"Our Time is Up": A Relational Perspective on the Ending of a Single Psychotherapy Session

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This paper, written from a relational perspective, examines the final minutes of an individual psychotherapy session, and is organized around the topics of boundary negotiation, unwitting self-disclosures, visual challenges, and countertransference. Attending to session-ending material is important because the separation involved lends heightened emotional intensity to the often-significant material that appears in the final minutes. This material often serves as a bridge to the psychotherapeutic work to be taken up in subsequent sessions. Session-ending dynamics call upon the therapist to prioritize empathy, validation, and support for the patient suffering from early deprivation; identify and heal narcissistic injury in the patient wishing to be special; judiciously alter the frame when doing so will benefit the patient and not constitute a boundary violation; avoid re-traumatization; admit mistakes; confront blatant denial; advance agency; address uncomfortable topics; set appropriate limits; and deal authentically with uncomfortable countertransference. Numerous clinical examples serve to illustrate these clinical phenomena.

INTRODUCTION

A casual observer who had never been in psychotherapy would probably find the ending of a psychotherapy session unremarkable. She would hear the therapist say something like, "Our time is up" or "We have to stop now," the patient would stand up, walk to the office door, and leave. Like many apparently simple phenomena, the ending of a psychotherapy session is relationally actually very complex. The purpose of this report is to enumerate and discuss these relational complexities and their significance for ongoing therapy with examples.

It would be so much simpler if there were only one way that psycho-

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therapy sessions end. However, I have found many of the endings to be so unique and varied as to preclude such consistency. The following examples highlight the often spontaneous, unpredictable, and distinctive nature of last-minute patient-therapist exchanges. Embedded in these examples is an appreciation of the many factors – for both therapist and patient – that may play some role in the final moments of a single psychotherapy session. These include character, history (especially with separation, loss, and attachment), developmental level, context, the phase of the therapy, the state of the therapeutic alliance, transference and countertransference, and the degree of therapist emotional attunement and/or empathic failure that has characterized the session.

Attending to session-ending relational matters is important because the separation involved lends heightened emotional intensity to the often significant material that surfaces in the final minutes, material that serves as a bridge to the psychotherapeutic work to be taken up taken up in subsequent sessions. The author subscribes to Stark's (2000) conceptualization of the relational therapist: a practitioner of a two person—subject and subject—model where healing results from the "interactive engagement with an authentic other" (p. 20).

The paper is organized around the following categories:

1. Boundary negotiation;
2. Dealing with unwitting self-disclosures;
3. Visual challenges;
4. Countertransference.

While the literature is replete with papers and books that discuss the ending of an entire therapy (Fortune, 1987; Gelso & Woodhouse, 2002; Hunsley, Aubrey, Verstervelt & Vito, 1999; Joyce, Piper, Ogrodnizuk & Klein, 2007; O'Donohue & Cucciare, 2008; Schlesinger, 2005; Wiggins, 1983). I found only four significant articles written on the ending of a single psychotherapy session. This omission may be considered strange, especially if one is now or has been a psychotherapy patient. Even as a former patient, one can probably remember where the clock was—if there was one—in the therapist's office or the transient feeling of dizziness experienced when standing up to leave. A patient may recall concern about whether, if she had been crying in the session, the next patient was in the waiting room, or whether or not there was a visual exchange between you and your therapist as you closed the office door. Or, did the patient leave the office door open and if so why? If as the one patient leaves the therapist's office and frequently finds the next patient in the waiting room as she exited, a certain imaginary kinship—or rivalry—may develop with

that person. The patient may have left the session disappointed in herself for having failed to call attention to the therapist's empathic failure—but feels determined to do so the next session. For many patients, a feeling of transient disorientation accompanies leaving the session and re-entering the "real" world.

