SENSORY DEFENSIVENESS SCREENING FOR ADULTS

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The Sensory Defensiveness Screening for Adults, composed of two parts, is used to determine if a patient is experiencing symptoms associated with sensory defensiveness and, if so, how it is affecting functional performance and relationships. Therapists in many settings have reported that it is a useful screening to help determine if sensory defensiveness is contributing to problematic behaviors, hypervigilance, social difficulties and withdrawal. People who have histories of abuse, trauma, sensory deprivation and self-harming behaviors often score highly on this screening and can benefit from treatment.

The Sensory Defensiveness Screening for Adults was used in the following study: Moore, K. & Henry, A. (2002). Treatment of adult psychiatric patients using the Wilbarger Protocol. *Occupational Therapy in Mental Health*, 18 (1), 43-63.

The additional tool provided in this PDF is the *Sensory Defensiveness Evaluation. It* was also used in the study to understand the person's history and how it might have contributed to developing sensory defensiveness and to understand all his or her roles and relationships in order to follow function in these roles before and after treatment.

The Sensory Defensiveness Screening for Adults is not standardized but is simply a reflection of the number of characteristics a person has that are consistent with sensory defensiveness and how those characteristics impact the person's life. Clinical judgement by an occupational therapist with an understanding of the phenomenon of sensory defensiveness must be used to interpret the results. People can be mildly defensive and check off almost all of the characteristics because they do not greatly impact function and the person has learned to work around them. Alternatively a person may be defensive in only one area such as visual or vestibular defensiveness and yet it is impacting their entire life.

A 96 item pilot version of the SDSA was administered to 33 psychiatric inpatients and 14 non-hospitalized controls. Data from the pilot was reviewed and items consistently checked by respondents with otherwise low scores were dropped (for example being bothered by tags in the back of a shirt). Fifty items that seemed most pertinent as well as distressing were included in the final screening tool (Moore, 1996). Twenty-two psychiatric inpatients (19 female and 3 male) participated in a test-retest reliability study of the 50-item version of the SDSA. These patients were administered the SDSA by the investigator twice; the second administration took place from three days to three months after the first. Test-retest reliability for the total score was examined using an intra-class correlation coefficient (ICC). The ICC was .97.

Directions for the Sensory Defensiveness Screening for Adults

In Part 1, the patient checks Yes or No beside a behavior associated with sensory defensiveness (e.g., do you avoid noisy places). Ask the patient if he has any questions regarding the items. For example, many patients have questions about addictive behaviors (which include substance abuse, gambling, and food addictions). Explain that a "Yes" response refers to a behavior that occurs often or has been a recent problem. If the behavior occurred a long time ago, but not recently, the answer is No. If the characteristic applies infrequently, the answer is No.

Begin Part II by explaining that the purpose of this section is to determine if those sensory defensive behaviors checked YES in Part I are having an impact on the patient's everyday functioning (e.g., socialization, hygiene, leisure). Functional problems can be the result of many factors, but for the purpose of this screening, the problem must be due to sensory related issues. For example, patients may be depressed and withdrawing from all social relationships. If they are avoiding others and it is not due to discomfort from touch or other symptoms related to sensory defensiveness, then they would circle N on the fifth functional situation addressing socialization. A patient may not realize that social withdrawal is due to sensory issues. If that patient has identified many behaviors in Part I, further investigation is suggested.

To further understand the patient's sensory processing, a short history is taken. At the end of Part II there is a short list of experiences, highly associated with sensory defensiveness, for the patient to check. A person with a history of these experiences does not necessarily have a sensory defensive problem but special attention should be taken on the part of the therapist to make sure these patients are not exhibiting sensory defensive symptoms.

The results must be interpreted by an Occupational Therapist familiar with Sensory Defensiveness. If the patient identifies a significant number of behaviors and if those behaviors are impacting patient function, further assessment is recommended.

