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 person 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 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.

A separate guide has been developed to help therapists to interpret the Sensory Defensiveness Screening.

Directions for the Sensory Defensiveness Screening for Adults

In Part 1, the person checks Yes or No beside a behavior associated with sensory defensiveness (e.g., do you avoid noisy places). Ask the person if he or she has any questions regarding the items. For example, many people 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 person'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, people 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 person may not realize that social withdrawal is due to sensory issues. If that person has identified many behaviors in Part I, further investigation is suggested.

To further understand the person'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 person 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 people are not exhibiting sensory defensive symptoms. Answering this section could possibly be triggering to some individuals. Clinical discretion is advised. The information may have to be obtained through the person's clinical record.

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

SENSORY DEFENSIVENESS SCREENING FOR ADULTS

Name: _____Date:_____

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 changes in 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

Take a moment to consider the sensory behaviors for which 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 **N/A.** 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.

***If your answer is "yes," please add a brief explanation.**

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