LITERATURE REVIEW

While medical doctors coined the term "Doorknob Syndrome" (Jackson, 2005), a designation that refers to patients who mention alarming symptoms as they leave the appointment, the psychoanalytic literature provides two accounts of the ending of a single psychotherapy session. Gabbard (1982) focuses on "exit lines" that can have many meanings: material the patient is ambivalent about addressing in the session; a fantasized continued relationship with the analyst outside of the session; a fantasized triumph over the finite limits of the session; an incipient transference manifestation or a defense against it; and an active mastery over what has been experienced passively. In his comprehensive treatment of the subject, Gabbard categorizes final communications as follows: the curtain call, the last second question, the stereotyped exit, the attempt to censor unacceptable material, the cry for help, reparation, and the analyst's exit line. The paper is noteworthy for its focus on "exit lines" as indicators of patients' pathology and the scant attention it gives to the analysts' contributions to their patients' "parting shots."

Writing from an intersubjective stance, Brody's (2009) exploration of the end of the analytic hour is notable on two accounts: her appreciation of the effect of the end of the session on the analyst, not just the patient, and her grasp of the "limitations and inevitabilities of life that are revived again and again when we approach and reach the end" (p. 87). Focusing on self-states, attachments, and mourning, she gives examples of how the ending of a session highlights disruption, separation, and loss.

Two articles take up the question of whether a therapist should extend a session—or not—beyond the traditional time limit when important material surfaces near the end of a session. Wiggins (1983) provides an example in which the patient makes positive use of the few extra minutes he provides: "the mental representation of that bit of time could be carried with her as a reflection of the concern and regard of her therapist" (p. 65). Arnd-Caddigan (2013), writing from a relational-intersubjective perspective, provides a rationale for occasionally extending a session with certain types of patients.

Boundary Management

Either patient or therapist may indicate that the session is over. In more straightforward endings, the therapist might say "Our time is up" or, for a painful or upsetting session, "I'm afraid we have to stop." Patients on extreme ends of a continuum respond to this time boundary in two ways. For one group, staying a minute after the time is up would be unthinkable. The other group, oblivious to the time boundary, could talk for another 50 minutes if the therapist didn't set a limit. In the middle of the continuum are patients who handle the end of the session in an unremarkable fashion, sometimes collaborating with therapist: "I see we are out of time, I will bring up that topic next week."

For patients who were neglected or (felt) unloved early in life, therapy can evoke massive longings for attention and love. Such patients often experience their unending neediness to be disgusting and shaming; at the same time, overwhelmed with longing, they find it excruciating to leave the session. A man in his late 50s, who felt that he had done nothing with his life and was an abysmal failure, would often ask at the very end of the session, "Do I have to go? I want to stay with you. Can't I just curl up in the corner of your office?" A highly successful woman who regressed massively upon retirement expressed the same longings. Such scenarios challenge the therapist to end the session without shaming the patient. With a caring tone and a warm smile, the therapist might say something like, "I appreciate that it is hard for you to leave. I will see you next week" or, alternately, "Leaving can be very hard," a less personal comment that invites further conversation about separation and loss.

This type of ending reminds the therapist of the patient's longing for a relationship. In subsequent sessions, the therapist prioritizes the patient's need for empathy, validation, and support, a stance that may continue for months or, in some cases, even years (Stark, 2000).

The asymmetry of the therapy can intensify these feelings of insignificance and unimportance. The end of a single psychotherapy session brings into bold relief a disquieting realization for some patients: the therapy is more important to the patient than it is to the therapist. Patients have their one therapy; therapists have many patients. Psychodynamically oriented therapy is designed to unleash unrealized longings (hopefully) more powerful in the patient than in the therapist. "I want to be the most important person in the world to you" captures the wish and longing to be special that patients deep into their psychotherapy feel. This discrepancy does not mean that the therapy is not important to the therapist, although patients

who experience the world on an all-or-nothing basis may draw that conclusion.

