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SOCRATES Assessment of Perceptual Abnormalities and Unusual Thought Content

Ian Kelleher

Royal College of Surgeons in Ireland, iankelleher@rcsi.ie

Mary Cannon

Royal College of Surgeons in Ireland, marycannon@rcsi.ie

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SOCRATES Assessment of Perceptual Abnormalities and Unusual Thought Content

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Ian Kelleher MB BCh, PhD and Mary Cannon MB BCh, PhD

The aim of the SOCRATES assessment is to provide a systematic and comprehensive approach to the assessment of perceptual abnormalities and unusual thought content in research and clinic settings. The method provides a template for the information that should be gathered in relation to reported phenomena. It provides a standardised approach to assessment that assists the identification of changes over time and facilitates comparisons between centres.

A separate SOCRATES assessment should be performed for each perceptual abnormality/unusual thought. Where this is impractical or where time limitations do not allow this (for example when the interviewee has experienced many different perceptual abnormalities) then it is recommended that priority be given to assessing the most severe or pre-occupying perceptual abnormality and unusual thought. In this case, the interviewer should also note when perceptual abnormalities and unusual thoughts first began. Severity is judged in relation to reality testing, which may be rated along a continuum of psychotic intensity as frankly psychotic or attenuated to varying degrees (see Figures 1 and 2).

Figure 1: Continuum of severity of perceptual abnormalities

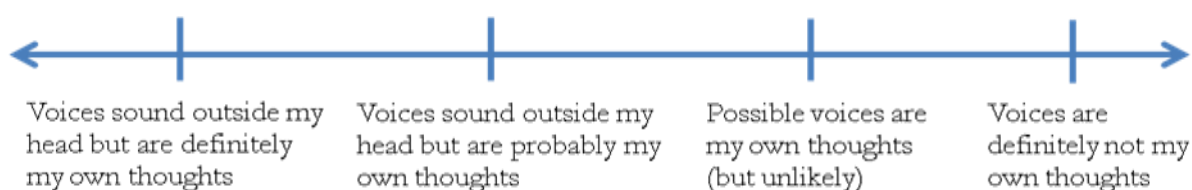
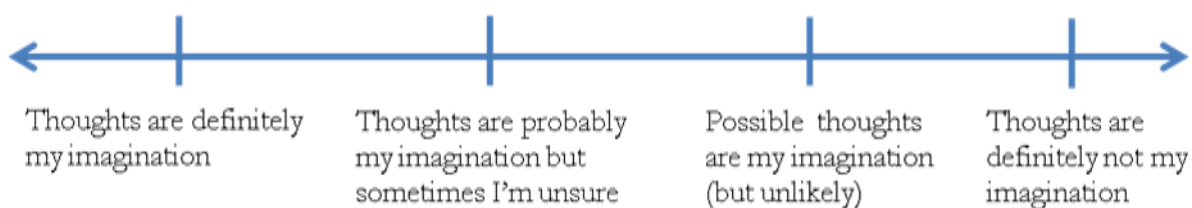


Figure 2: Continuum of severity of unusual thought content



Suggested questions to first enquire about the presence of perceptual abnormalities and unusual thought content are provided. Where perceptual abnormalities/unusual thought content are reported, SOCRATES should then be used to assess these.

A SOCRATES assessment may focus on experiences within the past year (or a narrower time period as desired by the interviewer). The interviewer should specify this when enquiring about experiences. Alternatively, the interviewer may perform a lifetime SOCRATES assessment. The interviewer may also note both lifetime and past year (or other time frame) ratings.

Questions to identify the presence of perceptual abnormalities

A 'warm up' period is necessary to build rapport and establish trust before enquiring about perceptual abnormalities. Questions about school, work, family, physical illnesses etc are useful in building rapport. It is also beneficial to enquire about symptoms of other mental disorders (e.g., depression) in advance of moving on to ask about perceptual abnormalities, as this 'sets the stage' for the questions to come. Often, a single question, given a background of good rapport building and a visibly unflappable interviewer, is enough to identify experiences of perceptual abnormalities.

You know how sometimes our imaginations can play tricks on us. Like something we thought was there, wasn't really there? Does your imagination ever play tricks on you? What kind of tricks?

