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.

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## 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).

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

Score Section I:  # Y_________ # N_________ out of 50 items       % Yes__________

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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

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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

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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________________________________________________________________

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

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

Most problematic Behaviors:                         | Intensity | STG | LTG
at start

1.________________________________

2.________________________________

3.________________________________

CONCLUSIONS/RECOMMENDATIONS:

________________________________________________________________________

________________________________

Signature of Occupational Therapist

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