PSYCHOANALYTIC PSYCHOLOGY *13*(4), 513–530

Impact of Therapist Vacations on Inpatients With Borderline Personality Disorder

Helen Stein
The Menninger Clinic, Topeka, Kansas

James E. Corter
Teachers College, Columbia University

James Hull
New York Hospital–Westchester Division

For patients with borderline personality disorder, separations from significant figures in their lives, including therapists, are thought to be particularly painful. According to clinical wisdom, these patients manifest aggressive and self-destructive behavior around the time of separation. However, virtually no empirical studies have been conducted to test these beliefs. In this study, the behaviors of a sample of 41 inpatients with borderline personality disorder were recorded and analyzed to determine what, if any, effect their therapists' vacations had on target behaviors, including acting up, self-destructive behaviors, and somatic complaints. Results indicated significant variations in the rates of acting up and somatic complaints before, during, and after therapist vacations. No significant variations were observed in the rate of self-destructive behaviors, failing to support the commonly held belief that self-destructive acts in borderline patients may be especially prevalent around therapist vacations. Possible reasons for the pattern of findings are discussed, as are the implications for clinical practice.

Patients with borderline personality disorder are believed to react strongly to separations from significant figures in their lives, including therapists. According

Requests for reprints should be sent to Helen Stein, PhD, Menninger Clinic, P.O. Box 829, Topeka, KS 66601.

to the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., Rev. [*DSM–III–R*]; American Psychiatric Association, 1987), "frantic efforts to avoid real or imagined abandonment" (p. 347) is one of eight diagnostic criteria for the disorder. Clinical case reports describe patients with borderline personality disorder as particularly prone to self-destructive action at the time of treatment interruptions (e.g., Adler, 1989; Doctors, 1981). On an informal level, lore about borderline reactions to separation is often passed down from teachers and supervisors to trainees, with experienced clinicians describing patients' reactions to therapist vacations the way combat veterans describe a battle. These war stories compel fascination, but they also transmit anxious expectations to trainees about the treatment of borderlines and about the consequences of taking vacations.

However, empirical studies of the effects of treatment interruptions on therapy patients are rare indeed. Bush (1989) conducted a qualitative descriptive study using semistructured interviews of the impact of the summer closing of a training clinic on therapists-in-training. Barchat's (1988) dissertation examined psychotherapy patients' internal representations of the therapist and of the psychotherapeutic relationship and their affective responses to the traditional August vacation as a function of time in treatment. To our knowledge, only one empirical study (Handley & Swenson, 1989) examined separation reactions in a patient with borderline personality disorder. This observational study of a single borderline inpatient described her enactment of separation conflicts within psychotherapy sessions (in dreams and in the transference) and in the inpatient milieu, noting a significant aggressive reaction at reunion.

Because patients with borderline personality disorder present significant management difficulties in inpatient and outpatient settings, it is important to investigate empirically whether separation events actually trigger problematic behaviors in these patients. Clearly, if extreme separation reactions are to be understood and worked through rather than sensationalized, and if appropriate interventions are to be designed, it is necessary to learn what behaviors actually occur, when they occur in relation to a treatment interruption, and what theoretical concepts might explain their occurrence.

THEORETICAL BACKGROUND

Several schools of theory and research contributed to the understanding of separation reactions. Bowlby (1973) first drew attention to similarities between ethologists' observations of mammalian young in the course of maternal separation and the reactions of young children separated from their mothers for days or weeks at a time. Bowlby suggested that early experiences with separation and attachment created sets of expectations, or internal working models, of self, other, and the environment that served to guide perceptions and expectations in future relation-

ships. Bowlby (1979) believed that early experiences of separation and loss formed the roots of certain kinds of psychopathology observed in adulthood. Thus, a patient with a history of early loss might well respond to separation with displaced anger, suicidal gestures, and conversion and hypochondriacal symptoms. In this way, working models were often enacted in the transference during the course of analysis, in spite of evidence that contradicted the patient's assumptions (Bowlby, 1973).

Bowlby's (1979) view that attachment styles are established early and persist throughout the life span was supported by later attachment research. Predominant attachment styles (secure, anxious–avoidant, anxious–resistant, and anxious–disorganized) were established, principally through the observation of reunion reactions of very young children exposed to Ainsworth's Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978; Main, Kaplan, & Cassidy, 1985). Particular attachment styles were thought to develop in response to the caretaking style of parents, to persist throughout childhood, and to be transmitted across generations (Ainsworth, 1989). Furthermore, attachment styles reflected in a particular set of behaviors in individuals at 12 months of age were correlated with cognitive and affective characteristics observed in the later periods of latency, adolescence, and adulthood. These traits included defensive functioning, affect regulation, coherence of early memories, fluency of discourse, and direction of attention (Kobak & Sceery, 1988; Main & Hesse, 1990; Spieker & Booth, 1988).