Sometimes people, when they're alone – and sometimes even when they're with other people – hear things or see things and they're not sure where they come from. Does that ever happen to you?

Sometimes people think they hear a voice speaking but then it seems as if no one is there. Does that ever happen to you?

Or sometimes people hear other sounds or music but then they realise that nothing is there. Does that ever happen to you?

Did you ever hear your thoughts as though they were out loud?

Did you ever see something and then realise that it wasn't really there at all? Like a person or a ghost? Or anything else?

As always, prompts such as, "Tell me more," are useful when answers are brief or vague.

SOCRATES assessment of perceptual abnormalities

Source

Did the voice sound like it was inside or outside your head?

If experienced both inside and outside heard, note what proportion inside/outside.

Onset, duration and frequency

When did it first happen?

How long did [the experience] typically last (per episode). Note the longest episode.

For how long did the person experience these episodes?

How often did [experience] occur?

Note any recent changes in frequency (e.g., onset 2 months ago, occurred about once a week but has been happening daily for past 2 weeks).

Content

What did the voice say?

How many voices were there?

Did voices talk to each other?

Did the voice comment on what you were thinking or doing?

Did the voice give commands?

If non-vocal, what was the content (e.g., music, other sounds)

Character of the voice

Did the voice sound male or female?

Young/old?

Did you recognise the voice? Was it the voice of someone you know?

Did it sound like my voice or did it sound different?

Did it whisper, shout?

Did it sound happy/angry/sad?

Was the voice good or bad (or neither)?

Reality testing and Attribution

Note: This is perhaps the most complex part of the assessment and requires clinical skill. Assessment of attribution should involve a step-wise approach. First, ask the interviewee an open-ended question about their attribution for the experience. If the interviewee states that they believe it was their imagination, the next step is to enquire whether they ever thought it could have been anything else (more unusual). If they never believed it could be anything else, then the interviewer should note this and move on.

If the interviewee notes a more unusual attribution (e.g., ghosts, aliens) either at the time of the experience or later, the interviewer should encourage the interviewee to elaborate on this. If, despite giving the interviewee time to discuss their attribution, the interviewee does not suggest that the experience may have arisen from their own imagination, the interviewer should directly (but non-confrontationally) challenge the interviewee on this. Care should be taken, especially with children, that the interviewee does not feel pressured to agree with the interviewer. A positive response bias should be avoided by forcing the interviewee to make a choice rather than allowing them to simply give a 'yes' response. For example, as detailed below, the interviewer should ask, "Did you ever think that [experience] could have been your imagination or was it definitely [interviewee's attribution]". The interviewer should not labour this point (as stated, it is important that the interviewee not feel that the interviewer is trying to get him/her to agree that it could be his/her imagination; rather, the interviewer is looking to establish the mental state of the interviewee); ask the question once, note the response and move on.

The interviewer should be able to choose one of the four options below with regard to attribution (either from what the person reports in response to questioning or, if necessary, by asking them directly to choose which option best fits their beliefs). Attribution may be changeable: the interviewee may currently accept that the experience arose from their own thoughts/imagination but it is crucial to assess whether the interviewee may believe at least intermittently (e.g., during the acute phase of the perceptual abnormality) that the experience did not arise from their own thoughts.

What did you make of it/what did you think was going on?

Did you ever think there might be a more unusual explanation? (e.g., ghosts, aliens, FBI etc)

Is there anything else that it could have been?

Did you ever think that it could have been your imagination or was it definitely [person's attribution]

If I asked you to choose one of the following, which would you choose

1. *The voices are my own thoughts/imagination*
(Reality testing not impaired)
2. *I think the voices are probably my own thoughts/imagination but sometimes I am not so sure*
(Mildly impaired reality testing)
3. *I think the voices are probably not my own thoughts/imagination but I accept that this is possible*
(Moderately impaired reality testing)
4. *The voices are not my own thought/imagination*
(Severely impaired reality testing – psychotic)

Note: substitute the word 'voices' for 'sounds' or 'experiences' as appropriate

Timing

Did you hear the voices only at certain times?

For example, only when alone, only when in a certain place, only at night time, only when waking up or falling asleep?

