When is it time to retire?

Anne Power explores some issues faced by therapists approaching retirement and the challenge of closing down a service they may have been offering for decades

For solo practitioners in private practice it's important to plan for retirement well in advance, and if we work with long-term clients, this is even more necessary. I became interested in the process of closing a practice when one of my supervisees began to consider retiring and needed to think through what was involved. As there was almost no existing literature on the subject, I set out to interview retired and retiring therapists and then extended my research to those who had closed their practice to move house, have a baby or to take sabbatical leave. I found that while retirement brought with it some very specific aspects of loss, all of these endings shared similar clinical challenges.

Why retire?

Some people meet the challenge of aging by inventing a more leisurely way of working, seeing fewer clients, working fewer days or taking more holidays. This can work well for a time but can't change the fact that, as we age, illness, death and cognitive decline become more likely. There is no single blueprint for retirement, but one principle is very clear: the responsibility to retire at an appropriate time lies with the therapist. We can't wait for a signal from an insightful colleague, or for referrals to dry up or clients to leave us. Only very rarely do peers feel it is their place to suggest retirement – and who really gets to observe how forgetful we may have become during our clinical sessions? Clients are even less able than colleagues to tell us because the asymmetry of the relationship makes this impossible. If the therapy is psychodynamic, it may be particularly hard for a client to 'sack' their therapist because of the multiple meanings she could have in the client's internal world. Supervisors have a duty to get involved if they have doubts about fitness to practise, but they can only respond to what a supervisee brings.

As a number of former clients have written about their traumatic endings with a therapist who had lost competency, we now have data that make this even clearer. One of these accounts depicts poignantly how trapped the patient may be by their loyalty to a therapist with dementia, and what lasting harm this might do: 'I reproach myself for my inability to end the analysis much sooner. I am still ashamed about this.'[1]

One of my interviewees, Celia, a very experienced practitioner, had been seeing a much older therapist who suddenly collapsed and stopped working: 'I could have seen if I wanted to see that my analyst was getting older and more unable to function – but I didn't want to see it. I turned up one day and she wasn't there. There was no answer to the doorbell.'*

There isn't a blueprint for retirement but one principle is very clear: the responsibility to retire at an appropriate time lies with the therapist

From the material I gathered, I became even more convinced of the need for responsible retirement. Of course, illness and death can overcome us in any decade, but the odds increase as we age, and if we miss the chance to make a timely retirement, we could put clients at risk. A carefully drafted clinical will with two or more capable therapeutic executors can make us as well prepared as we reasonably can be for an emergency ending. An outline plan for how we will eventually close our practice could be another appropriate preparation.

The 13 retired, or retiring, therapists who shared their stories with me were working in private practice. I was interested in how a practitioner working alone could best close down the service he or she had been offering, often for decades. I saw the 12 women and one man as falling into four groups and I will write about them under these headings, reflecting on what we might learn from their retirement process.

Retiring at a young age

This subgroup of five therapists ranged in age from 61 to 68 and they all mentioned wanting to retire while still young enough to enjoy life; their decision was largely influenced by pull factors. For some, it was partners and families who wanted their companionship, or help. For others, it was a determination to have fun in later life after watching parents who had declined suddenly in retirement, never enjoying the leisure they had earned. Denise, for example, said: 'I want a life after work finishes, and a good life with energy and creativity. I don't want to retire to die.'

Perhaps it was because they didn't need to retire that these therapists showed the highest ambivalence about the decision. It was interesting that this younger group took less time to close their practice. The shortest notice given to patients was six months and this condensed timescale appeared to be very stressful for the therapist and for some clients.

Reluctant to retire but planning carefully

I interviewed three therapists who were a little past 70 and had come to a particularly measured decision about retirement – on the one hand, feeling very attached to their role as a therapist and sad to let it go, yet at the same time feeling bound to retire by a strong duty of care to their patients. Mary commented: 'It was an age thing really. I just thought it was right, once you got near 70, to start thinking about finishing. I think it's about this idea of dying "in the saddle"; I'm really opposed to people going on until they are past it.'

Like the younger group, these therapists wanted to have time for grandchildren and hobbies, but their decision to retire came from their concern to protect clients. These three practitioners made the process of closure very gradual: they stopped taking new patients some years before their ending. By the time of retirement, they had just a handful of clients left and they gave these patients 18 months' notice of the termination date. Two of the three pondered whether this had in fact been longer than necessary, as initially patients could ignore that distant threat, and only closer to the time wake up to what it meant.

