na mizofonię całkowity wynik w skali SQoL-F wyniósł 71,4 ± 4,6 w porównaniu z 89,4 ± 4,7 w grupie kontrolnej ($p = 0{,}007$). Wyniki funkcji erekcji u partnerów kobiet cierpiących na mizofonię wyniosły 20,1 ± 3,2 w porównaniu z 27,2 ± 2,8 w grupie kontrolnej ($p = 0{,}015$). U osób cierpiących na mizofonię obu płci, które miały współistniejące zaburzenia psychiczne, wyniki charakteryzujące jakość życia były jeszcze niższe.

Wnioski: Mizofonia obniża jakość życia seksualnego zarówno u osób cierpiących na tę dolegliwość, jak i ich partnerów.

Słowa kluczowe: relacje • mizofonia • nadwrażliwość słuchowa • życie seksualne • erekcja

Key to abbreviations	
A-Miso-S	Amsterdam Misophonia Scale
DD	depressive disorder
FM	female misophonics
FP	female partners of misophonic males
FSFI	Female Sexual Function Index
GAD	generalized anxiety disorder
IIEF	International Index of Erectile Function
MM	male misophonics

Key to abbreviations	
MP	male partners of misophonic females
OCD	obsessive-compulsive disorder
PD	panic disorder
QoSL	quality of sexual life
ROCD	relationship obsessive-compulsive disorder/ relationship OCD
SQoL-F	Sexual Quality of Life–Female
SQoL-M	Sexual Quality of Life–Male

Introduction

Misophonia or selective 'hatred of sound' is a mental disorder characterised by intense negative emotional reactions, feelings, and thoughts (with or without impulsive behavior) to specific irritating sounds [1,2]. The term *misophonics* has been used to refer to people living with misophonia [3]. The annoying sounds, or triggers, are typically produced by the human mouth, throat, or nose and include chewing, crunching, slurping, breathing, sniffing, and so on. The sounds of cutlery and environmental or machine sounds can also be triggers [4]. Unfortunately, misophonia can negatively impact relationships in complex ways [5]. A major effect reported by misophonics is a destructive impact on close partner marked by aggression, 'fight or flight' responses, and a worsening, or even ruinous, effect on the romantic relationship [6–8].

It is known that various neurological or psychiatric diseases have a negative impact on the sexual function and behavior of patients. For example, multiple sclerosis can affect the sexuality of sufferers [9]. Depression and use of antidepressants can significantly worsen sexual function [10]. Reduced sexual desire is associated with many personality disorders: schizoid personality disorder, character schizoid accentuation, accentuations of the cycloid, asthenoneurotic, hysteroid, unstable, psychasthenic, sensitive and infantile-dependent types. Similar effects are seen in mood (affective) disorders such as dysthymia (depressive neurosis), bipolar disorder, schizophrenia, mental retardation, dementia, epilepsy, and organic brain damage [11].

Recently misophonia has been recognised as a mental disorder and its incidence in the population may reach 33% [12]. More specifically, there can be sound triggers from their sexual partners so that the misophonic becomes dissatisfied with their intimate relationship, sometimes expressed at a visit to their doctor. This problem requires further study and systematization. Although the nosology is novel, there are a considerable number of cases of misophonics presenting with sexological complaints to sexologists, urologists, and gynecologists, with the result that we were prompted to plan and conduct this study.

The aim of our study was to evaluate the quality of sexual life (QoSL) in misophonics of both sexes and their close partners.

Material and methods

We enrolled 91 misophonics aged 25.1 ± 5.4 years old with a male-to-female ratio of 1: 2.8 (24 males and 67 females). We also enrolled their opposite-sex partners without misophonia, this time with a male-to-female ratio of 2.8 : 1 (67/24) aged 27.3 ± 4.9 years old. Only couples in loving relationships that had lasted more than 6 months were included in the study to avoid honeymoon euphoria.

Individuals with misophonia were recruited during their visits to psychiatrists/ psychotherapists ($n = 42$, 46%), otorhinolaryngologists ($n = 20$, 22%), gynecologists ($n = 17$, 19%), and urologists ($n = 12$, 13%).

Their misophonia was confirmed by use of the Amsterdam Misophonia Scale (A-Miso-S) questionnaire developed by Schröder et al. [13]. We used 1 point as cut-off on the A-MISO-S scale. Participants with confirmed misophonia were divided, as recommended, into the following subgroups according to their A-Miso-S total score: scores from 1 to 4 were considered subclinical misophonic symptoms ($n = 22$), 5–9 mild ($n = 46$), 10–14 moderate ($n = 18$), 15–19 severe ($n = 3$), and 20–24 extreme ($n = 2$) [14,15].