Elvin Semrad (Rako & Mazur, 1980), a revered teacher of psychotherapy, once said, "It is disillusioning to be mamma's fair-haired boy and then find out that the rest of the world doesn't treat you that way. It can scare the life out you" (p. 55). Walking into the waiting room after a session can have a similar effect: the presence there of the therapist's next patient makes it difficult to sustain the fiction of the patient being uniquely special to the therapist. The mini-separations that are part of each session's ending provide repeated opportunities to work through these unrealistic longings.

Alerted to the patient's wish to be special, the therapist attends closely to the inevitable narcissistic injuries that are an intrinsic part of the psychotherapeutic process. Acknowledging, bearing, and putting in perspective these emotional wounds become an important phase of the therapy. As the patient slowly realizes that his therapist's caring for her other patients does not invalidate or diminish her caring for him, a stepping-stone on the path to maturity is achieved.

Patients with borderline disorders (Gunderson, 2008), who have been traumatized by abandonment early in their lives, are especially sensitive to or apprehensive about the ending of a session. They often experience the session's ending as abandonment or rejection. To establish a modicum of empowerment, they may leave (the session) before they are left or not leave when the session is over and not take responsibility for the boundary violation (Gutheil & Simon, 1995) involved.

Example

> During my first year of psychiatric residency, a self-destructive, manipulative young woman with a history of having been a victim of sexual abuse refused to leave sessions on time. Because of my small repertoire of therapeutic skills at the time, I failed first to explore the meanings of this behavior and, instead, insisted that she leave the office when the session ended. She proceeded to end the next session on time, only to faint as she reached the office door—which only opened inward. I was then forced to commit the boundary violation of touching her to open the door!

This experience taught me about the futile, if not destructive, effects of trying to control another's behavior. I soon realized that my attempts to control were more in the service of medicating my feelings of powerlessness than in the service of helping the patient. I slowly began to learn the value of exploring and learning about the experience that shaped the patient's inner world. Experiences like this one taught me that using

the therapeutic relationship to understand—not to control—the other resides at the core of the psychotherapeutic process. A valuable lesson to learn early in one's career!

Another patient, whom I have treated for more than 25 years, feels that she is an "untouchable." Full of self-hatred and self-loathing, she, nevertheless, yearns to be touched. Ten years into the treatment she asked if we could hug at the end of each session. While this was a boundary I did not cross, I felt that this extremely psychologically damaged woman needed more than words to experience my caring for her.

After discussing with her why I felt agreeing to her request would be confusing for her, and examining the request in peer supervision, I agreed to touch index fingers at the end of each session. Even a handshake felt like too much—something I have never done with any other patient in my 47 years of practice. She has never taken advantage of this boundary crossing and states that the touching helps her feel more like a human being. This experience taught me how the infrequent but judicious alteration of the frame of therapy, when in the service of the patient's needs, and first discussed in peer supervision, can increase the patient's feelings of safety and trust.

The termination phase of therapy itself can lend intensity and poignancy to the final minutes of the remaining sessions, especially for patients whose early lives were particularly painful. The therapist's love, as the example below describes, becomes a bittersweet reminder of all that they have missed, as Feldman (1956) described in his paper, "Crying at the happy ending."

> Ned was the youngest of 11 children. As he put it, "By the time I was born, my parents were worn out. They had nothing left to give." Ned made impressive gains in the six years he was in treatment: heightened self-reflection and self-esteem, a greater sense of personal agency, and improved interpersonal skills that translated into success at work. During his last three months in treatment, he found himself crying very near the end of several sessions, sad tears related to all the deprivation and emotional pain that he had faced and worked through to have his present life.

The focus of therapy often shifts to the common humanity of patient and therapist as the termination phase takes hold. Leaving a session in this phase of therapy takes on a different feeling tone as two human beings deepen their appreciation of their shared journey. The playing field levels. Therapists share their experience of the therapy, and, sometimes, more about themselves. They may indicate non-verbally, or tell their patients directly, the ways in which they have derived inspiration from their

patients' courage and persistence in dealing with their demons. They may express gratitude for the privilege of being entrusted with intimate knowledge of another human being.