SENSORY DEFENSIVENESS SCREENING FOR ADULTS

Name: _____Date:_____Circle: Male or Female

Age: ___ Circle: Patient Staff Student Other Occupation: _____

Diagnosis:_____ Living situation:_____

PART I

Please score first and immediate response by circling **Y (if behavior usually applies)** or **N (if behavior rarely applies).**

Do you:	**Do you:**
Y N layer your clothing often	Y N avoid food with mixed textures
Y N overdress for the temperature	Y N have difficulty swallowing
Y N prefer long sleeves, even in summer	Y N like noxious odors (gasoline, etc.)
Y N pick illogical clothing preferences	Y N seem overly sensitive to smells
Y N repeatedly wear favorite clothes	Y N avoid noisy places
Y N experience discomfort with dressing or undressing	Y N need absolute quiet to concentrate
Y N get irritated by showering	Y N get agitated by white noise (fan, etc.)
Y N get irritated by face washing, or shaving	Y N get irritated by sounds others would ignore
Y N get irritated by tooth brushing	Y N have trouble staying on the line when reading/writing
Y N have poor personal hygiene	Y N get overly bothered by lights at night
Y N like wrapping yourself in bedding	Y N get distraught by occluded vision (such as a blindfold)
Y N sit with hands or feet underneath you	Y N become upset by complex visual stimuli (lots of colors or moving objects)
Y N bite hand/wrist/arm when upset	Y N find yourself staring at things
Y N bang head or part of body when upset	Y N over-react to unstable surfaces
Y N grind teeth	Y N often bump into things
Y N prefer to touch rather than be touched	Y N lose balance easily
Y N become upset when someone comes behind you	Y N rock back and forth to calm yourself
Y N find touch to be painful/ harmful	Y N dislike heights
Y N get anxious when being hugged	Y N fatigue easily
Y N like an exaggerated personal space	Y N feel uncomfortable with body or looks
Y N find that closed rooms bother you	Y N cut or hurt self when anxious or upset
Y N avoid crowded places	Y N not feel pain
Y N startle more easily than others	Y N dislike routine
Y N have patterns of social withdrawal	Y N exhibit addictive behaviors
Y N have unexplained emotional outbursts	
Y N feel you are always "on guard"	

Score Section I: # Y_____ # N_____ out of 50 items % Yes_____

PART II
FUNCTIONAL IMPLICATIONS

First, consider the sensory behaviors that you checked "Yes" in Part I.

Then, thinking about the sensory behaviors, read each of the questions below. Circle **Y for yes** or **N for no** beside each question. If the question does not apply to you, write NA. Note: Do not respond with yes if these problems are caused by something other than sensory problems. For example poor hygiene could be due to fatigue caused by depression, not because bathing is irritating.
Please explain answer if it is YES.

Y N Do these sensory behaviors interfere with your **hygiene** and your ability to dress and care for yourself the way you would like?

Y N Do these sensory behaviors prevent you from being **independent** in the community (driving, going to public places)?

Y N Do these sensory behaviors interfere with your **relationships** with other people?

Y N Do these sensory behaviors interfere with your ability to enjoy an **intimate relationship**?

Y N Do these sensory behaviors interfere with your ability to **socialize** with others?

Y N Do these sensory behaviors interfere with your ability to **care for your home or your family**?

Y N Do these sensory behaviors interfere with your ability to go to **school** or to perform your **job** or to seek employment?

Y N Do these sensory behaviors interfere with your ability to enjoy **leisure** activities and to have fun?

Y N Do these sensory behaviors interfere with your **safety**?

Check any experiences that apply:

___History of sexual abuse	___Respiratory problems	___Serious injury or surgery
___History of physical abuse	___Multiple hospitalizations	___Traumatic birth
___Self-harming behavior	___Torture	___Suicide attempts
___Eating disorder	___Serious stomach problems	___Period of sensory deprivation

SENSORY DEFENSIVENESS EVALUATION

Name _____Age_____ Sex_____
Address_____
_____
Phone: Home_____ Work_____

Diagnosis: Axis I _____ Medications:
Axis II_____
Axis III_____
Axis IV_____
Axis V _____

Treatment History: Onset_____ # Hospitalizations_____

Therapy/Treatment Programs - Present:_____
Past: _____

Suicide attempts_____

Self Abuse: Present _____What form?_____ Frequency_____
Past _____What form?_____ Frequency_____
Past abuse: Physical Sexual Psychological Torture
Approximate # years_____ Age_____
Any ongoing abusive relationships? _____

Medical History: Circle applicable categories

General Good Health	Substance Use
Seizure Hx	Allergies
Gastro-intestinal problems	Vision Problems
Headaches	Hearing Problems
Respiratory Problems	Ambulation/Motor Problems
Chronic Pain	Surgeries_____
Other_____	Weight/Nutrition Problem/Eating Disorder