For evaluation of the quality of sexual life in males, we used the International Index of Erectile Function (IIEF) and Sexual Quality of Life–Male (SQoL-M) self-report questionnaires [16,17]. In females, we used the self-report questionnaire Sexual Quality of Life–Female (SQoL-F) and the Female Sexual Function Index (FSFI) [18–20].

To evaluate the scores of misophonics we compared them with the survey results of controls without misophonia, 91 males and 91 females who were couples in love (aged 26.5 ± 5.1 years old) and did not have any distinct mental/ urological/ gynecological pathology.

All the patients with complaints of selective sound hypersensitivity and elevated A-Miso-S total scores were referred to a psychiatrist/ psychotherapist for deeper examination in order to confirm misophonia and to detect or exclude concomitant mental illnesses.

To exclude hyperacusis and tinnitus, otorhinolaryngologists performed routine audiological testing; relevant questionnaires were also retrospectively gathered from the records of the patients. Measures included pure tone audiometry and uncomfortable loudness levels; questionnaires included the tinnitus impact questionnaire, the hyperacusis impact questionnaire, and the screening for anxiety and depression in tinnitus questionnaire (as recommended in [21]).

Mann–Whitney *U*-tests to compare the two groups were used. Statistical significance was judged at $p < 0.05$ [22].

Results

Among the 91 persons with confirmed misophonia, there were 32 (35%) who had misophonia only (without concomitant mental disorders) comprised of 21 (64%) females and 11 (36%) males. Comorbid mental disorders in misophonics were registered in 59 (64%) patients: 46 (78%) females and 13 (22%) males, and included generalized anxiety disorder (GAD), $n = 21$ (36%), 16 females, 5 males; depressive disorder (DD), $n = 12$ (21%), 9 females, 3 males; panic disorder (PD), $n = 11$ (19%), 8 females, 3 males; obsessive-compulsive disorder (OCD), $n = 8$ (14%), 6 females, 2 males; and relationship obsessive-compulsive disorder (ROCD), $n = 7$ (10%), 7 females, 0 males.

Taking into account the presence of mental comorbidities, we analysed misophonics with each comorbid mental disorder separately from those who have misophonia only. Survey data in female misophonics, female partners of misophonic males, and female controls are presented in **Table 1**. Total FSFI and SQoL-F scores in examined females are presented graphically in **Figure 1**.

As shown in **Figure 1**, the quality of sexual life in female misophonics (FM) and female partners of men with misophonia (FP) is worse than in the control group. Total SQo-F score in females with misophonia only was 62.7 ± 3.5 vs 89.4 ± 4.7 in controls ($p = 0.004$). In females, partners of misophonic males SQoL-F total score was 71.4 ± 4.6 vs 89.4 ± 4.7 in controls ($p = 0.007$). Concomitant mental disorders further impair QoSL, with accompanying depressive disorders, generalised anxiety disorder, and panic disorder having the worst impact in females with misophonia.

Survey data in male misophonics, male partners of misophonic females, and male controls are presented in **Table 2**, while total IIEF and SQoL-M scores in examined males are presented graphically in **Figure 2**.

As shown in **Figure 2**, the quality of sexual life in male misophonics (MM) and male partners of women with misophonia (MP) is lower than in the control group. In males with misophonia only the SQoL-M total score was 38.3 ± 4.2 vs 60.7 ± 4.6 in controls ($p = 0.002$), while IIEF total scores were 40.6 ± 5.8 vs 68.1 ± 6.3 correspondingly ($p = 0.001$). Comorbid mental disorders further impair QoSL, with accompanying depressive disorders having the worst impact in males with misophonia.

In males with depressive disorder and misophonia (MM+DD), the SQoL-M total score was 18.3 ± 5.1 vs 60.7 ± 4.6 in controls ($p = 0.0001$), while IIEF total scores were 24.9 ± 2.4 vs 68.1 ± 6.3 correspondingly ($p = 0.0005$). Erectile function score in males with misophonia only (MM) was 16.3 ± 2.4 vs 27.2 ± 2.8 in controls ($p = 0.003$), while in male partners of misophonic females (MP), that score was 20.1 ± 3.2 vs 27.2 ± 2.8 in controls ($p = 0.015$) as presented in **Table 2** in the domain “Erectile function”.

In general, as presented in **Table 1** and **Table 2**, the quality of sexual life in males and female partners of misophonics was statistically lower than in their controls. Female partners of misophonic males (FP) reported lower orgasm and less sexual satisfaction after intercourse with preserved arousal and sexual desire. Decreased orgasmic feelings, sexual desire, intercourse, and overall satisfaction with preserved erectile function were registered in male partners of misophonic females (MP).

