Chapter 1
Introduction

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Abstract

Psychiatry is the branch of medicine appointed to the diagnosis, treatment and prevention of mental disorders. Throughout ages, the concept of mental illness had changed many times and today the biopsychosocial model tries to explain mental disorders as the result of the complex interaction between biological correlates, psychological factors and the socio-cultural background. The psychiatric interview is the fundamental element for the evaluation of the subject with mental illness. It allows to have access to the patient's psychic state, enabling to collect the information that will guide the professional in formulating a diagnosis and through the choice of therapy.

Key words: Mental Health, Mental Disorder, History, Interview, Assessment.

1.1. Definitions

- **Mental Health**

The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

It should be noted that the concept of mental health goes beyond the simple absence of disease, extending it to all the aspects of life. It is a human condition that takes shape in personal

development and social relationships, in the ability to adapt, in the emotional and affective awareness and whose definition is inextricably linked to the cultural context.

- **Psychiatry**

According to the American Psychiatric Association (APA), psychiatry is the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders.
Mental disorders are categorized and grouped in manuals, based on diagnostic criteria. The two most important diagnostic manuals in psychiatry are the Diagnostic and Statistical Manual of mental disorders (DSM), currently in its fifth edition, and the International Classification of Diseases, tenth revision (ICD-10).
Psychiatry is therefore a medical discipline, which scientifically deals with the prevention, diagnosis and treatment of mental illness. It is a relatively young discipline and thus extremely dynamic and constantly expanding. As estimated by the WHO, psychic pathology is overgrowing and will reach the top places in the coming years in terms of social and economic impact, making this branch of medicine even more relevant.

- **Mental Disorder**

In the Diagnostic and Statistical Manual of mental disorders, fifth edition (DSM 5), "a mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities".
The definition of mental illness, as well as of mental health, is complex and not unambiguous. Over the years there have been continuous attempts to formalize and make this concept as universal as possible. Numerous human conditions have been included or excluded from the psychopathology chapter based on cultural and social changes. Also for this reason, periodically, a revision of the criteria for defining mental pathologies is carried out. This results in a new edition of the reference manual of this branch of medicine, the DSM.

1.2. History

Although Psychiatry is considered a fairly young medical discipline, the interest in the psyche and its disease has accompanied the history of humanity. The stages that led to the modern conception of psychiatry will be summarized, starting from the 5th century BC up to present days.

The Origins: Greece and Roman Psychiatry

Although notions of mental illness seem to trace back to the Neolithic, the history of "properly called" Psychiatry begins in ancient Greece. While among the most ancient civilizations of Egypt and Mesopotamia the concept of mental illness oscillated between natural and supernatural explanations, the Greeks expressed themselves in a rather decisive way on the biological origin of pathologies. The main representatives of the Greek medical school may be considered Hippocrates (460-377 BC) and Galen (129-201 AC). There are few direct testimonies of their approach to mental illness, indeed much of what we know is owed to indirect sources, such as Celsus, Aretheus of Cappadocia and Soranus of Ephesus.

The classical theory of Hippocrates and Galen is best known as Theory of Humors: the body and its state of health or sickness depends on the prevalence of one of the four humors which are fundamental constituents of human body.

The prevalence of one of the humors on the others leads to an imbalance, therefore to the disease. Thus, the prevalence of black bile is the source, for example, of melancholy.

Although this represents the best known theory in ancient Greece, starting from the 4th century BC New Greek schools were established, and the most important is probably that of the Solidists. Their greater exponent was Soranus of Ephesus (100 BC). The Solidist School took this name because its opposition to the Theory of the Humors and it focused on the solid components of the body. As mentioned before, the Solidist School recognizes as its best known representative in methodist Sorano of Ephesus. In methodist conception, mental disease would take origin from excessive tension (status strictus) or loosening (status laxus) of tissues. In his treatis on general medicine, Sorano reserves at least three chapters to the description of mental illnesses: frenite (from "fren", diaphragm, seat of the soul according to the Greeks), mania and melancholy. None of the Greco-Roman interpretations correspond to any current clinical picture, in fact the syndromes described included features which belonged to the spectrum of Mood Disorders and Psychosis, as well as symptoms of pathologies that (nowadays) we can define organic. Despite all, the Greek and Roman psychiatry earned the merit of giving the first descriptions, as well as the first attempts of classification and treatment of mental illnesses. Among the methods of treatment, the most applied

were rudimentary and totally empirical, based on physical techniques, however, during those times it was already possible to find traces of what will be further known as psychotherapy.