Some patients become very upset when they are in the middle of painful material and the therapist calls time. They seem unaware they have waited until near the end of the session to bring up such material. They experience the abrupt ending as a metaphorical slap in the face and feel victimized by the power they perceive the therapist possesses. This dynamic offers an opportunity for the therapist to challenge the patient's experience of being a victim of the therapist's perceived power. The therapist might ask, "How has it come to be that I am the one who ends the session? What do you think keeps you from noting the time?" Or "Why do you think you waited until the end of our time to talk about this painful material." The patient who takes ownership of his/her part in feeling victimized often emerges with a greater sense of agency, a stance that contributes to the strengthening of the therapeutic alliance.

Therapists especially attuned to patients with trauma histories may take special pains to make sure these patients don't get re- traumatized by the session's ending (Saporta & Gans, 1995). Suppose such a patient, with five minutes left in the session, embarks on a particularly sensitive or shame-filled topic. Asking, "Would it be better to wait until next session to talk about this material?" may help the patient avoid further emotional injury.

> I rarely fail to end sessions on time, but one exception was memorable. Ed was a therapy veteran, having been a patient in a variety of therapy modalities. At the time I was treating him, he was also heavily into meditation. He came into one of our 50-minute, afternoon psychotherapy sessions that began at 4:30, and for which he paid $180/session, and ten minutes into the session he announced that he preferred to spend the rest of the session meditating. Knowing of his distrust of authority, and sensing that this was not a propitious time to challenge that stance, I went along with his wish. The next thing I knew, it was 5:22. The last time I remembered being awake was 5:00. As I said, "We have to stop now," Ed opened his eyes, and we ended the session. The next session no mention was made by either of us about what had transpired in the previous session. As we started the next session, I said to Ed that I needed to talk with him about an administrative matter. His body stiffened as if he were about to be punished. I said, "I think I owe you some money." He asked what I meant, and I said, "Your prerogative as a patient is to use your therapy time in a way that we both feel is productive. My job is to be here for your benefit and to be awake and attentive for the 50 minute hour. Two weeks ago I was asleep for the last 20 minutes of the session" to which Ed replied,

> "I KNOW." In subsequent sessions he elaborated on why my disclosure meant so much to him: it felt like a corrective to his experience with his punitive, untrustworthy parents. We then figured out what his refund would be; I've never spent a more productive $72.

Subsequent sessions alerted me to the intensity of Ed's negative feelings toward authority, feelings that frightened him. Upon reflection, these feelings frightened me as well and probably played some role in my having fallen asleep. I found a way to welcome Ed's hostility into the sessions by processing my countertransference.

Unwitting Self-disclosures

Unwitting self-disclosures (USDs), unconscious yet observable parts of personality, are often behavioral relics of past suffering and, as such, constitute valuable though frequently underutilized clinical information (Gans, 2011). While ego-syntonic aspects of personality can be commented on with impunity, dealing therapeutically with patients' USDs—manifestations of their blind spots—requires sensitivity, empathy, and timing. Such therapist understanding and competence becomes even more important when unwitting self-disclosures occur in the final minutes of a session.

> Joe treated his morbid obesity as if it were as serious as a hangnail. He joked with members of the therapy group he just joined that his role was to ensure that other members felt thin. It took all Joe's strength to extricate himself from his chair when sessions ended; the effort left him breathless. This behavior went unaddressed for several sessions; I said to the group, "To what lengths does poor Joe have to go to get someone to acknowledge the seriousness of his condition," a comment that finally elicited expressions of concern. Slow suicide comes in many forms.

This example illustrates how some patients are experts at getting their major problems overlooked. They do so by minimizing these problems or conditions with self-denigrating humor and remarkable indifference. Joe's ability to entertain the group contributed to their collusion in his denial, an impressive accomplishment given his physical struggles at the sessions' endings. Therapists must redouble their efforts to resist being disarmed by such blatant denial. My "poor Joe" comment was an attempt to achieve this goal.