According to ethological and biopsychological studies of reactions of young mammals to separation and of adult humans to loss, there is a drive-related component to separation reactions. It is thought that the mother's presence ordinarily maintains an optimal level of stimulation and arousal modulation that is most adaptive for survival. According to Field (1985), contact with important companions throughout the life span maintains psychobiological synchrony. Taylor (1987) suggested that agitation at the time of separation (or just before, in the case of young children) serves as a form of protest, an active effort to get the mother to return. A depressed reaction observed across species during separation, including predominance of parasympathetic activity, immobility, quiescence, and anabolic changes in metabolism (Engel & Schmale, 1972), probably results from reduced stimulation and arousal modulation occasioned by the mother's absence. This reaction conserves internal resources until her return. During prolonged separation, resistance to disease seems to fall; in humans, it may be accompanied by emotions of helplessness and hopelessness. Individual differences in sensitivity to social separation were observed across species (Engel & Schmale, 1972; McKinney, 1985; Reite & Capitanio, 1985). Reite and Capitanio hypothesized that borderline disorders, in which patients demonstrate heightened sensitivity to separation and loss, might represent some type of hyperactivity of brain structures underlying attachment behavioral systems.

Two other points of view regarding the possible origins of severe separation distress observed in patients with borderline personality disorder deserve brief consideration here. Developmental object relations theorists consider the development of libidinal object constancy before age 3 crucial for the mastery of separation. When events during this period go awry, pathology in object relations and in psychological functioning reportedly develops. Various syndromes of mental illness have sometimes been located along a developmental continuum, with particular diagnoses corresponding to different degrees of self–object differentiation (e.g., Coonerty, 1986). According to Adler and Buie (1979); Diamond, Kaslow, Coonerty, and Blatt (1990); Kernberg (1975); Mahler (1972); Rinsley (1986); Searles (1986); and others, unresolved difficulties during the separation-individuation process, most likely during the rapprochement subphase, result in the symptom picture associated with borderline personality disorder.

Although object relations theory connects separation distress in borderline personality disorder to failed negotiation of a relatively brief period of psychosocial development, Herman (1992) drew connections between borderline symptoms and a childhood history of sexual and physical abuse. She questioned whether the diagnostic category *complex posttraumatic stress disorder* might be a more accurate delineation of the symptoms of many patients with borderline personality disorder. According to Herman, abusive relationships hinder formation of inner representations of a safe, consistent caretaker. Prone to disruption of normal bodily states due to chronic hyperarousal, these individuals do not develop the capacity for emotional self-regulation. Consequently, they are highly dependent on external sources of comfort and on activities such as self-cutting and substance abuse to regulate internal states. A number of studies documented significant histories of sexual and physical abuse, neglect, and early loss in patients with borderline personality disorder (Gallagher, Hurt, Flye, & Stone, 1992; Gunderson & Zanarini, 1989; Herman, 1992; Stone, 1990; Zanarini, Gunderson, Marino, & Schwartz, 1989).

These theoretical descriptions of the etiology of borderline disorder are not necessarily inconsistent with each other. It is certainly possible that an abused child would be less likely to negotiate stages of the separation-individuation process successfully. However, abuse is often not limited to a particular developmental period. Abuse and trauma can begin before or long after rapprochement, compromising other development periods and tasks through the distortion of important relationships and the disruption of trust. This study did not aim primarily to evaluate or distinguish between these theories. Rather, these accounts are offered to explain why problems with separation are thought central to the development of borderline personality disorder, to illuminate the types of behaviors that might be used to measure separation distress in these patients, and to consider possible links between childhood abuse and borderline personality disorder.

THIS STUDY

The purpose of this study was to attempt to corroborate beliefs about separation reactions of patients with borderline personality disorder by observing the effects of treatment interruptions on certain relevant behaviors in a sample of inpatients with borderline personality disorder. Therapist vacations were chosen as one type of separation experience amenable to study. Three kinds of behaviors were measured: acting up, or disruptive behavior (as measured by three specific indexes: behavioral acting up, verbal acting up, and agitation); self-destructive behavior (as measured by two indexes: self-destructive actions and verbalizations); and somatic complaints. These particular behaviors were chosen for study because the literature suggested they were characteristic of patients with borderline personality disorder and they were observed to be associated with separation events for humans or other animals. Mean daily frequencies of the target behaviors were compared during four separation time periods surrounding the vacations: anticipation of separation (3 days before the start of the vacation), the separation itself (the duration of the vacation), reunion (3 days following the end of the separation), and baseline (all other times). Thus, behaviors of this patient group were not compared to those of another diagnostic group; rather, behaviors around vacations were compared to baseline rates. The main research question of this study was, Do average daily rates of the three target behaviors (acting up, self-destructive behaviors, and somatic complaints) change significantly before, during, or after a therapist vacation?

METHOD

Participants

The participants were 41 female psychiatric patients who were hospitalized on a long-term inpatient unit for severe character pathology. A diagnosis of borderline personality disorder was established by administration of the Structured Clinical Interview for *DSM–III* (SCID–II; Spitzer & Williams, 1985), given to each patient on the unit shortly after admission. Only those patients meeting the SCID–II criteria were included in the study. Participants ranged in age from 14 to 45 years, with a mean age of 25.46 years. The length of stay on the unit for participants ranged from 76 to 648 days, with an average length of stay of 403 days. A total of 96 vacation separations was studied, ranging in length from 7 to 18 days. Therapist vacations of less than 1 week were not designated as vacation separations and were excluded from the data. Individual participants experienced from one to five separations; the mean number of therapist separations per participant was 2.34. All participants were engaged in multiple treatment modalities during their hospital stay, including

psychoanalytic psychotherapy three times per week; family, group, and milieu treatment; and pharmacotherapy, when indicated.