Check any of the following which are characteristic of individual:

__History of physical or psychological trauma	__ Intense or tense
__History of extended hospitalization	__ Irritable
__History of institutionalization	__ Controlling
__History of sensory deprivation	__ Obsessive
__Hyperactive	__ Compulsive
__Unpredictable explosions of emotions	__ Impulsive
__Isolative	__ Preservative verbalizations
__Difficult to calm once aroused	__ Preservative behaviors

Significant Others: _____

Living Situation _____

Education _____Primary Source of Income_____

Work History_____

Supports _____

Most difficult time/situation in a day_____

Hypersensitivities_____Pain Responses_____

Seeking and avoidance responses_____

Sleep Patterns at night (quantity/quality)_____

Sleep/rest/isolation patterns during the day_____

Self Calming activities_____

Addictions_____

ROLES	**Description/Expectations**	**Quality/Quantity/Engagement**
Physical Self Care Hygiene/appearance/nutrition		
Emotional Self Care Therapy/self calming/relaxation		
Homemaker/Caretaker		
Close Relationships		
Socialization		
Leisure Hobbies/fun/relaxation		
Exercise		
Work/Productive Activities Volunteering/programs/school		
Member Clubs/AA/Church		

Hygiene and Grooming Problematic? _____ Circle if appropriate:
avoidance of certain routines uncomfortable in shower dislike hair cuts dislike shaving
dislike trimming nails dislikes brushing teeth ritualized routines limited clothing preferences
avoids shoes avoids barefoot dislikes hair washing/combing dislikes face washing
layers clothing Frequently adjusts clothing pushes up pant legs/sleeves/shirts

Nutrition Problematic? _____ Circle if appropriate:
Prefers liquids Avoids mixed textures Dislikes certain textures
Seeks strong flavors Avoids strong flavors Ritualized eating routines
Increased gag reflex Unusual eating habits Anorexia Bulimia

Relationships Problematic? _____Circle if appropriate:
Difficulty with physical touch Hugs uncomfortable Problems with intimacy
Abusive relationships Short tempered Deliberate distancing from others/push away
Difficulty with authority figures Impaired communication/self expression Labile
Habits make others uncomfortable Difficulty trusting others Patterns of self abuse

Socialization Problematic?_____ Circle if appropriate
Patterns of Isolation Difficulty with crowds Uncomfortable with self image
Uncomfortable at parties Decreased Self Expression Impaired communication
Short tempered Difficulty with authority figures Labile Lonely
Fear of space being invaded Self conscious Dislike unpredictable situations
Embarrassed by habits Hyper-vigilant

Independence in Community Problematic?_____ Circle if appropriate:
Difficulty driving/riding in car Problems with walking Problems with stairs
Difficulty with shopping Problems with elevators/escalators Difficulty with crowds
Difficulty waiting in lines Lose balance easily Afraid of heights Afraid of wide open spaces
Afraid of closed spaces

Leisure/Hobbies/Exercise Problematic? _____Circle if appropriate:
Uncomfortable in beach clothing/sports clothes Easily distracted Avoid unfamiliar
Balance problems Physical effort uncomfortable Upset by noise Upset by lights
Time management problems No interests Fatigue Bothered by sticky/messy substances
Upset by visual stimuli(fast moving or changing images)

Homemaker/Caretaker Roles Problematic? _____Circle if appropriate:
Lack of energy Too much time in bed/isolating Bothered by noise Ritualistic
Obsessive-compulsive Dislike feel of water/wet things Avoid chemicals Irritated by smells
Upset by confusion Handling rough textures bothersome Pain Physical effort uncomfortable

Work/Volunteering/Programs Problematic? _____Circle if appropriate:
Avoiding people Uncomfortable in car/bus Afraid of unpredictable situations
Fatigue Fatigue Easily agitated Anxiety Poor grooming Easily distracted
Uncomfortable in work clothes

Related Problem Behaviors: Please have client circle any problems on attached form

Most problematic Behaviors:	Intensity at start	STG	LTG

1._____

2._____

3._____

CONCLUSIONS/RECOMMENDATIONS:

_____

Signature of Occupational Therapist