Middle Ages and Renaissance

During the Middle Ages, psychiatry (and whole medicine in general), underwent an involution. Despite in classical culture it was considered to all effects as a subject related to medical profession, in Middle Ages psychiatry had been brutally dismembered: such as surgery was yet executed by barbers, so psychiatry was related to exorcists and inquisitors. However, this kind of view may be reductive and defeatist, considering how long did Middle Ages last: in this time, especially in Middle East and Arabian countries, can be placed the birth of the first psychiatric wards of hospitals (Baghdad, Il Cairo, but also London, Paris, Basel and Munich). Doubtless, Middle Ages represents the historical period in which people left space to mystical-religious interpretations of mental illness, rather than to natural-related explanations which were most popular in ancient Greece. According to this kind of theories, fools were people possessed by demons or evil. Actually, the term “fool” comes from “fallitatem”, which was coined in that period and literally means “bag fool of wind”. Mental illness became a matter of religion and the most representative textbook about this concept is the “Malleus Maleficarum” (1487 AC), written by Dominicans H. Kramer and J. Sprenger.

Renaissance was an historical age characterized by huge contradictions. On one side, the so called “witch hunting” reached its edge of glory, on the contrary some brilliant minds were emerging from the community, whose intent was to contrast the inquisitorial tradition. Shortly later, they will be those who will lead the “First Psychiatry Revolution”. Among the greatest of them, we can mention Cornelio Agrippa, Paracelso and Johannes Weyer.

Although inextricably linked to their time, to them is recognized the merit of rediscovering the presence of a natural component among the causes of mental illnesses. This conception had been related exclusively to evil possessions for almost a millennium. Paracelsus (1491-1541), undoubtedly the most famous physician of his time, devoted himself profusely to the study of psychiatry. In his text "Von den Krankheiten so die Vernunfft Berauben" (1567) he describes and classifies mental illnesses in five main categories and then he focused on possible natural causes, taking the distances from both the religious conception proper of his time and the "humoral" Greek one. The most important of Paracelsus' achievements was the introduction of chemical treatments of mental illness. Although the use of substances was still mostly linked to the alchemical tradition, it represented the beginning of new concept of treatment.

17th and 18th Centuries

The seventeenth century was dominated by the social crisis. Epidemics, wars and economic crises produced severe consequences on social system, to which the absolutist regimes responded with the internment of the marginalized people. The “hôpital general” in France, “Zuchthaus” in Germany and “workhouse” in England were filled with beggars, orphans, prostitutes, homosexuals, heretics, criminals and mentally ill. At that time, mental illness was considered as delinquency and treated as such. When hospital facilities weren’t enough, prisons became the place dedicated to receiving the alienated, including psychiatric patients. Although it is difficult to classify the descriptions of these (alienated) patients referring to modern categories, in most cases the clinical pictures corresponded to dementia, psychosis, and cerebral consequences of alcoholism.

In concomitance to the internment (or imprisonment) of most severe psychiatric patients, considered socially unacceptable, the psychiatry of the seventeenth century almost completely loss its interest in psychosis to focused on neuroses. Exactly in this period, Sydenham (1621-1689) coined terms such as “hysteria” and “hypochondria”. He described this conditions as multiform, affirming that they lie on the border between physical and mental disorder, and that they can mimic a wide spectrum of medical conditions, which goes from migraine to "iliac passion" (chronic inflammation of the small intestine) and which would have benefited from therapies based on ferrous compounds, milky diet and horse riding.

Worthy of mention are also the works of the neurologist and anatomist Thomas Willis (1621-1675), who was the first to have considered hysteria as a mental pathology and not as related to uterus (“hysteria” derives from Greek “hystera”, which means uterus). If the seventeenth century was a century of crisis, the eighteenth was a period of revolutions. The most important was certainly the cultural and philosophical revolution that took the name of Enlightenment. The primacy of reason and scientific positivism characterized this period inevitably influenced also Psychiatry, so that it finally freed from the medieval concept of demonic possession and becomes an autonomous discipline. The trust towards mind capacities and in its healing abilities that characterized this historical period reflected at a social level in a philanthropic movement, which aimed to take care of the mentally ill patients (including psychotics).

