

Schizophrenia Spectrum and Other Psychotic Disorders  
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## CASE 2.2

### **Increasingly Odd**

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Gregory Baker was a 20-year-old African American man who was brought to the emergency room (ER) by the campus police of the university from which he had been suspended several months earlier. The police had been called by a professor who reported that Mr. Baker had walked into his classroom shouting, "I am the Joker, and I am looking for Batman." When Mr. Baker refused to leave the class, the professor contacted security.

Although Mr. Baker had much academic success as a teenager, his behavior had become increasingly odd during the past year. He quit seeing his friends and spent most of his time lying in bed staring at the ceiling. He lived with several family members but rarely spoke to any of them. He had been suspended from college because of lack of attendance. His sister said that she had recurrently seen him mumbling quietly to himself and noted that he would sometimes, at night, stand on the roof of their home and wave his arms as if he were "conducting a symphony." He denied having any intention of jumping from the roof or having any thoughts of self-harm, but claimed that he felt liberated and in tune with the music when he was on the roof. Although his father and sister had tried to encourage him to see someone at the university's student health office, Mr. Baker had never seen a psychiatrist and had no prior hospitalizations.

During the prior several months, Mr. Baker had become increasingly preoccupied with a female friend, Anne, who lived down the street. While he insisted to his family that they were engaged, Anne told Mr. Baker's sister that they had hardly ever spoken and certainly were not dating. Mr. Baker's sister also reported that he had written many letters to Anne but never mailed them; instead, they just accumulated on his desk.

His family said that they had never known him to use illicit substances or alcohol, and his toxicology screen was negative. When asked about drug use, Mr. Baker appeared angry and did not answer.

On examination in the ER, Mr. Baker was a well-groomed young man who was generally uncooperative. He appeared constricted, guarded, inattentive, and preoccupied. He became enraged when the ER staff brought him dinner. He loudly insisted that all of the hospital's food was poisoned and that he would only drink a specific type of bottled water. He was noted to have paranoid, grandiose, and romantic delusions.

He appeared to be internally preoccupied, although he denied hallucinations. Mr. Baker reported feeling "bad" but denied depression and had no disturbance in his sleep or appetite. He was oriented and spoke articulately but refused formal cognitive testing. His insight and judgment were deemed to be poor.

Mr. Baker's grandmother had died in a state psychiatric hospital, where she had lived for 30 years. Her diagnosis was unknown. Mr. Baker's mother was reportedly "crazy." She had abandoned the family when Mr. Baker was young, and he was raised by his father and paternal grandmother.

Ultimately, Mr. Baker agreed to sign himself into the psychiatric unit, stating, "I don't mind staying here. Anne will probably be there, so I can spend my time with her."

## Diagnosis

- Schizophrenia, first episode, currently in acute episode

## Discussion

Mr. Baker's case involves an all-too familiar scenario in which a high-functioning young man undergoes a significant decline. In addition to having paranoid, grandiose, and romantic delusions, Mr. Baker appears to be responding to internal stimuli (i.e., auditory hallucinations) and demonstrating negative symptoms (lying in bed all day). These symptoms have persisted and intensified over the prior year. The history does not indicate medications, substances of abuse, or other medical or psychiatric disorders that could cause these symptoms. Therefore, he meets DSM-5 criteria for schizophrenia. Although a family history of psychiatric illness is not a requisite for his DSM-5 diagnosis, Mr. Baker's mother and grandmother appear to have also had major mental disorders.

Schizophrenia is, however, a heterogeneous disorder. For example, Mr. Baker's most prominent symptoms are delusions. Another person with schizophrenia might present most prominently with disorganization of speech and behavior and without any delusions. DSM-5 tries to address this heterogeneity by encouraging a dimensional viewpoint rather than a categorical one. In other words, instead of clarifying whether a patient has "paranoid" or "disorganized" schizophrenia, DSM-5 encourages an assessment of a variety of specifiers. One important specifier, the course specifier, requires a longitudinal assessment to determine whether this is a first episode or one of multiple episodes, and whether it is an acute episode, in partial remission, or in full remission.

DSM-5 also encourages specific ratings of symptoms. For example, is this schizophrenic episode accompanied by catatonia? On a 5-point scale (from 0 to 4), how severe is each of the five cardinal schizophrenia symptoms? DSM-5 also encourages an assessment of cognition, mania, and depression domains. For example, some of Mr. Baker's behaviors (e.g., interrupting a class to proclaim his identity as the Joker) may seem to be symptomatic of mania, but they are unaccompanied by disturbances in sleep, mood, or level of activity. Similarly, Mr. Baker said he felt "bad" but not depressed. These clinical observations likely distinguish Mr. Baker from other sub-categories of people with schizophrenia.

The schizophrenia diagnosis can be made without assessing these severity specifiers. Nevertheless, the use of dimensional ratings improves the ability to assess Mr. Baker for the presence of core symptoms of schizophrenia in a more individualized manner. The inclusion of dimensions that cut across diagnostic categories will facilitate the development of a differential diagnosis that includes bipolar disorder and schizoaffective disorder. These assessments may clarify Mr. Baker's functional prognosis in major life roles (e.g., living arrangement or occupational status). Finally, repeated dimensional assessments may facilitate a longitudinal understanding of Mr. Baker's symptomatology, development, and likely responses to treatment.

