A Journey of Retirement: A Personal Account

Margo P. Goldman, MD, DLFAPA

At APsaA's 111th Annual Meeting, I attended the session, "The Older (over 70 year old) Analyst Who is Still Working." Chaired by Charles Fisher MD and Judy Kantrowitz PhD, the presenters outlined the early phase of their research on analysts' reluctance to retire as well as the pitfalls of continuing to work as one ages. As a relatively recent retiree, I was very interested in the subject, especially because our profession allows for a range of late career options.

I was struck by a recurrent theme in the presented material - clinicians' fear of abandoning "lifer" patients who may be substituting the analytic relationship for ones outside the consulting room. Another deterrent to retirement was the loss of peer contact and intellectual stimulation derived from our work. Some younger research subjects posited they would become better therapists with age, thereby creating an incentive to delay decisions to stop seeing patients. This raised a question for me: Does one continue working primarily for oneself or one's patients? Other dilemmas came to light: What safeguards are necessary in the event of the therapist's diminished cognitive function or another infirmity if still seeing patients? What provisions should be made if the therapist does not acknowledge impaired function, has a sudden illness or dies? And are we reckoning with our own aging, vulnerability and mortality if we continue treating patients without a clear exit plan or safety net?

In the context of these professional and personal issues, I will share some of my retirement story. I retired from practice in December 2021 after a gratifying 41+ yearlong psychotherapy career in solo practice. As I approached age 70, I was aware of a strong desire to retire "on a high note" when still healthy enough to productively treat patients and confront the logistic and emotional issues associated with the transition. In mid-2018, I started "winding down" my patient load by not accepting new patients but did not yet identify an end date. My wish to stop work before I was unable to work was reinforced in the winter of 2019, by a phone call from a trusted former mentor - she was gravely ill and needed to rapidly close her practice. As I brainstormed with her about potential dispositions for some of her patients, I was struck by my own need to set a retirement timeline soon, to enable a smooth (albeit difficult) process - for myself and my patients. In the interest of full disclosure, I will add that my office lease was to expire October 2020, and I needed to decide whether to renew and for how long. Another factor was my awareness of omnipresent concern for my patients' well-being, and my need to divest from that responsibility.

So, in late 2019, I made a life-changing decision: I would stop seeing patients at the end of 2021. I downsized my office and began telling patients of my retirement plans 12 to 18 months prior to termination. Unfortunately, when Covid-19 arrived, all treatment became virtual, so it was necessary to inform patients "on screen" rather than in person. Telling people was dreadful and dreaded - the impact of loss, separation, anticipatory

grief, and treatment dispositions loomed large. I was fortunate to have an exceptional resource from the Massachusetts Psychiatric Society, a retirement interest group that met every two months to help senior psychiatrists navigate their late career, regardless of if and when they planned to stop work. We grappled with retiring during Covid, saying goodbye to our patients in person (and how), searching for suitable therapists for patients needing ongoing treatment, and formulating our post-retirement plans.

Having the opportunity to talk with other senior colleagues in various stages of retirement (or continued work) helped me manage the retirement transition and also reinforced some of the questions and recommendations raised at last June's program. First, if continuing to see patients, practitioners should execute a "practice will" and appoint a custodian to help patients cope with one's unanticipated absence. In addition, some participants last June mentioned taking an annual cognitive exam to identify early signs of impairment. A trusted, more junior colleague could also be designated as a "truth-teller" to inform a "failing" therapist of functional concerns. At least one question remains: Should analytic institutes or professional organizations establish a mandatory retirement age to forestall potential patient harm? In the face of these clinical and personal binds, there are clearly numerous legitimate approaches to one's late career, including stimulating professional (clinical or non-clinical), and non-professional endeavors. However, adequate supports (ideally through one's professional organization and colleagues) are necessary.

As I reflect on my final 1 1/2 years of practice, while terminating with patients and talking with colleagues about potential referrals, I believe the process was invaluable to everyone involved. Retiring during Covid posed some unique challenges, i.e finding creative, safe ways to say goodbye in person for patients who preferred to do so. As psychoanalytic therapists, we know termination provides a unique opportunity to work through a myriad of universal, previously unresolved issues: separation, abandonment, anger, grief, envy, loss, etc - on both sides of the dyad. I retired feeling rewarded and grateful for the privilege of positively impacting people's lives, and reassured (and relieved) that my patients would survive and hopefully thrive with their new therapists. Though retirement may not be for everyone, my transition from clinical work to non-clinical chosen professional and personal endeavors, was a journey worth taking.

--from the American Psychoanalytic Association's Psychotherapist Associate Newsletter