During this historical period, G.E. Stahl (1660-1734), with his nosological theory, reintroduced the concept of “soul” in psychiatric discipline, which had been substantially based on a somatic orientation, starting from Hippocrates until that moment. According to his theory, mental illness represents soul’s reaction to harmful stimuli that compromise its equilibrium. In parallel to the somatic orientation (which was constantly evolving itself, thanks to the recent contributions of

anatomopathology and neurophysiology), the psychological orientation was about to blossom. However, the major contribution to the psychiatric revolution was given by the French school, in particular by Philippe Pinel (1745-1826) and his main student, Jean Etienne Dominique Esquirol.
Pinel's contribution to the development of psychiatry was enormous and eclectic. In particular, as a director of Salpetriere's and Bicetre's Psychiatric Hospital, he decided to release psychiatric patients from the chains they were obliged to wear in the psychiatric wards, this way laying the foundations (at least symbolic) for the re-evaluation of the psychiatric patient from the human point of view. Nevertheless, his contribution was not limited to philanthropy: he introduced the concept of heredity into mental illnesses, investigated the role of social institutions and lifestyle, physical factors (such as trauma) and alcoholism. The French psychiatrist, although rooted in the eighteenth century, pushed Psychiatry towards modernity.

Eight hundred

In the nineteenth century the heart of the debate and evolution of Psychiatry shifted from Enlightenment France to Germany. The first half of the '800 was characterized by the movement of thought that takes the name of Romanticism and that, precisely in contrast with the Enlightenment, marks the primacy of spirituality over rationality. In the psychiatric field this current of thought is structured in the so-called Psychiker (who considered mental illness as a pathology of the soul, with a solid moral connotation) as opposed to the Somatiker (supporters of a somatic genesis).
Alongside the ideological and theoretical debate on the nature of psychiatric pathology, an important work of institutional reorganization was carried out: modern care institutions were founded and asylum psychiatry was replaced by university psychiatry. Among the architects of this change we find Wilhelm Griesinger (1817-1868).
The Stuttgart doctor represented a turning point for Psychiatry, whose full autonomy he advocated as a medical discipline. He was a fervent supporter of the cerebral localization of all psychic pathologies. In "Die Pathologie und Therapie der psychischen Krankheiten" (1845) he wrote: "Psychiatric diseases are diseases of the brain" and again "Madness is only a complex of symptoms to be traced back to different abnormal states of the brain".
Several decades before Freud he hypothesized that most psychic activities were unconscious.
According to Griesinger, sensory perceptions constitute, at the cerebral level, abstract concepts, representations. These mental ill representations can be abnormal or false (delusions) and lead the subject to consequent abnormal behavior: a kind of "theory of psychic reflexes" that was the basis of the work of the German psychiatrist. According to Griesinger, the set of representations of a subject are structured in his ego. When the subject's ego is in a situation of equilibrium, he can be

free and self-determining. From the ego's imbalance arises, instead, the psychic pathology that in the most serious forms can lead to the shattering of the ego itself.

Griesinger's work was revolutionary, he made a synthesis of different disciplines, describing mental pathology from an anatomical, neurophysiological, psychological and clinical point of view.

Like the first, the second half of the nineteenth century was led by German Psychiatry, the works of K.Westphal (1833-1890), T. Meynert (1833-1893), B.K.Wernicke (1848-1905) were representative of the so-called "Psychiatry of the brain" whose basic idea was the close correlation between psychic pathology and cerebral anatomical alteration.

The second half of the '800, however, sees as protagonists two of the most famous names in the history of Psychiatry: Emil Kraepelin (1856-1926) and Eugen Bleuler (1857-1939), the two major representatives of the "clinical school" thanks to which the transition from the simple classification of symptoms to the evaluation of the pathology in a longitudinal sense, along its overall course, was realized.

The German psychiatrist Emil Kraepelin is considered the founder of modern biological psychiatry and psychiatric nosography, but he was also a pioneer in the field of psychopharmacology. One of the most famous Kraepelin's contributions for psychopathology was the distinction of two distinct clinical entities of psychosis, namely "Dementia Praecox" and "Manic Depression". If the first condition was associated with a progressive loss of cognitive functions, the second in contrast was considered as an episodic disorder. Even if in the recent years these conditions have been considered more as a continuum rather than completely separated, this observation is valid still today and represents the fundamental difference between schizophrenic psychosis and affective disorders (major depressive disorders and bipolar disorder).