Childhood experiences of separation, loss, and trauma. To examine the possible connection between childhood trauma and abuse and borderline personality disorder, information about participants' early histories was collected. To do this, Helen Stein reviewed discharge summaries and case conference protocols that had been written about each participant by her therapist. The following categories of events were abstracted from these records: (a) early separations and losses, including adoption, death of a parent, serious illness of the participant requiring hospitalization, separation or divorce of parents, abandonment by a parent; (b) history of reported physical or sexual abuse or assault (however, emotional and verbal abuse were not recorded); and (c) other traumatic events or serious problems reported as occurring within the family, such as parents with substance abuse histories and serious illness of self or family members. The majority of patient charts contained reports of significant separations or losses (25; 61%), physical or sexual abuse (25; 61%), or other significant family difficulty (29; 71%) including serious illness, alcoholism, and family violence.

Measures

Target patient behaviors. The nursing staff maintained a staff communication log on the unit in order to transmit information about patient behaviors and to facilitate behaviorally consistent staff responses. In order to collect data on patient behaviors during the 29-month study period, entries relevant to the participants and to the behaviors under consideration were extracted from the log and coded. The coding system was initially developed by Hull (Hull, Okie, Gibbons, & Carpenter, 1992). Satisfactory item reliability was demonstrated with this system ($\alpha > .85$ for all scales). The system was expanded and modified for this study to include the following measures:

1. Behavioral acting up (BAU): Violations of unit rules, refusal to comply with reasonable staff demands including routine medical procedures, physical aggression in which the patient's actions appeared to cause or attempt to cause damage to others or to property rather than to self, socially unacceptable or regressed physical behavior, attempts to leave the hospital against medical advice.
2. Verbal acting up (VAU): Socially disapproved verbal behaviors, such as screaming and yelling, cursing someone directly (as opposed to using curse words), making threats or accusations that do not involve self-harm, threatening, or expressing an impulse to act up (see BAU).

3. Agitation (AGI): Obvious physical (behavioral) manifestations of anxiety. Staff members' entries that describe sending a patient to the Quiet Room or administering medication for "agitation" were not coded unless agitated behavior was also described.

4. Self-destructive action (SDA): Accidents and actions that result in self-injury; refusal to comply with medical procedures or self-care so that physical self-harm could result.

5. Self-destructive verbalization (SDV): Threat or expression of the desire or impulse to commit suicide or to inflict self-injury.

6. Somatic complaints (SOM): Participants' complaints of physical distress or illness.

Finally, two summary measures were created. The first combined BAU, VAU, and AGI to create a summary measure representing total acting-up behavior (TAU). The second summary measure combined SDA and SDV into one measure of overall self-destructive behavior (SDB).

Because the target behaviors were coded as frequencies (i.e., from 0 to 10 or more instances of each target behavior in a given day), reliability was assessed by Pearson product–moment correlations. Two judges, Helen Stein and a graduate student, coded 3 months of records. At the time that the communication logs were coded, neither judge was aware of the dates of the therapists' vacations. The interrater correlations for each variable were as follows: BAU, $r(39) = .94$, $p < .01$; VAU, $r(39) = .89$, $p < .01$; SDA, $r(39) = .75$, $p < .01$; SDV, $r(39) = .90$, $p < .01$; SOM, $r(39) = .97$, $p < .01$; AGI, $r(39) = .95$, $p < .01$. Following this reliability check, Helen Stein coded the remaining observations.

Treatment chronologies. Dates of stay on the unit and dates of therapist vacations were extracted from patients' charts. When vacation dates could not be clearly established by chart review, other sources of information (e.g., contacting the therapist directly) were used. If vacation dates could not be verified by a combination of these methods, the period in question was not coded and was not included in the study. Six unusual or unexpected separations were excluded from the data: absences due to the therapist's illness, family death, and transfer of a patient to a general hospital for major surgery. It was assumed that these separations differed from planned vacations in basic ways and would activate different dynamics.

RESULTS

Compilation of Behavioral Data

Data on each target behavior (e.g., SOM) were collapsed into four numeric summary scores for each patient. These four summary scores were the patient's

mean daily rate of the behavior across the four separation time periods: baseline, anticipation, separation, and reunion. Mean daily rate of a behavior (e.g., SOM) for a particular period (e.g., baseline) was calculated as the total number of somatic complaints seen during all baseline days for that patient (whether or not several of the same incidents occurred on the same day), divided by the total number of baseline days for the patient. Table 1 lists the means and standard deviations of all dependent variables by the four separation time periods.

The main research question of this study was, Do average daily rates of the summary variables—TAU, SDB, and SOM—vary significantly by separation time period? To answer this question, a repeated measures analysis of variance (ANOVA) was performed for each summary variable, with separation time period serving as the independent variable. Data from all 41 participants were used in this analysis. Because the data violated the assumptions of compound symmetry of the variance–covariance matrix, as shown by the results of Mauchly sphericity tests, Huynh–Feldt Epsilon correction factors were used in assessing significance of the tests of the Separation Time Period factor (Kirk, 1982).

Acting-Up Behavior

Figure 1 shows the pattern of means across periods for the TAU variable and its three component measures: BAU, VAU, and AGI.