Did it only occur when you had you taken alcohol or drugs? Or did it only occur when you were ill or had a fever?

Note: it is important to distinguish between hypnopompic/hypnagogic experiences and experiences that occur when alone at night or while in bed. It is often at night time that individuals are alone and perceptual abnormalities may be more likely to occur during these periods. If the individual is not actually in the process of waking up or falling asleep then the experience should not be rated as hypnopompic/hypnagogic.

Effects on functioning

Did [experience] affect how you behaved? Did it ever stop you from doing something? (e.g., too frightened to go to sleep, unwilling to be alone/with other people, unwilling to go to school/college/work).

Note: in addition to noting specific functional impairments, it may be beneficial to assess overall functioning with a formal instrument such as the Global Assessment of Functioning (GAF) or socio-occupational functioning assessment scale (SOFAS) in adults or the Children's Global Assessment Scale (CGAS) in children and adolescents.

Severity of distress (1-10)

When you experienced [perceptual abnormality], did you find it distressing or upsetting, or did it not bother you? Record if rated as distressing – yes or no.

If I asked you to rate how distressed you were when it happened on a scale of 1 to 10, where 1 is 'you weren't bothered at all' and 10 is 'the most distressed you could ever possibly be', where would you rate yourself [Note: rate the most severe score ever]

Questions to identify the presence of unusual thought content

A 'warm up' period is necessary to build rapport and establish trust before enquiring about unusual thought content. Questions about school, work, family, physical illnesses etc are useful in building rapport. It is also beneficial to enquire about symptoms of other mental disorders (e.g., depression) in advance of moving on to ask about unusual thought content, as this 'sets the stage' for the questions to come. Often, a single question, given a background of good rapport building and a visibly unflappable interviewer, is enough to identify experiences of unusual thought content.

Do you believe in anything other people don't believe in?

Have you ever had any ideas that you were afraid to tell other people about because you thought they might not understand?

Did you ever think that someone was spying on you? Or that someone was out to hurt you?

There are a lot of books and movies about the world ending. And some people believe that this is really going to happen. Did you ever believe that the world was going to end?

Did you ever think that you were a very special or very important person? In what way?

Did you ever feel like someone or something was putting thoughts into your head that weren't your own? Or taking thoughts out of your head? Or broadcasting your thoughts for others to hear?

Did you ever feel like you were getting hidden messages that were just for you? Like from the TV or somewhere else?

Did you ever feel like you weren't fully in control of your body? Like something else was in control?

As always, prompts such as, "Tell me more," are useful when answers are brief or vague.

SOCRATES assessment of unusual thought content

Source: Not applicable

Onset, duration and frequency

When did you first start thinking this?

How long did you think it for? Note the longest episode.

For how long did the person experience these episodes?

How often did you think about [thought]? Did you spend much of your day thinking about [thought]? Note how many hours spent thinking about this [and other] unusual thoughts

Note any recent changes in frequency (e.g., onset 2 months ago, used to spend about one hour a day in total thinking about unusual thought content but has been spending at least 3 hours pre-occupied with unusual thoughts per day for past 2 weeks).

Content

Record a description of the unusual thought content

Reality testing and **A**ttribution

Note: This is perhaps the most complex part of the assessment and requires clinical skill. Assessment of attribution should involve a stepped approach. First, ask the interviewee an open-ended question about their attribution for the experience. If the interviewee states that they believe it was their imagination, the next step is to ask whether they ever thought it could have been anything else (more unusual). If they never believed it could be anything else, then the interviewer should note this and move on.

If the interviewee notes a more unusual attribution (e.g., ghosts, aliens), either at the time of the experience or later, the interviewer should encourage the interviewee to elaborate on this. If, despite giving the interviewee time to discuss their attribution, the interviewee does not suggest that the experience may have arisen from their own imagination, the interviewer should directly (but non-confrontationally) challenge the interviewee on this. Care should be taken, especially with children, that the interviewee does not feel pressured to agree with the interviewer. A positive response bias should be avoided by forcing the interviewee to make a choice rather than allowing them to simply give a 'yes' response. For example, as detailed below, the interviewer should ask, "Did you ever think that [thought content] could have been your imagination or was it definitely [interviewee's attribution]". The interviewer should not

labour this point (as stated, it is important that the interviewee not feel that the interviewer is trying to get him/her to agree that it could be his/her imagination; rather, the interviewer is looking to establish the mental state of the interviewee); ask the question once, note the response and move on.