The Swiss psychiatrist Paul Eugen Bleuler is considered one of the most important clinicians who contributed to define modern psychiatry. Bleluer is mainly known for having coined the term "schizophrenia". He argued that the "Dementia Praecox" described by Kraepelin was not necessarily associated with a dementia, pointing out that the splitting ("Spaltung") of psychic functions was the central feature of the disorder.

Although in the nineteenth century, the greatest scientific advances in the psychiatric field have German nationality, the work of the French Jean-Martin Charcot (1825-1893) cannot be forgotten. Director of Salpetrière for about 30 years, in addition to being considered the father of modern neurology he made important contributions in the study of hysteria and in the application of hypnosis techniques. His work will be used as the basis for the work of Freud in the first half of the '900.

The twentieth century and the contemporary era

Sigmund Freud (1856-1939) was one of the most famous names in the field of Psychiatry: the Austrian psychiatrist and neurologist, starting from the work of Charcot and Breuer on hysteria, devoted himself to the elaboration of a full-fledged scientific-philosophical theory based on the role of unconscious processes in the determination of human thought and behavior. In the clinical field, the application of these principles led to the birth of psychoanalysis, of which Freud is considered the father. The Austrian psychiatrist introduced (and disseminated with extreme effectiveness) a new therapeutic approach based on free mental associations, concepts such as drive, libido, lapsus, missed and unintentional acts, the interpretation of dreams. He placed psychosexual development at the center of his investigation and formalized the three intrapsychic instances of Ego, Id and Super-Ego. Freud's ideas were enormously popular, although there were critics, first of all Alfred Adler and Carl Gustav Jung. The greatest criticism directed at Freud is probably the excessive dilation of the concept of sexuality, the overestimation of the importance of childhood experiences and his extreme determinism. The work of the Austrian doctor has been partly surpassed over the last century with the advent of more modern "theories of mind", however the impact of his thought, even in popular culture, is undeniable.

The first half of the '900 was sadly marked by the application of psychiatric knowledge for political purposes. In Nazi Germany and later in the Soviet Union the concept of mental illness became an instrument of eugenic doctrines and political repression. The diagnosis of mental illness woefully became an instrument of the regime and the psychiatric patient became an enemy to be eliminated.

The end of the Second World War and the second half of the twentieth century marked a radical turning point in the psychiatric field: the advent of psychotropic drugs.

In 1951, chlorpromazine, the first antipsychotic medication, was synthetized in the laboratories of Rhône-Poiulenc by Paul Charpentier and in 1952 its role in psychiatry as sedative was first recognized by the physiologist Henri Laborit. At the end of the 1940s, the Australian physiologist John Cade published one of the first papers on the use of lithium in the treatment of bipolar disorder. Eventually, in the 1950s the clinical introduction of the first antidepressants occurred, namely iproniazid, an antitubercular compound and imipramine, the first tricyclic antidepressant.

Advances in the pharmacological field (alongside those in the psychotherapeutic field) provided new tools for the treatment of psychiatric patients. With the increase in the available molecules and with the advent of generations of new and more effective drugs, the conception of the psychiatric patient gradually changed, which from "alienated" returned, not without difficulty, to be considered

an integral part of society. This process had in Law 180 of 1978 (passed into history as the Basaglia Law) its maximum political and social expression. The Italian psychiatrist was a pioneer in the process of deinstitutionalization of the psychiatric patient, no longer destined for the asylum for life but reintegrated into the social fabric and treated primarily on an outpatient basis.

Parallel to the paradigm shift in the treatment of psychiatric patients and thanks to advances in the fields of genetics, pharmacology, instrumental investigation techniques, a new theoretical model for psychiatric pathology was finally developed: the biopsychosocial model.

Conceptualized in 1977 by Dr. George Engel, the biopsychosocial model is today the role model for mental health. It tries to explain mental disorders as the result of the complex interaction between biological correlates, psychological factors and the socio-cultural background.