Daily frequencies of TAU differed significantly by separation time period, $F(3, 40) = 4.19, p < .05$, with a Huynh–Feldt Epsilon correction factor of .44. The pattern

TABLE 1
Means and Standard Deviations of Target Patient Behaviors (Summary Variables and Component Behaviors) by Time Period

	Baseline		*Anticipation*		*Separation*		*Reunion*	
Behavior	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
TAU	.243	.184	.207	.255	.195	.238	.429	.727
BAU	.147	.122	.125	.179	.129	.213	.292	.617
VAU	.075	.072	.054	.144	.048	.060	.102	.155
AGI	.021	.026	.028	.078	.018	.037	.035	.099
SDB	.156	.100	.164	.235	.153	.176	.110	.178
SDA	.038	.039	.039	.110	.048	.088	.051	.098
SDV	.118	.084	.125	.215	.105	.124	.060	.143
SOM	.195	.179	.074	.115	.217	.259	.182	.330

Note. AGI = agitation; BAU = behavioral acting up; SDA = self-destructive action; SDB = overall self-destructive behavior; SDU = self-destructive verbalization; SOM = somatic complaints; TAU = total acting up; VAU = verbal acting up.

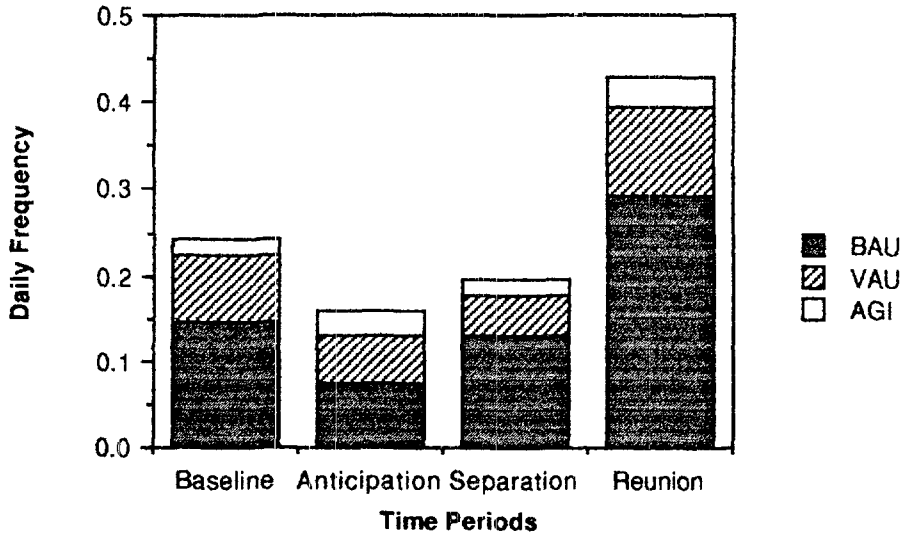

FIGURE 1 Histogram of daily frequency of TAU and its component measures over four time periods.

of means in Figure 1 reveals the nature of differences among separation time periods in terms of acting-up behaviors. Compared to baseline rates, participants showed less acting up during anticipation and separation periods, followed by a dramatic rebound of such behaviors at reunion to a level far exceeding baseline values. The reliability of this finding is underscored by the observation that this general pattern holds for both of the component acting-up measures (BAU and VAU). Rates of AGI also show a similar pattern, with the rate remaining relatively stable but showing a slight elevation at anticipation and a larger increase at reunion.

Self-Destructive Behavior

Rates of SDB are shown in Figure 2, along with the rates for the two component measures: SDA and SDV.

Results of the test of significance of the Separation Time Period factor were not significant, $F(3, 40) = .85$, $p > .05$, with a Huynh–Feldt Epsilon correction factor of .81. Thus, the apparent pattern of changes in rates of SDB across separation time periods cannot be assumed to reflect reliable differences, although it is interesting to note that the pattern resembles that for AGI.

Somatic Complaints

The pattern of rates of SOM across separation time periods is shown in Figure 3.

Daily frequencies of SOM do vary significantly by separation time period, $F(3, 40) = 3.97$, $p < .05$, with Huynh–Feldt Epsilon correction of .86. Inspection of the pattern of means shown in Figure 3 indicates that SOM decreased markedly during the anticipation period, compared to baseline. Rates for separation and reunion periods did not differ markedly from the baseline rate.

Controlling for Day-of-Week Effects

One possible problem in interpreting these results was the confounding of separation time period (anticipation, separation, etc.) with another potentially significant factor: the day of the week on which an observation was recorded. Investigation of this possibility revealed that specific days of the week were differentially distributed throughout the four separation time periods. Vacation times were relatively heavily loaded with Saturdays and Sundays because vacations typically began on a Saturday and ended on a Sunday. For the same reason, anticipation and reunion periods contained virtually all weekdays. For example, of 285 anticipation days and 285