> Another patient may not realize that her hostility is masquerading as a social grace. Elizabeth's marital relationship worsened during weekends when her husband was not working. Elizabeth felt she was living in an existential hell, and yet she feared that she could not make it living on her

own. She was my last patient on Friday afternoon. As she left each session, she would say, "Have a good weekend." It became painfully obvious—at least to me—that I was going to have a much better weekend than she was. I began to feel that her parting pleasantry was not as friendly as she imagined. After some months, I brought the pleasure discrepancy between our respective weekends to her attention. At first, she denied meaning anything by that social grace but over time got in touch with its hostile component. Her acknowledgment of her anger over my having such a better (imagined) life than she did opened up a new phase in therapy. As she realized in therapy that she was not being punished for her anger and that, in fact, I seemed to welcome it, she began to stand up for herself and insist on better treatment in her marriage. This increased sense of agency began to permeate other sectors of her life.

One's body may involuntarily reveal what normally stays hidden. I noticed blood on one of my light brown suede office chairs as one of my female patients was leaving the office. She had gotten her period during the session. Ordinarily, I would have flagged this bodily betrayal as something it would be important to talk about in our next session. Caught off guard and too uncomfortable to do so, I did think often during the week about our upcoming session. What would the next session be like, how would my patient feel, and how would I conduct the session? Would she be embarrassed by a private female function becoming public or more worried about having stained—ruined—my furniture? Or neither? And how would I handle the situation? Would I be more uncomfortable than my female patient? Would I bring up what had happened if she didn't?

Like many unexpected happenings in psychotherapy, her involuntarily produced blood broke through both of our defenses and allowed us a moment of being quite real with each other. She was able to talk about her feelings of mortification when she discovered the blood on her skirt. She associated to the awkward manner with which her mother reacted to her menarche. I talked about my discomfort and concern that, as a man, I might not know how to be most helpful when we discussed her embarrassment. As we both relaxed, we discussed why a natural bodily function should produce so much shame (Lazare, 1987; Morrison, 1987) and awkwardness.

This example also illustrates how the ending of a single session may linger and reverberate during the week between appointments. Occasionally I have been awakened during the night with disturbing thoughts about the ending of a session (as well as what transpired during the session). Patients, often unwittingly, find ways to be remembered.

Enactments are a type of unwitting self-disclosure, as illustrated in the following example:

> Dorothy, a very polite woman from a nearby wealthy suburb, entered therapy with a chief complaint of depression and interpersonal problems at work. She had found fault with bosses in her last three jobs and was beginning to realize that *her* behavior was part of the problem. And yet, in the sessions, she came across as reasonable and relatable. I send out bills at the end of the month and expect patients to pay within a month. Dorothy began therapy in February and at the end of the last session in March she took out her checkbook as the session ended and said, "Let me write you a check." She wrote in a slow, deliberate manner and was careful to subtract the amount of the check from her balance before handing me the check. Five minutes elapsed by the time she checked the amount of her bill, wrote the check, did the math in her check register, and handed me the check.
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> I noticed my mixed feelings around this transaction. On the one hand, I like getting paid; on the other, I value my 10 minutes between patients. Dorothy seemed unaware of her entitlement to an extra five minutes of my time. I sensed that important meaning might reside in this possible enactment (Chused, 1991; McLaughlin, 1991). I decided to delay commenting on this behavior until I could decide if it was a one-time phenomenon or a pattern. Over the course of the next five months, it became clear that this behavior was a pattern. As we came to the last session in August, she again got out her checkbook just as the session ended. Having metabolized my counter-transference feelings to this enactment and before she was able to get her pen out I said, "We have to stop." She said, "But I'm about to pay you" to which I replied, "Yes, I know but our time is up." She looked at me with a combination of incredulity and muted fury and said, "Well, fuck you, I'll pay you when I want to." It was at this moment that therapy really began. She had a week to think about her eruption and came to the next session in an embarrassed but self-reflective mode. She realized that her anger was triggered when her boss did not appreciate all the work she had done. Not surprisingly, we found that she had a long history of feeling not appreciated. We were then able to sort out whether paying her bill was something she was "doing for me"—and thus something I should show appreciation for—or if paying her bill was simply part of our initial agreement, paying a fee for a professional service. As a result of this clarification, Dorothy felt the degree to which not being unappreciated was an emotional trigger for her. Generating meaning from this financial transaction – mentalizing (Fonagy, 1991) it – advanced the therapy.