To conclude, a consideration on the evolution of the conception of mental illness throughout history. Advances in the field of Psychiatry, more than in other medical disciplines, have been accompanied by a progressive change in the way of seeing the psychiatric patient. Over time, the mentally ill person has been considered cursed, possessed by the devil, has been considered and treated like a criminal, a social burden. In recent decades we are witnessing a progressive reintegration of these patients into the social tissue. However, the prejudice with respect to this condition is still strong in the popular imagination. The notion of mental illness is still too often compared to the concepts of social danger, unproductivity, and incurability that overall fall under the definition of stigma.

It is to be hoped that, like the great effort aimed at research in the field of Psychiatric, which has led to a real revolution in the diagnosis and treatment of mental pathology, we will also invest in the information and communication necessary to erase the social stigma that often, like the disease itself, is a source of suffering for the patient.

1.3. Clinical Interview

The psychiatric interview is the central element that guides the diagnosis and therapy of the patient suffering from mental pathology. The interview is an active, dynamic and multidimensional process of gathering information in which the actors establish a relationship not only of communication, but of trust.

The formal structure of the clinical interview will be described in the following paragraphs.

Stages of the interview

We can identify three main phases:

- *Initial or "exploration" stage*: It is the first contact with the patient and includes the presentation phase (by both parties) and the manifestation, by the interviewee, of the reasons that brought him to the interviewer's attention.
- *Intermediate stage:* it is the phase of the detailed interview, in which the professional will complete the collection of information.
- *Final stage:* it is the moment in which the information previously gathered is summarized, possibly completing it with additional questions. Finally, the treatment plan is explained and arranged.

Box 1: Setting the interview

- Duration of the interview: 30 - 90 minutes
- Environment: quiet, comfortable
- Language: accessible, non-technical, non-judgmental
- Participants: interviewee, interviewer, maximum 1-2 family members (or close acquaintances)

Initial stage:

The initial phase includes the formal identification of the patient with the collection of his personal data and first exposure of the problem. This is the foremost, delicate moment in which the doctor-patient relationship is established.

- Identification
  - Personal data: name, age, occupation, marital status, nationality, place of residence
  - Identification of any accompanying people
  - Acquisition of any documentation related to the patient's clinical history
- Chief complaint (CC): "What brings you here today?" The patient spontaneously describes his experience and what brought him to the interviewer's attention.
  This first approach allows information to be obtained on the patient's idea of his condition, on the path that brought him to the interviewer's attention and on the attitude towards the professional.

Intermediate stage

The intermediate part of the interview is the quantitatively most relevant. The professional reconstructs the patient's history, from birth up to the present. The information gathered in this phase falls into two broad categories:

- *The psychiatric history*: it consists of the detailed study, conducted with method, of what the patient has freely described in the exploratory phase of the interview. Furthermore, all the information necessary to precisely reconstruct the interviewee's personal history will be collected.
- *The Mental Status Examination (MSE)*: is the set of psychic phenomena observed by the interviewer.

> ***Box 2: The cone technique***
> During the interview it is often useful, in order to let the patient feel at ease, to begin with open questions and move gradually on to closed questions.

Psychiatric history

- Family history:
    - Description of the family of origin: information on the family members with particular attention to a possible history of psychiatric illness, reconstruction of the family tree (genogram).
      Many of the most frequent psychiatric diseases have a hereditary component and in the same way the response or tolerance to many drugs can have a genetic basis.
    - Description of the patient's current family unit: spouse, children, grandchildren.
      It provides information on the patient's life context and closest social relationships.

- Physiological history:
    - Reconstruction of the patient's personal history:
        - Youth: delivery, full-term or preterm, milestones of somatic and psychic development, childhood diseases, social relationships, temperament, schooling, family relationship.
          Events or conditions that occurred in childhood can have long-term consequences. Factors related to temperament can be identified already at a young age, as well as psychomotor deficits.

        - Adulthood: work activities, social and emotional relationships, sexual development, menstrual cycle, pregnancies, menopause, eating habits, hobbies and peculiar interests.
          Social relationships and work activity is an important reference parameter for evaluating the patient's functioning over time. Sexual habits, eating habits or hobbies complete the evaluation of the patient's lifestyle, whether physiological or pathological.