Retiring due to ill health

As I was looking at planned, rather than emergency, retirement, my interviewees did not include people who had suffered an acute illness, but each of these three interviewees faced very painful circumstances. One had been working part time after cancer treatment when symptoms recurred and she ended therapy with her remaining patients. Another was suffering with a neurological condition for which no diagnosis and therefore no prognosis or treatment could be given, yet it was clearly progressive and she had been obliged to plan the full closure of her practice. The third, Rosemary, had a more minor condition of slight memory loss, which was actually dismissed by her GP and colleagues. She was in her mid-60s when she found it harder to recall details and made the conscientious decision to retire, gradually reducing her hours as each client left. Her words convey her careful self-monitoring, which might raise the question in us – will I be as honest with myself? I had asked if she had faced a dilemma about retiring: 'I didn't have a dilemma, I just didn't want to do it, but I also knew that there was really no choice. You can't take the risk of thinking "What the hell is she talking about? Who is this Philip?"'

Retiring as an old person in the ninth decade

Two of my sample were notably older – both 88 at the point of retirement. One had closed his practice two years prior to our meeting and in that time his health had declined painfully. The other therapist, Beatrice, was in her last year of work when I met her. She was very fit and her sharpness and capacity to reflect on her process dislodged my fixed idea that people should retire before this age. Critiquing her own clinical work, she said: 'It is as though I was being less vigilant and therefore in more danger of acting out... it is simply that my mind was so engrossed in her state of mind, that I was... not driving my car properly.'

As well as observing this slackening in her analytic capacity, this 88 year old also recognised the need to protect her patients from her inevitable death. When asked about the positive claims that are sometimes made for older therapists, she replied: 'I think I would agree with people who say that with age we become a bit wiser in the way we can reach patients, but this is offset by the fact that we may tire more easily so that our attention drifts and we may be less vigilant.'

Clinical and practical considerations

When the therapist imposes an ending, there are both risks and opportunities in the clinical work. For clients who have become comfortable in therapy, this might serve as a wake-up call and could be beneficial if it resulted in more openness. In contrast, some clients may be at a stage where the news is particularly disturbing and, in their case, defences might harden.

One former client told me that her therapy ended the day her therapist said he was moving abroad: the work continued for six months but the client had already signed out. For clients with fractured early attachments – fostering, adoption, loss of a parent – the notice of ending may be most disturbing. If enough reparative work has already been done, perhaps this planned ending could be positive, but there is a risk of such a patient being re-traumatised through this abandonment. Psychodynamic practitioners will be mindful of the stage in the transference that each client has reached, as clearly, too sudden a dissolution of this can put a client at risk.

In her final year of work, a therapist could be managing an assortment of challenges: anxiety about the coming transition, pressures from family and a heightened dynamic with the clients. It will be important to keep in mind which clients have been told and how they are each responding to the news. Several interviewees spoke of one client whom they found it particularly hard to tell and who received the news much later than others. Even though we know they are skilled at hiding their distress, it can be hard to remember that the more avoidant/dismissing clients will be feeling the abandonment at some level. As a therapist who is leaving her clients, we might be relieved to feel that some of them are untroubled by the forced ending, but it could be a mistake. We know from regular endings with clients that sometimes the truth about separation crashes in rather close to the time for parting. In contrast to these self-sufficient clients, those with a more ambivalent/preoccupied pattern may be keenly aware of their sadness. They may feel overwhelmed and doubt that they can cope. They may need us to believe in the adult part of them, which could be temporarily disabled by the news of retirement.

Decisions about onward referral will depend on the model we use and on the stage clients have reached in their journey. There may be a risk that we interpret their need of referral according to our needs. If we want reassurance about the importance of what we have been doing with clients, we might encourage them all to go on to another therapist. If we're anxious about future therapists hearing all about our work, we may not want to refer on at all. Most therapists discuss the options with clients and can help with referral for those who do want to continue.

There will be much in these clinical challenges which applies to other types of forced endings – relocation, maternity and sabbatical leave – and there will also be an overlap in practical considerations. One point that needs forethought is the question of how much to stagger the ending. When we announce the news of closure, some clients will immediately want to know the date of their last session. If we rent a room, there may be financial reasons for wanting to use it fully until the end of the lease. Yet saying goodbye to several clients in one week might mean they do not get the best from us. As costs of supervision, registration and insurance all continue at the same rate, however much we have tapered off our hours, our financial planning will need to allow for a shortfall.

Only very rarely do peers feel it is their place to suggest retirement – and who really gets to observe how forgetful we may have become during our clinical sessions?

It can be hard for clients to remain engaged with the work once the limit has been set, and this may apply to therapists too. Participating in stimulating CPD and being appropriately challenged in supervision could help. Talking to colleagues is usually a great way to work through our difficulties, but sadly retirement is often still a taboo subject. This may be because of the association of retirement with aging and dying, the fear of being seen as a 'has been', as well as the risk that referrals might dry up before we are ready to stop.