Is it possible that a gentler approach may have resulted in the same

therapeutic work? I could have said something like "I notice you have a pattern of paying after the session has ended. I wonder if there is anything we can learn from exploring this behavior." Perhaps we could have achieved the same insights but probably not with the equivalent affective valence.

Visual Challenges

The visual interplay between therapist and patient at the session's ending can bristle with possible meaning. Does the patient not look at the therapist as the session ends? If so, is that because the patient does not want to see the therapist or is it because the patient does not want to see the therapist looking—or not looking - at the patient? And what is it that the patient doesn't want seen, his or her appearance, emotions, or facial expression—or the therapist's facial expression?

Case Example

Audrey had a lifelong struggle with feelings of shame. Her father, who was an alcoholic, called her stupid and ugly, and he made derogatory comments about her body in front of his drinking buddies. Her mother provided no protection.

The endings of sessions provided the opportunity to explore her shame dynamics in the transference. Upon preparing to leave a session, Audrey would pick up her coat, put it on, and turn to leave the office without looking at me. I also noted that her absence of eye contact made me feel like a "dirty old man," an induced feeling worthy of exploration. When I thought that the timing was right, I commented on her behavior, keeping my reaction, for the time being, to myself. Her first associations were to shame about her body. Because of her father's demeaning comments about her body, Audrey didn't want to give another man the opportunity to disgrace her with his eyes. If she did not look at me, I magically would not see her either. If she risked looking at me, another danger presented itself: projections from her inner world, more than my actual facial expression, would determine what she experienced (Havens, 1976). Paradoxically, because she rarely looked at me, I was provided the opportunity to look at her unobserved.

Repeatedly focusing on this visual dynamic at the session's end helped us deconstruct the negative self-image that had emerged from her early experience. We were able to talk about the reality of her personhood in the present as compared to her distorted version of herself from the past. We affirmed her many good qualities: her values, her integrity, her kindness, and her reliability.

It then became difficult for her to look at me for another reason: she was

> overcome with feelings of sadness as she recounted the many years of therapy and financial resources it had taken her to detoxify feelings from her childhood. Recently, as she is able in a more relaxed fashion to look at me as she leaves and talk about the feelings that accompany such looking, she can speak about feelings of gratitude (Gabbard, 2000) for the years we have worked so hard together.

Distracted therapists may not look at their patients for any number of reasons: preoccupation with a previous patient who left the session threatening to terminate treatment; their own children's illnesses; recent financial reversals; arguments with spouses; or something as banal as a air-conditioning repairman failing to return a call after patients have complained about the office being too warm. Patients tend to infuse such therapist distractions with meanings determined by their individual histories, *especially when the distractions occur at the end of the session*. Intuitive patients may accurately speculate about the reason(s) for their therapists' distraction.

Therapists may prefer their patients not look at them as the session ends when the topics in play include money and sex. Therapists sometimes receive payment at the end of a session. As DiBella (1986) has observed, therapists often do not look at the checks they have just received because of their feelings of guilt and greed, as if, somehow, patients will intuit these feelings. One patient said to me, "I notice that you look at every check I hand you. Why do you do that?" I replied, "I want to make sure you see how pleased I am at getting paid for my work." This session-ending exchange provided me the opportunity to bring out into the open – hopefully for discussion – an avoided therapy dynamic: the meanings of payment for both the patient and the therapist.