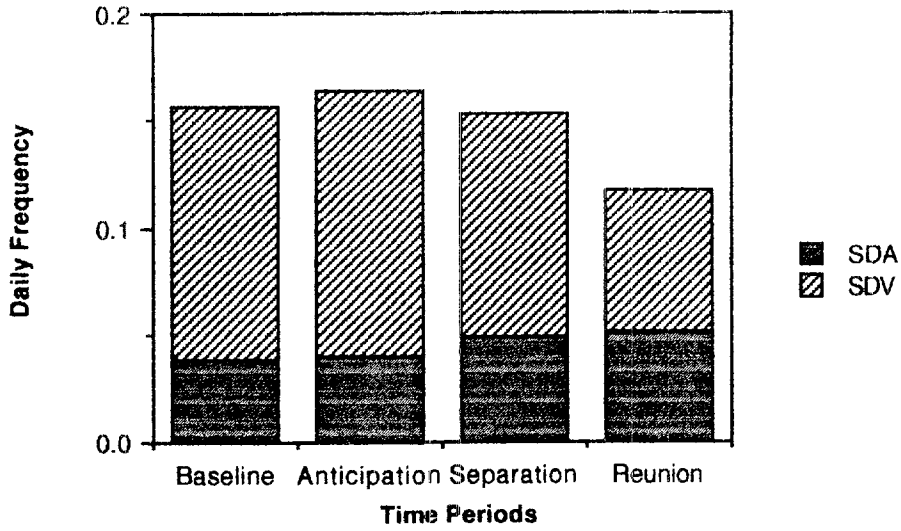

FIGURE 2 Histogram of daily frequency of SDB and its component measures over four time periods.

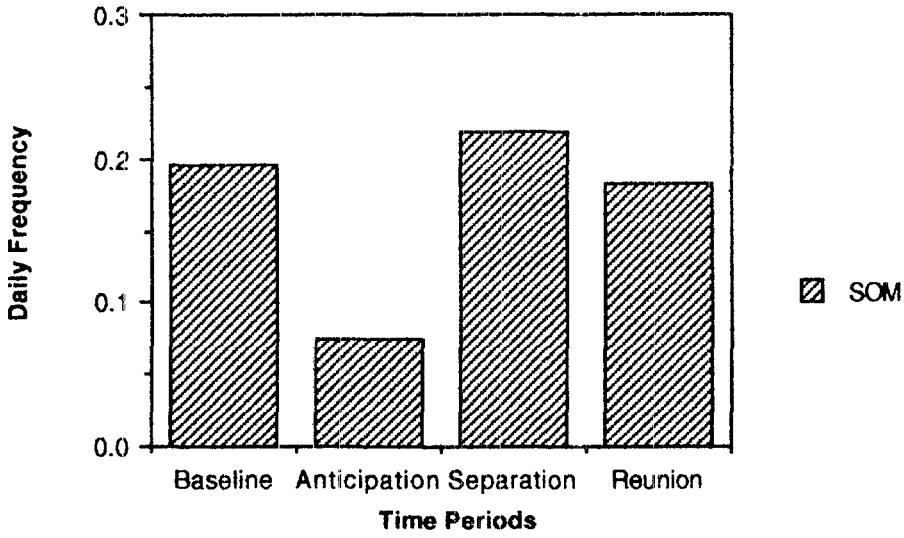

FIGURE 3 Histogram of daily frequency of SOM over four time periods.

reunion days, 98.5% in each case were weekdays. In contrast, of 1,035 separation days, 60% were weekdays. A cross-tabulation of the frequency of each day of the week within the four separation time periods was performed. The association between day-of-week and separation time period was statistically significant: $\chi^2(18, N = 41) = 560.04, p < .00001$.

This confounding is worrisome because weekend days and weekdays differ in important ways that could affect rates of target behaviors. For example, on weekends there are fewer official activities; patients generally have more contact with family and other visitors; some patients are away on passes, whereas others stay on the unit all weekend; therapists and other nonnursing professional staff are usually absent; and fewer staff are on duty to monitor and record patient behaviors. Indeed, a series of ANOVAs testing for differences in target behaviors using day-of-week as the independent variable found that there were marginally significant differences in the rate of TAU among days of the week, $F(6, 40) = 2.07$, $.10 > p > .05$, with Huynh–Feldt Epsilon correction of .66, although the rates did not seem to differ significantly for the other target behaviors. This is problematic because it means that at least part of the effect of separation time period on the target behaviors may be due to day-of-week rather than separation time period.

Examination of the pattern of these means by day-of-week seemed to indicate that most of the differences in reported rates of target behaviors occurred because the mean rates for weekend days (Saturday and Sunday) differed markedly from

those reported for weekdays. In order to control for the confounding of separation time period with the important weekend–weekday distinction, another series of repeated measures ANOVAs were performed using data from weekdays only. To check if this constituted an effective control for day-of-week effects, ANOVAs were conducted on the summary variables (TAU, SDB, and SOM) using day-of-week as the independent variable (but with only five levels, corresponding to Monday–Friday, instead of seven levels). In these weekday-only analyses, no significant differences among days of the week were found for any of the three summary variables, indicating that elimination of the weekend data effectively controlled for day-of-week differences for these target variables. The results were as follows: For TAU, $F(4, 160) = 1.01$, $p > .05$, with a Huynh–Feldt Epsilon correction of .79; for SDB, $F(4, 160) = .46$, $p > .05$, with a Huynh–Feldt Epsilon correction of .79; for SOM, $F(4, 160) = 1.36$, $p > .05$, with a Huynh–Feldt Epsilon correction of .80. Accordingly, ANOVAs testing for differences in the target behaviors (TAU, SDB, and SOM) across separation time periods were repeated, using these weekdays-only data.