Table 1. Results of surveys of 67 female misophonics, 24 female partners of misophonic males, and 91 female controls using three tools: A-Miso-S, SQoL-F, and FSFI

Scales		FM+DD (*n* = 9)	FM+GAD (*n* = 16)	FM+PD (*n* = 8)	FM+OCD (*n* = 6)	FM+ROCD (*n* = 7)	FM (*n* = 21)	FP (*n* = 24)	Controls (*n* = 91)
A-Miso-S	Total score	8.6 ± 3.7*	11.3 ± 4.1*	9.5 ± 6.3*	11.8 ± 3.7*	8.4 ± 6.2*	9.4±4.2*	0	0
SQoL-F	Psycho-sexual feelings	16.2 ± 3.6*	18.7 ± 3.1*	20.8 ± 5.7*	21.4 ± 6.4*	20.7 ± 6.3*	26.8 ± 4.1*	30.5 ± 3.7*	37.2 ± 4.1
	Sexual and relationship satisfaction	10.3 ± 2.8*	12.4 ± 2.4*	11.6 ± 4.1*	16.2 ± 2.1*	16.3 ± 3.2*	17.6 ± 3.2*	19.4 ± 4.3*	22.9 ± 4.7
	Self-worthlessness	5.6 ± 1.6*	6.7 ± 1.9*	6.3 ± 2.4*	8.7 ± 3.1*	7.2 ± 2.8*	10.4 ± 2.6*	11.3 ± 1.9*	14.7 ± 2.8
	Sexual repression	4.5 ± 1.2*	5.4 ± 2.7*	7.6 ± 2.3*	7.2 ± 2.1*	6.4 ± 0.8*	8.4 ± 1.9*	10.2 ± 0.7*	15.6 ± 2.9
	Total score	37.2 ± 3.3*	43.2 ± 3.8*	48.3 ± 2.6*	53.5 ± 3.2*	50.6 ± 3.8*	62.7 ± 3.5*	71.4 ± 4.6*	89.4 ± 4.7
FSFI	**Total score**	15.2 ± 1.9*	14.3 ± 2.6*	15.7 ± 2.3*	17.1 ± 2.4*	16.5 ± 1.8*	17.8 ± 1.4*	22.4 ± 1.8*	32.2 ± 3.1

Note: FM, female misophonics without mental comorbidities; FM+DD, female misophonics with depressive disorder; FM+GAD, female misophonics with generalized anxiety disorder; FM+PD, female misophonics with panic disorder; FM+OCD, female misophonics with obsessive compulsive disorder; FM+ROCD, female misophonics with relationships obsessive compulsive disorder; FP, female partners of misophonic males; * $p < 0.05$ compared with female controls

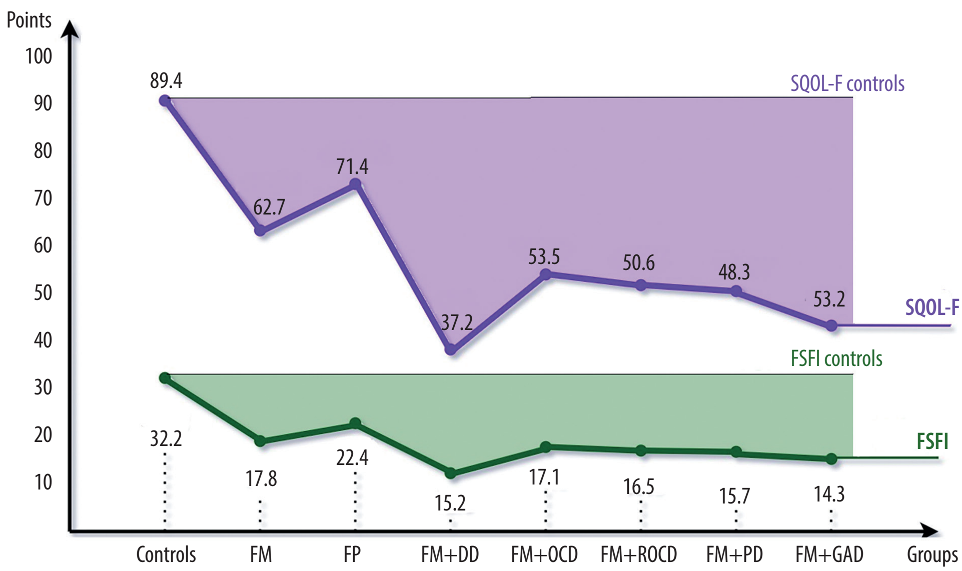

Figure 1. Total FSFI and SQoL-F scores in examined females. Legend: FM, female misophonics; FP, female partners of misophonic males; FM+DD, female misophonics with depressive disorder; FM+OCD, female misophonics with obsessive-compulsive disorder; FM+ROCD, female misophonics with relationships obsessive-compulsive disorder; FM+PD, female misophonics with panic disorder; FM+GAD, female misophonics with generalised anxiety disorder

