Patients with a Manic Episode or Schizophrenia will sometimes engage in criminal activity, but it is episodic and accompanied by other manic or psychotic symptoms. Milo steadfastly denied any behavior suggesting either a mood or a psychotic disorder. Mentally retarded patients may break the law, either because they do not realize that it is wrong or because they have been influenced by others. Although Milo did not do especially well in school, there is no indication that he was held back in school or had specific learning disabilities.

Substance-related disorders are important in the differential diagnosis, because many addicted patients will do nearly anything to obtain money for their substance of choice. Milo had used cocaine and amphetamines, but (according to him) only briefly. Most of his antisocial behaviors were not associated with drug use. Patients with impulse-control disorders will engage in illegal activities, but this is confined to the context of Pathological Gambling, Kleptomania, or Pyromania. Patients with the eating disorder Bulimia Nervosa sometimes shoplift, but Milo had no evidence of bulimic episodes. Of course, many of these disorders (as well as anxiety disorders) can be encountered as associated diagnoses in antisocial patients.

Career criminals whose antisocial behavior is confined to their "professional lives" may not fulfill all of the criteria for Antisocial Personality Disorder. They may instead be diagnosed as having Adult Antisocial Behavior, which is recorded as a V code (V71.01) on Axis I. It constitutes part of the differential diagnosis of the personality disorder.

Milo’s complete diagnosis would be as follows:

<table>
<thead>
<tr>
<th>Axis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>V71.09</td>
<td>No diagnosis</td>
</tr>
<tr>
<td>Axis II</td>
<td>301.7</td>
<td>Antisocial Personality Disorder</td>
</tr>
<tr>
<td>Axis III</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Axis IV</td>
<td></td>
<td>Arrest for ATM fraud</td>
</tr>
<tr>
<td>Axis V</td>
<td>GAF = 35</td>
<td>(current)</td>
</tr>
</tbody>
</table>

301.83 Borderline Personality Disorder

Patients with Borderline Personality Disorder sustain a pattern of instability throughout their adult lives. They often appear to be in a crisis of mood, behavior, or interpersonal relationships. Many feel empty and bored; they attach themselves strongly to others, then become intensely angry or hostile when they believe that they are being ignored or mistreated by those they depend on. They may impulsively try to harm or mutilate themselves; these actions are expressions of anger, cries for help, or attempts to numb themselves to their emotional pain. Although borderline patients may experience brief psychotic episodes, these episodes resolve so quickly that they are seldom confused with psychoses like Schizophrenia. Intense and rapid mood swings, impulsivity, and
unstable interpersonal relationships make it difficult for borderline patients to achieve their full potential socially, at work, or in school.

Borderline Personality Disorder runs in families. These people are truly miserable and in some cases (up to 10%) complete suicide.

The concept of Borderline Personality Disorder was devised about the middle of the 20th century. These patients were originally (and sometimes still are) said to be on the borderline between neurosis and psychosis. The existence of this borderline is disputed by many clinicians. As the concept has evolved into a personality disorder, it has achieved remarkable popularity, perhaps because so many patients can be shoehorned into its capacious definition.

Although 1-2% of the general population may legitimately qualify for the diagnosis of Borderline Personality Disorder, it is probably applied to a far greater proportion of the patients who seek mental health care. It may still be the most overdiagnosed condition in DSM-IV. Many of these patients have Axis I disorders that are more readily treatable; these include Major Depressive Disorder, Somatization Disorder, and substance-related disorders.

**Criteria for Borderline Personality Disorder**

- Beginning by early adult life, the patient has unstable impulse control, interpersonal relationships, moods, and self-image. These persistent or recurrent qualities are present in a variety of situations and shown by at least five of the following:
  - Frantic attempts to prevent abandonment, whether this is real or imagined (don’t include self-injurious or suicidal behaviors, covered below)
  - Unstable relationships that alternate between idealization and devaluation
  - Identity disturbance (severely unstable self-image or sense of self)
  - Potentially self-damaging impulsiveness in at least two areas, such as binge eating, reckless driving, sex, spending, substance use (don’t include suicidal or self-mutilating behaviors)
  - Self-mutilation or suicide thoughts, threats, or other behavior
  - Severe reactivity of mood leading to marked instability (mood swings of intense anxiety, depression, or irritability, lasting a few hours to a few days)
Josephine Armitage

"I'm cutting myself!" The voice on the telephone was high-pitched and quavering. "I'm cutting myself right now! Ow! There, I've started." The voice howled with pain and rage.

Twenty minutes later, the clinician had Josephine's address and her promise that she would come in to the emergency room right away. Two hours later, her left forearm swathed in bandages, Josephine Armitage was sitting in an office in the mental health department. Criss-crossing scars furrowed her right arm from wrist to elbow. She was 33, a bit overweight, and chewing gum.

"I feel a lot better," she said with a smile. "I really think you saved my life."

The clinician glanced at her nonswathed arm. "This isn't the first time, is it?"

"I should think that would be pretty obvious. Are you going to be terminally dense, just like my last shrink?" She scowled and turned 90 degrees to look at the wall. "Sheesh!"

Her previous therapist had seen Josephine for a reduced fee, but had been unable to give her more time when she requested it. She had responded by letting the air out of all four tires of the therapist's new BMW.

Her current trouble was with her boyfriend. One of her girlfriends had been "pretty sure" James had been out with another woman two nights ago. Yesterday morning, Josephine had called in sick to work and staked out James's workplace so she could confront him. He hadn't appeared, so last evening she had banged on the door of his apartment until neighbors threatened to call the police. Before leaving, she'd kicked a hole in the wall beside James's door. Then she got drunk and drove up and down the main drag, trying to pick up a date.

"Sounds dangerous," observed the clinician.

"I was looking for Mr. Goodbar, but no one turned up. I decided I'd have to cut myself again. It always seems to help." Josephine's anger had once again evaporated, and she had turned away from the wall. "Life's a bitch, and then you die."

"When you cut yourself, do you ever really intend to kill yourself?"

"Well, let's see." She chewed her gum thoughtfully. "I get so angry and depressed, I just don't care what happens. My last shrink said all my life I've felt like a shell of a person, and I guess that's right. It feels like there's no one living inside, so I might just as well pour out the blood and finish the job."

✓ Chronic feelings of emptiness
✓ Anger that is out of control or inappropriate and intense (demonstrated by frequent temper displays, repeated physical fights, or feeling constantly angry)
✓ Brief paranoid ideas or severe dissociative symptoms related to stress