In general, the patterns of means for the target behaviors closely resembled the patterns based on all days, but the significance levels were reduced somewhat. Daily rates of TAU differed by separation time period to a marginally significant degree, $F(3, 40) = 3.37$, $.10 > p > .05$, with a Huynh–Feldt Epsilon correction of .44. Daily rates of SDB did not vary significantly by separation time period, $F(3, 40) = 1.16$, $p > .05$, with a Huynh–Feldt Epsilon correction of .82. SOM did differ significantly by separation time period, $F(3, 40) = 3.71$, $p < .05$, with a Huynh–Feldt Epsilon correction of .80. Thus, when day-of-week effects were controlled in the manner described, basically the same pattern of results was obtained as was found in the original analyses. However, the significance level of the differences was reduced somewhat, probably due to a decrease in power associated with eliminating approximately 29% of the data.

Exploratory analyses were conducted in which the sample was divided in terms of a number of dimensions, including level of object relations, as measured by two different object relations scales (Blatt, Brenneis, Schimek, & Glick, 1976; Cooner ty, 1986): length of therapist vacation and point in treatment when the separation occurred. These analyses did not yield significant differences in patterns of separation behavior.

DISCUSSION AND CONCLUSIONS

This study investigated the behavioral reactions of a sample of patients with borderline personality disorder to their therapists' vacations. Acting-up behaviors varied significantly across separation time periods, largely due to an increase at reunion. This result confirms Handley and Swenson's (1989) description of aggressive reunion behavior occurring in a single borderline inpatient.

An aggressive reunion response is reminiscent of the reunion responses described as typical of insecurely attached infants. For example, an anxious–avoidant 12-month-old child often displaces anger toward objects or people other than mother. An anxious–resistant infant displays alternately hostile and clingy behavior (Ainsworth et al., 1978), whereas an anxious–disorganized 6-year-old child may treat the parent in a punitive, caretaking, or overly sexualized manner after a brief separation (Main & Hesse, 1990). There may be a special link between anxious–disorganized attachment and borderline pathology. Anxious–disorganized attachment is disproportionately represented in samples of maltreated infants (Carlson, Cicchetti, Barnett, & Braunwald, 1989); their mothers, furthermore, are more likely to be depressed (Belsky & Nezworski, 1988) or to have suffered unresolved traumas including early losses, sexual and physical abuse, and recent traumas (Main et al., 1985; Main & Hesse, 1990). Borderlines, too, have been increasingly recognized as being likely to have suffered abuse as children, as mentioned previously. Overall, patient histories reviewed in this study corroborate previous findings that histories of abuse and trauma are typical of patients with borderline personality disorder.

Aggression at reunion can be explained from an object relations perspective. If the patient experiences the therapist's vacation as an abandonment because of the reactivation of past experiences in the transference, reunion provides an opportunity to express the upset directly to the therapist and, perhaps, to extract vengeance. At reunion, too, the participants may have felt safe to express the aggressive feelings engendered by the separation, knowing the therapist would be able to contain, understand, and perhaps modulate or regulate the painful feelings. If patients with borderline personality disorder struggle with issues of distance and closeness, as suggested by Horwitz (1985), Mahler (1972), Searles (1986), and others, reunion may provoke aggression as a momentarily helpful defense. Thus, as the patient struggles with feelings of anxiety, dependence, and fears of rejection and loss aroused by the separation, he or she may use aggression to distance from these affects and feel more autonomous.

The results included some unexpected findings. In contrast to young children, who typically become agitated around the time of separation, this sample of patients did not experience a significant increase in acting up at anticipation. Possibly the lack of protest was due to the difficulties patients with borderline personality disorder seem to have anticipating, fantasizing, and planning. Hartocollis (1977) noted that patients with borderline personality disorder seem to experience affect only in the here-and-now, with little ability to integrate past experience or forecast future events.

Furthermore, although quiescence is a typical response of human and mammalian young during separation, these participants did not appreciably decrease their level of acting up during the therapist's absence. Of course, most aspects of each participant's world remained intact during the therapist's vacation, including other therapy modalities and one-to-one contact with several other staff members and

with peers on the unit, all of whom were aware of the participant's situation. Perhaps these other relationships and treatment modalities provided containment for the patient during separation, as well as a continuing audience for acting-up behaviors.

Studies of bereavement in adults and separation in human and mammalian young have described initial protest at the time of separation or loss, followed by depressed physiological functioning and, often, increased vulnerability to illness. The participants in this study showed a different pattern. SOM were relatively stable at baseline, separation, and reunion, but fell markedly at anticipation. Separations and losses span a wide continuum, and it is likely that events at the traumatic end, such as death of a parent, activate different mechanisms than do events at the milder end, such as the vacation of a therapist. It is possible that physiological functioning did not deteriorate during the separations studied because vacations were rarely long and, as just described, patients' routines and other relationships were undisrupted. In fact, studies linking bereavement and decreased immunity have been criticized for not taking into account all the changes that might accompany the death of a close friend or relative that could affect health status (Geiser, 1989). However, the drop in SOM at anticipation seems curious. Possibly the therapist's upcoming vacation marked a shift in attention for the participants, from concern with their own subjective state to a preoccupation with the therapist's actions. Perhaps the imminent vacation propelled the patients to marshal their resources for the impending crisis. Or, the cessation of complaints may have served some as a counterdependent maneuver in order to ward off feelings of neediness and vulnerability, as if to say to the therapist, "You think I need you? I'm doing just fine!" Thus, participants actually may have anticipated separation, but possibly more by denial than through protest.