Discussion

Intimacy is a special, tender part of being human. According to literature data and our own more than three decades of medical experience, several factors have a negative impact on the quality of sexual life. Among them there are somatic, mental disorders, stress, and psychological interpersonal conflicts [23–26]. Based on the results of our previous studies, we have continued to evaluate the QoSL in misophonics [6,27,28].

It has been previously found that persons with misophonia cannot maintain a constant close relationship with loved ones. Sound triggers produced by partners were the cause of breakup. Moreover, when misophonics were asked: "Would the relationship with each abandoned partner last longer if he did not produce trigger sounds?" they answered: "Most likely so", "Probably yes", and "Yes". Taking into account frequent changing of sex partners in examined misophonics, we asked them: "Would you so often terminate the relationships if you did not have the misophonia?". The answers were "Probably not", "Unambiguously not", "I think not", and "It seems to me

Table 2. Results of surveys of 24 male misophonics, as well as of 67 male partners of misophonic females and 91 male controls, using three tools: A-Miso-S, IIEF, and SQoL-M

Scales		MM+DD (*n* = 3)	MM+GAD (*n* = 5)	MM+PD (*n* = 3)	MM+OCD (*n* = 2)	MM (*n* = 11)	MP (*n* = 67)	Controls (*n* = 91)
A-Miso-S	Total score	9.8 ± 3.4*	10.3 ± 3.5*	8.7 ± 3.4*	9.5 ± 4.5*	8.9 ± 5.7*	0	0
IIEF	Erectile function	8.1 ± 0.7*	9.6 ± 0.7*	10.8±1.6*	10.9 ± 1.5*	16.3 ± 2.4*	20.1 ± 3.2*	27.2 ± 2.8
	Orgasmic function	4.2 ± 1.3*	4.1 ± 1.2*	5.1 ± 2.7*	6.5 ± 2.0*	7.4 ± 2.6*	8.8 ± 1.6*	13.6 ± 2.9
	Sexual desire	4.6 ± 2.5*	5.3 ± 0.8*	6.4 ± 1.8*	5.0 ± 2.5*	4.9 ± 1.6*	6.4 ± 2.7*	8.1 ± 1.7
	Intercourse satisfaction	4.8 ± 1.6*	5.8 ± 3.7*	6.1 ± 3.2*	7.5 ± 1.5*	7.8 ± 2.1*	8.3 ± 3.3*	11.5 ± 2.4
	Overall satisfaction	3.2 ± 1.1*	3.5 ± 1.6*	4.3 ± 0.7*	5.5 ± 1.5*	4.5 ± 2.3*	5.7 ± 2.1*	7.7 ± 1.6
	Total score	24.9 ± 2.4*	28.3 ± 3.6*	32.7 ± 2.8*	35.4 ± 2.2*	40.6 ± 5.8*	49.3 ± 5.2*	68.1 ± 6.3
SQOL-M	**Total score**	18.3 ± 5.1*	22.6 ± 4.3*	26.5 ± 5.5*	32.1 ± 3.6*	38.3 ± 4.2*	44.2 ± 5.5*	60.7 ± 4.6

Note: MM, male misophonics without mental comorbidities; MM+DD, male misophonics with depressive disorder; MM+GAD, male misophonics with generalized anxiety disorder; MM+PD, male misophonics with panic disorder; MM+OCD, male misophonics with obsessive compulsive disorder; MP, male partners of misophonic females; * $p < 0.05$ compared with male controls