- Pathological Anamnesis:
    - Past medical history:
        - Organic: organic pathologies of which the patient has been or is suffering, taking specific therapies in the past or currently, surgery, previous hospitalizations, trauma or accidents, allergies.
          Any organic pathology can give manifestations comparable to the most common psychiatric conditions. Conversely, many of the most frequent psychiatric diseases can have physical expressions or consequences.
        - Psychiatric: reconstruction of the patient's psychiatric history, previous psychiatric symptoms, duration of the illness, times of remission or recovery, periods of remission, duration and dosage of the medication, previous hospital admissions and psychotherapy.
          A detailed psychiatric history significantly reduces errors in the diagnostic phase and in the choice of the therapeutic path, both in the present and in any future episodes.

- History of Current Disorder: Information about the condition that brought the patient to the interviewer's attention. Type of symptoms, chronology of manifestations, duration and intensity, impact on work and social functioning, changes in habits, medications prescribed. This is often the most challenging part of the interview in which the professional, with method and empathy, investigates the most central aspects of the patient's suffering or discomfort by carrying out an initial processing work that will lead to a diagnosis based on the criteria.

Mental status examination

The mental status examination (MSE) is a structured assessment of the patient's level of general behavior, speech, mood, perception, thought and cognitive (knowledge-related) function.

Table 1. Steps of the mental status examination

General Description	• General appearance, dress, sensory aids • Level of consciousness and arousal • Attention to the environment • Posture (standing and seated) • Gait • Movements of limbs, trunk, and face (spontaneous, resting, and after instruction) • General behavioural (including evidence of responses to internal stimuli) • Response to examiner (eye contact, cooperation, ability to focus on interview process) • Native or primary language
Language and Speech	• Comprehension (words, sentences, simple and complex commands, and concepts) • Output (spontaneity, rate, fluency, melody or prosody, volume, coherence, vocabulary, paraphasic errors, complexity of usage) • Repetition • Other aspects: 1. Object naming 2. Colour naming 3. Body part identification 4. Ideomotor praxis to command
Thought	• Form (coherence and connectedness) • Content 1. Ideational (preoccupations, overvalued ideas, delusions) 2. Perceptual (hallucinations)
Mood and Affect	• Internal mood state (spontaneous and elicited; sense of humour) • Future outlook • Suicidal ideas and plans

	• Demonstrated emotional status (congruence with mood)
Cognition	• Memory 1. Spontaneous (as evidenced during interview) 2. Tested (incidental, immediate repetition, delayed recall, cued recall, recognition; verbal, nonverbal; explicit, implicit) • Visuospatial skills • Constructional ability • Mathematics • Reading • Writing • Fine sensory function • Finger gnosis • Right–left orientation • Executive functions • Abstraction
Insight	• Self-appraisal and self-esteem • Understanding of current circumstances • Ability to describe personal, psychological, and physical status
Judgment	• Appraisal of major social relationships • Understanding of personal roles and responsibilities

Final stage

In the last phase of the interview, all the information collected is processed and used to complete the last three steps of the clinical interview. A systematic review is carried out on the information collected to allow a diagnosis based on criteria. It is not always possible to make a diagnosis after a single interview. In this case the professional can formulate a provisional diagnosis (or not formulate at all) and, in subsequent interviews, will collect the data necessary to complete the diagnostic process. At that point he will be able to provide information on the therapeutic path.

1- *Summary*: the interviewer gives a brief summary of the patient's history, describes the main problem, and discusses the biological, psychological and social factors that may play a role in the interviewee's condition.
2- *Formulation*: the medical interviewer can formulate a diagnosis (albeit provisional).

3- *Therapy*: in this phase the doctor describes the treatment plan identified on the basis of all the points described above and the possible pharmacological or non-pharmacological strategies. Instrumental or laboratory studies may be recommended (Box 3). The patient can also be referred to another professional (doctor, psychologist, social worker) if useful or necessary.

BOX 3: Additional investigations

In some cases it may be necessary to supplement the information gathered during the interview with further investigation. We mention the main ones:

- Physical parameters and vital signs: Blood pressure, Heart rate, Temperature, Weight, Height, BMI, waist circumference
- General physical examination and neurological physical examination
- Blood tests: full blood count, liver, thyroid and renal function
- Instrumental investigations: CT-scan, MRI, ECG, EEG
- Psychological assessment/ Psychometric tests

Suggested readings

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