SDB and its component measures did not show significant variation across separation time periods. SDAs were remarkably infrequent and difficult to count accurately. On the unit, their occurrence was met with stringent sanctions, ostracism, and preventive measures against recurrence—factors that provided obstacles and encouraged secrecy. Doctors (1981) suggested that self-cutting, at least, is often performed in solitude. As the judges read the communication log, they noted that many SDAs could not be counted because the participants "confessed" many months after the fact or peers' reports could not be verified.

Thus, the nonsignificance of Separation Time Period as a factor in SDB may be due largely to the extremely low base rates of these behaviors, coupled with measurement problems caused by the secrecy surrounding SDAs. Furthermore, SDA and SDV showed different patterns across the separation time periods (see Table 1), no doubt contributing to the nonsignificance of the SDB summary measure. For SDA, rates were stable across baseline and anticipation periods but increased during separation and remained high during reunion. For SDV, rates increased during anticipation (as if the patients were threatening their therapists with dire consequences if they left) but fell during separation and reunion.

The results contradict clinical reports and folklore that suggest a strong association of self-destructive reactions with therapist vacations by patients with borderline personality disorder. In this sample of 41 inpatients observed for an average of 272.65 days each, only 410 SDAs were recorded—an average of 10 per patient for the total period. Perhaps SDA is more prevalent as a separation response when it is not so rigorously restricted as it was here in the inpatient setting. Or perhaps it is rare in any setting (although less rare among patients with borderline personality disorder than among other groups) and receives emphasis simply because when it does occur it is dramatic and distressing to therapists and other health professionals. This interpretation is consistent with the literature on perception of risks that shows that people overestimate the relative frequency of risks that are particularly vivid or dramatic (Nisbett & Ross, 1980). In any case, these results suggest reconsideration of the clinical wisdom that links SDAs and acting up as aspects of the same phenomenon.

Limitations

The conclusions of this study must be viewed with caution. The study did not directly compare the behavior of these inpatients with that of other inpatient diagnostic groups or with the behavior of outpatients with borderline personality disorder. The results provide evidence for particular patterns of separation behavior in this sample of inpatients with borderline personality disorder, but they do not provide information about the reactions of other kinds of diagnostic groups. Other diagnostic groups must be studied to determine the extent to which these findings are specific to patients with borderline disorders.

Other limitations deserve mention. This study examined only behavioral responses, not cognitive and affective reactions. Reactions exhibited during actual treatment sessions were not recorded, and therapists' handling of the separations was not considered. The study relied on archival data. Consequently, there were probably variations in the level of detail and accuracy with which different nursing staff members recorded behavior. In addition, the private nature of SDB limited the accuracy with which they could be recorded.

Summary

In spite of these limitations, significant patterns of behavioral reactions were observed. During their hospital stays, the participants in this study experienced all kinds of separations and losses, some of tragic dimensions. Furthermore, they participated in a rich and varied interpersonal environment. Therefore, the observation of changes in patient behaviors around therapist vacations is perhaps all the more impressive.

That the patients with borderline personality disorder in this study reacted aggressively at the time of reunion was an expected finding. However, the apparent lack of connection between SDB and treatment interruptions seems to call into question common beliefs about borderline separation reactions. Clearly, more study is needed. It would be important to determine if any subgroup of this very heterogeneous diagnostic category is particularly prone to SDB at times of separation. It would also be interesting to investigate whether SDB around treatment interruptions is exhibited to a greater degree in less structured settings (e.g., outpatient contexts).

In this group of very ill patients with borderline personality disorder, a relatively clear pattern of behaviors did emerge in response to therapist vacations. This information can be valuable to practitioners. To know that separation reactions of some kind are likely, that they may be associated with disturbances in early family relationships, and that they follow particular patterns can perhaps lessen therapists' and staff members' uncertainty and fearfulness concerning potential patient reactions. It is important for therapists to note, too, that a patient may come through the actual separation calmly, only to react aggressively just after the therapist's return. This description of separation reactions may serve as a guide for helping particular therapist–patient pairs develop strategies for coping with the difficulties that separation brings. Planning together in this way may steer the patient toward active collaboration and anticipation of the event rather than toward passive experiences of abandonment and anger.

REFERENCES

Adler, G. (1989). Psychodynamic therapies in borderline personality disorder. In A. Tasman, R. E. Hales, & A. J. Frances (Eds.), *Review of psychiatry* (Vol. 8, pp. 49–64). Washington, DC: American Psychiatric Press.

Adler, G., & Buie, D. H. (1979). Aloneness and borderline psychopathology: The possible relevance of child development issues. *Journal of Psycho-Analysis, 60,* 83–96.

Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist, 44,* 709–716.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., Rev.). Washington, DC: Author.

Barchat, D. E. (1988). *Vicissitudes of patients' internalized representations of their therapists and affective responses to temporary situations.* Unpublished doctoral dissertation, Columbia University, New York.