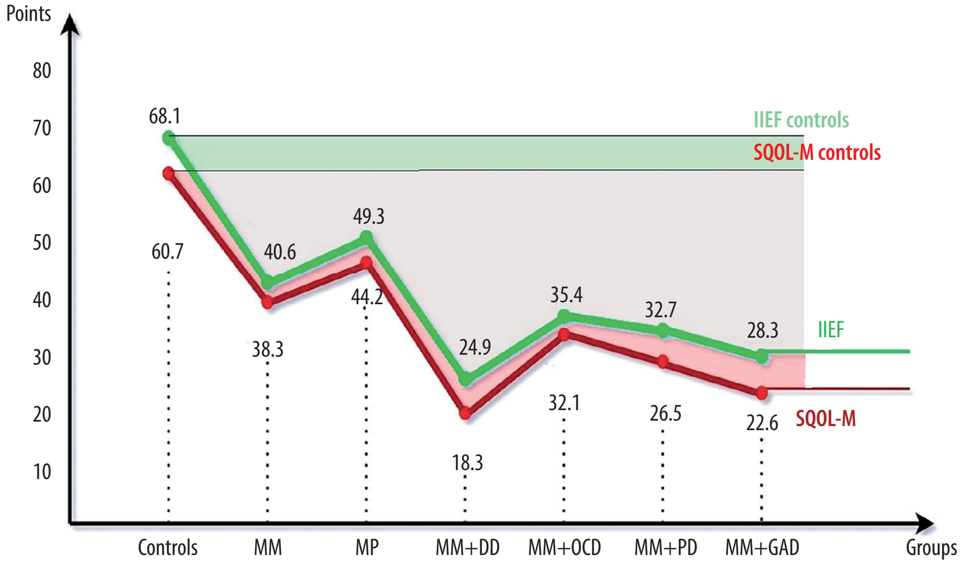

Figure 2. Total IIEF and SQoL-M scores in examined males. Legend: MM, male misophonics; MP, male partners of misophonic females; MM+DD, male misophonics with depressive disorder; MM+OCD, male misophonics with obsessive-compulsive disorder; MM+PD, male misophonics with panic disorder; MM+GAD, male misophonics with generalised anxiety disorder.

that no". Obviously, although they had a desire to live longer with a stable partner, misophonia sufferers were aware that their selective sound sensitivity and induced negative emotions deprived them of that opportunity [6].

The presented study addresses the intimate topic of QoSL in persons with misophonia. Using approved standard questionnaires, we have shown that individual total scores characterising the quality of sexual life in misophonics of both sexes and their partners differed greatly from the same indicators among their peers without misophonia (the controls). According to our results, the presence of concomitant mental disorders makes QoSL even lower.

Interestingly, the QoSL scores of females with misophonia but without mental comorbidities were statistically lower that in controls but higher than in individuals with other comorbidities (**Figure 1**). Similarly, misophonic males with misophonia only had lower total QoSL scores than controls, but had higher scores than comorbid cases (**Figure 2**).

We appear to be the first to study aspects of the sexuality in misophonics and their partners. The present research confirms our previous findings about the negative impact of misophonia on the quality of life in patients of both sexes and their partners [27,28].

Our observations show that misophonia often prevents patients from maintaining long-term and stable intimate relationships. The condition might be considered a major cause of inadequate intimacy and broken close relationships. According to our survey, misophonics are not the only initiators of the relationship breakup. Some case reports reveal that the partners of misophonic women left them because the partners were annoyed by the need to limit their behavior and restrain natural physiological sounds during communication, meals, or sex. The constant claims of misophonics about their partner's eating behavior "did not suit them [the partner]" and therefore the healthy partner was the first to take steps towards ending the relationship [6].

The effect of misophonia on close relationships and QoSL indicates the need to bring together sexologists, urologists, and gynecologists into multidisciplinary teams for complete misophonia management [28].

More studies on this issue have yet to be conducted, so we invite our colleagues with larger patient databases for cooperation. In our opinion, it would be appropriate to use the questions proposed by us ("Would the relationship with each abandoned partner last longer if he did not produce trigger sounds?" and "Would you so often terminate the relationships if you did not have the misophonia?") during surveys of misophonics. We consider it reasonable to use the SQoL-F, SQoL-M, IIEF, and FSFI questionnaires among misophonics to analyse their sexual function and satisfaction, although some modifications may be appropriate.

Our results may induce clinical researchers to focus on assessing the sexuality of misophonia sufferers and their partners. New therapeutic strategies need to be developed with the aim of improving the QoSL in couples where one has misophonia. If needed, a sexologist may be included into a multidisciplinary team for misophonia management.

Limitations

The small sample of enrolled males with misophonia might be considered the main limitation of our study. Statistically, the small number of misophonics with mental comorbidities is also a limitation.

Conclusions

Misophonia diminishes the quality of sexual life in sufferers of both sexes and their partners. Male misophonics may suffer erectile dysfunction, as may healthy males who are the partners of female misophonics. These aspects should be taken into account by psychiatrists, psychotherapists, and psychologists during the management of couples where one has misophonia.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975 as revised in 2008.

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Statement of interests

The authors declare no competing interests.

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