Patients may provide challenging visual images a session. I can only speak from the perspective of a male therapist working with an occasional female patient who presents a provocative visual challenge as the session ends. A woman wearing a low-cut blouse bends forward to pick up her purse at the session's end, offering a view of her breasts. This scenario recurs in subsequent sessions. Does the male therapist look? Is the female patient aware that she is exposing her breasts and, if so, does she want her male therapist to look—or not? Again, this provocative session-ending behavior provides the male therapist with the opportunity to flag for future discussion—depending on a number of variables—this often-unwitting bodily self-disclosure (Gans, 2011). It is worth noting that in today's environment, male therapists will likely avoid processing this sexually

charged material for fear of being accused of improper behavior – something they would not have worried about 30 or 40 years ago.

Countertransference

Objectively serious threats made at the end of a session may feel more like communications to the attuned therapist. Fred made a serious suicide attempt two months after joining my psychotherapy group. He re-entered the group a few weeks later and received caring and support from the group. As a result of our concomitant every-other-week individual therapy appointment and his greater attachment to the group, the therapeutic alliance deepened over time. However, six months later, and just before I was scheduled for vacation, he announced very near the end of a group session that he was feeling extremely suicidal once again. I trusted my gut that the announcement of his suicidal state was more of a communication to me than an indication of his dangerousness to himself. I said to the group, "Fred wants to make sure that I won't forget about him when I am on vacation. We can look forward to the day when he can convey that wish in a more direct and less alarming fashion." Fred came into our next individual session relieved that I had deciphered the true intent of his suicidal statement.

Unexpected questions from a patient at the end of a session can evoke uncomfortable countertransference feelings. Betty learned that her job relocation necessitated her leaving the area in six months. With several months of her three-year therapy remaining, she selected the very end of a session to ask, "Will you miss me?" Taken by surprise, her therapist had the presence of mind to say, "You have a way of saving important questions for the end of the session. Let's begin next session with your question." Her therapist was actually relieved by the timing of her question because his present feeling was "not so much." Given the opportunity to examine his feelings between sessions, he realized that because the patient had been unable to discuss her feelings about him—or even discuss why she couldn't discuss such feelings—the therapy had had a sterile, there-and-then, news- of-the-week, flavor. Thinking how to respond in the next session, he considered saying, "I think I would miss you more if we had been able to talk openly and honestly about our relationship." Deciding that that response sounded withholding and unappreciative, he decided upon, "In our remaining time together, I look forward to our talking about our relationship. Doing so will help me remember you even more." The process of deciding how best to answer the question resulted in the therapist remembering a comment Betty had made a decade earlier when

she was a member of one of his psychotherapy groups, "I desperately want to be held but I feel like I have no skin. When you try to hold me, I anticipate feeling only pain." That recollection allowed her therapist to conduct the remaining sessions with a greater appreciation of the risks involved for Betty when participating in any intimate encounter.

CONCLUSION

This report, which draws upon the author's 47 years of clinical experience, provides a microanalysis and discussion of a neglected topic in the psychotherapy literature: the last few minutes of a psychotherapy session. This focus is important because of the challenging complexities and unique opportunities for accomplishing psychotherapeutic work that the session-ending, relational material provides. Attending to this material serves as a bridge to the work of the future sessions. While most previous reports have focused on the effects of the session's ending on the patient and the patient's responses to these separations, *this paper looks at how the therapist responds to session endings that are often spontaneous, unpredictable, and highly varied*. Too distinctive to be understood by any one theoretical orientation, these clinical challenges call on the therapist to be variously creative, authentic, empathic, firm, non-judgmental, and introspective, all in the service of avoiding shaming the patient and providing optimal responsiveness (Bacal, 1985).

Achieving these goals is a real challenge. Psychotherapists in private practice get left approximately eight times a day, and can become inured to the emotional reverberations that these repeated mini-separation create. The author will have realized his goal if those reading this paper become even more responsive to the therapeutic possibilities embedded in the ending of a single psychotherapy session.

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