Belsky, J., & Nezworski, T. (1988). Clinical implications of attachment. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 3–17). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Blatt, S. J., Brenneis, C. B., Schimek, J. G., & Glick, M. (1976). *A developmental analysis of the concept ofthe object on the Rorschach.* Unpublished scoring manual, Yale University, New Haven, CT.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation* (2nd ed.). New York: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Bush, R. W. (1989). *August vacation: A planned treatment interruption.* Unpublished doctoral dissertation, University of Massachusetts, Amherst.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. G. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology, 25,* 525–531.

Coonerty, S. (1986). An exploration of separation-individuation themes in borderline personality disorder. *Journal of Personality Assessment, 50,* 501–511.

Diamond, D., Kaslow, N., Coonerty, S., & Blatt, S. J. (1990). Changes in separation-individuation and intersubjectivity in long-term treatment. *Psychoanalytic Psychology, 7,* 363–397.

Doctors, S. (1981). The symptom of delicate self-cutting in adolescent females: A developmental view. In S. C. Feinstein, J. G. Looney, A. Z. Schwartzberg, & A. D. Sorosky (Eds.), *Annals of the American Society for Adolescent Psychiatry: Adolescent psychiatry: Developmental and clinical studies* (Vol. 9, pp. 443–460). Chicago: University of Chicago Press.

Engel, G. L., & Schmale, A. H. (1972). Conservation-withdrawal: A primary regulatory process for organismic homeostasis. In *Physiology, emotion and psychosomatic illness* (Ciba Foundation Symposium 8, pp. 57–75). Amsterdam: Associated Scientific Publishers.

Field, T. (1985). Attachment and psychobiological attunement: Being on the same wavelength. In M. Reite & T. Field (Eds.), *Psychobiology of attachment and separation* (pp. 415–454). New York: Academic.

Gallagher, R. E., Hurt, S. W., Flye, B. L., & Stone, M. H. (1992). Retrospective assessment of traumatic experiences (RATE). *Journal of Personality Disorders, 6,* 99–108.

Geiser, D. S. (1989). Psychosocial influences on human immunity. *Clinical Psychology Review, 9,* 689–715.

Gunderson, J. G., & Zanarini, M. C. (1989). Pathogenesis of borderline personality. In A. Tasman, R. E. Hales, & A. J. Frances (Eds.), *Review of psychiatry* (Vol. 8, pp. 25–48). Washington, DC: American Psychiatric Press.

Handley, R. B., & Swenson, C. R. (1989). Acting out of separation conflicts in borderline pathology. *Bulletin of the Menninger Clinic, 53,* 18–30.

Hartocollis, P. (1977). Affects in borderline disorders. In P. Hartocollis (Ed.), *Borderline personality disorders* (pp. 495–507). New York: International Universities Press.

Herman, J. (1992). *Trauma and recovery.* New York: Basic Books.

Horwitz, L. (1985). Divergent views on the treatment of patients with borderline personality disorder. *Bulletin of the Menninger Clinic, 49,* 525–545.

Hull, J., Okie, J., Gibbons, B., & Carpenter, D. (1992). Acting up and physical illness: Temporal patterns and emerging structure. *Journal of the American Psychoanalytic Association, 40,* 1161–1183.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Aronson.

Kirk, R. E. (1982). *Experimental design.* Belmont, CA: Wadsworth.

Kobak, R. R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representation of self and others. *Child Development, 59,* 135–146.

Mahler, M. (1972). Rapprochement subphase of the separation-individuation process. In *Selected papers of Margaret Mahler* (Vol. 2, pp. 131–148). New York: Aronson.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161–182). Chicago: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development, 50*(1–2, Serial No. 209).

McKinney, W. T. (1985). Separation and depression: Biological markers. In M. Reite & T. Field (Eds.), *Psychobiology of attachment and separation* (pp. 201–222). New York: Academic.

Nisbett, R. E., & Ross, L. (1980). *Human inference: Strategies and shortcomings of social judgment.* Englewood Cliffs, NJ: Prentice-Hall.

Reite, M., & Capitanio, J. (1985). On the nature of social separation and social attachment. In M. Reite & T. Field (Eds.), *Psychology and attachment and separation* (pp. 223–255). New York: Academic.

Rinsley, D. B. (1986). Object constancy, object permanence, and personality disorders. In R. F. Lax, S. Bach, & J. A. Burland (Eds.), *Self and object constancy* (pp. 193–207). New York: Guilford.

Searles, H. F. (1986). *My work with patients with borderline personality disorder.* Northvale, NJ: Aronson.

Spieker, S. J., & Booth, C. L. (1988). Maternal antecedents of attachment quality. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 95–135). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Spitzer, R., & Williams, J. (1985). *Instruction manual for the Structured Clinical Interview for DSM–III (SCID).* New York: New York State Psychiatric Institute, Biometrics Research Department.

Stone, M. H. (1990). *The fate of patients with borderline personality disorder: Successful outcome and psychiatric practice.* New York: Guilford.

Taylor, G. (1987). *Psychosomatic medicine and contemporary psychoanalysis.* Madison, CT: International Universities Press.

Zanarini, M. C., Gunderson, J. G., Marino, M. F., & Schwartz, E. O. (1989). Childhood experience of borderline patients. *Comprehensive Psychiatry, 30,* 18–25.