The interviewer should be able to choose one of the four options below with regard to attribution (either from what the person reports in response to questioning or, if necessary, by asking them directly to choose which option best fits their beliefs). Attribution may be changeable: the interviewee may currently accept that [thought content] was their imagination but it is crucial to assess whether the interviewee may believe at least intermittently that the experience was not his/her imagination.

What did you make of it/what did you think was going on?

Did you ever think there might be a more unusual explanation? (e.g., ghosts, aliens, FBI etc)

Is there anything else that it could have been?

Did you ever think that it could have been your imagination or was it definitely [person's attribution]

If I asked you to choose one of the following, which would you choose

1. *[thought content] was just my imagination*
(Reality testing not impaired)
2. *[thought content] was probably my imagination but sometimes I am not so sure*
(Mildly impaired reality testing)
3. *[thought content] was probably not my imagination but I accept that this is possible*
(Moderately impaired reality testing)
4. *Thought content was not my imagination*
(Severely impaired reality testing – psychotic)

Timing:

When you thought [thought content], had you taken any alcohol or drugs? Did you have a fever or did you feel ill?

Effects on functioning

Did [thought content] affect how you behaved?

Did you act on your thoughts? (e.g., if they thought someone was spying on them, note if they ever confronted someone on this)

Did it ever stop you from doing something? (e.g., loss of contact with friends/family, school/college/work problems, unwilling to go to certain places).

Note: in addition to noting specific functional impairments, it may be beneficial to assess overall functioning with a formal instrument such as the Global Assessment of Functioning (GAF) or socio-occupational functioning assessment scale (SOFAS) in adults or the Children's Global Assessment Scale (CGAS) in children and adolescents.

Severity of distress (1-10)

When you thought about [thought content], did you find it distressing or upsetting, or did it not bother you? Record if rated as distressing – yes or no.

If I asked you to rate how distressed you were on a scale of 1 to 10, where 1 is 'you weren't bothered at all' and 10 is 'the most distressed you could ever possibly be', where would you rate yourself [Note: rate the most severe score ever]

SOCRATES Assessment of Perceptual Abnormalities

ID:

Date of Assessment:

Interviewer:

Specify perceptual abnormality:

Source: Inside head
 Outside head
 Mixed (Proportion inside/outside: ____/ ____)

Onset:

Duration: Average:
 Longest duration ever:

Frequency (note also any recent change in frequency):

Content: _____

Character (e.g., male/female, young/old, volume, emotional valence)

Reality testing and Attribution:

Circle reality testing rating 1 2 3 4

Timing (e.g., hypnagogic, hypnopompic, when intoxicated, using substances, physically unwell)

Effects on functioning:

Severity of distress: Distressed: Yes/No

Distress severity 1-10:

Reality testing and Attribution:

Rating of reality testing (circle) 1 2 3 4

Timing (e.g., hypnagogic, hypnopompic, when intoxicated, using substances, physically unwell)

Effects on functioning:

Severity of distress: Distressed: Yes/No

Distress severity 1-10:

SOCRATES Summary Sheet: Perceptual Abnormalities

Number of distinct PAs reported:

Most severely impaired reality testing (1-4):

Earliest onset:

Onset of PA associated with most severely impaired reality testing:

Frequency (PAs combined):

Longest duration of a single PA:

Impaired functioning:

Most severe level of distress (1-10):

Occurred <u>outside of</u> the context of:	Drug use	Yes	/	No
	Alcohol use	Yes	/	No
	Febrile illness	Yes	/	No

SOCRATES Summary Sheet: Unusual Thought Content

Number of distinct UTs reported:

Most severely impaired reality testing (1-4):

Earliest onset:

Onset of UT associated with most severely impaired reality testing:

Longest duration of a single UT:

Impaired functioning:

Most severe level of distress (1-10):

Occurred <u>outside of</u> the context of:	Drug use	Yes	/	No
	Alcohol use	Yes	/	No
	Febrile illness	Yes	/	No