Afterwards

For some people, the transition out of work is a difficult process and a few of my interviewees found it useful to return to personal therapy for a brief period. Two losses, which were named by almost all retirees, were the engagement in meaningful reparative work, and stimulating friendships with colleagues. A number also mentioned how retirement brought their own aging and mortality into focus. The weight of these challenges means that it is normal to feel ambivalent about the decision. It's natural to have doubts and regrets and perhaps envy of peers who continue working longer. Clementine commented: 'Sometimes there was perhaps some envy on my part, because I don't think it's easy to be completely wholehearted about such a life change.'

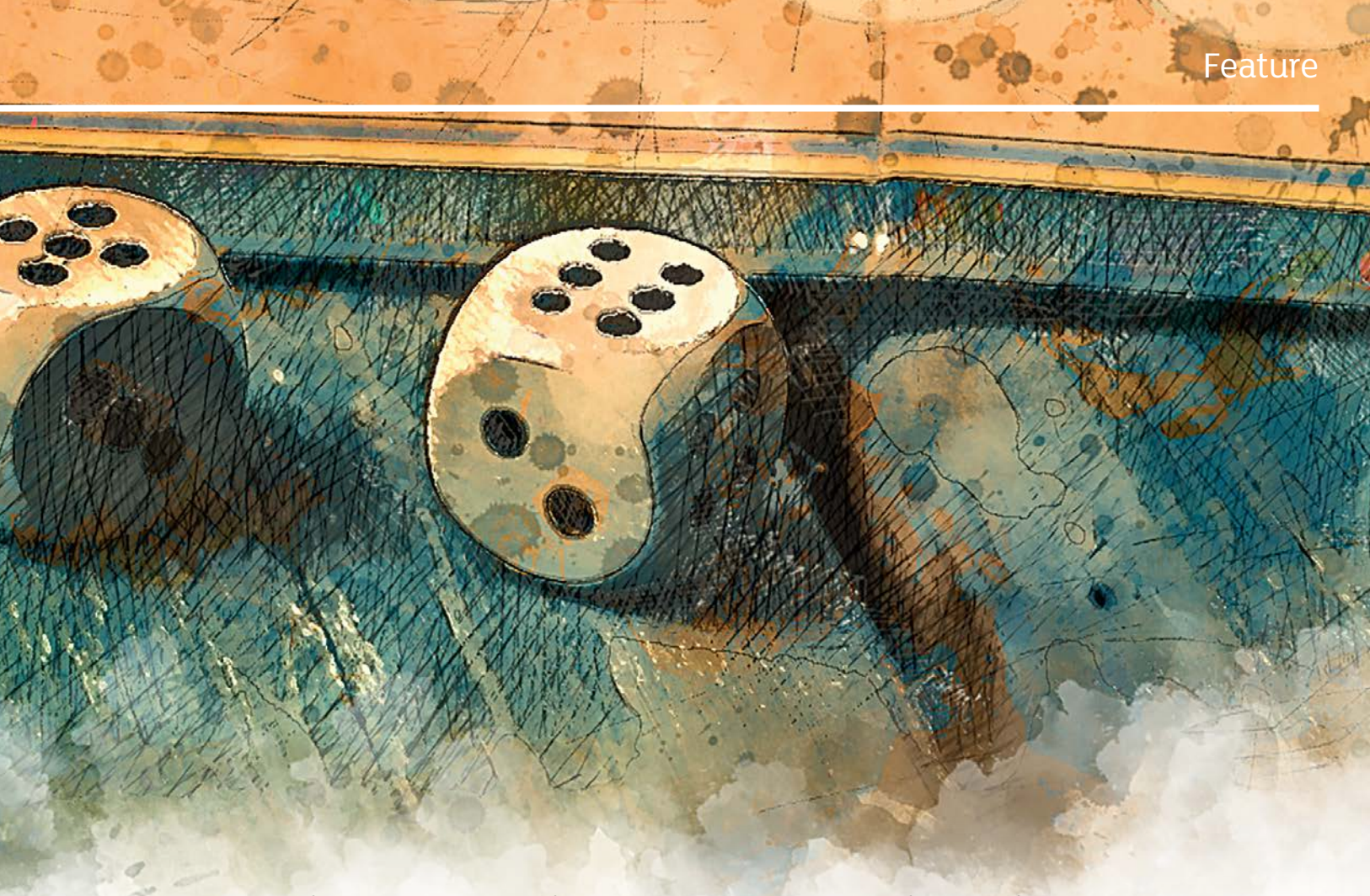
As with any new life stage, it appears that retirement can open a honeymoon period, which is followed by a dip before finding a new kind of satisfaction. Interviewees spoke of relief from no longer carrying clinical responsibilities, and in a few cases, their health had improved measurably after stopping work. Often there is a tension between wanting to build a new structure and not wanting to over-commit to the opportunities for volunteering, third age learning and helping with grandchildren.

For some of us, retirement will bring an obligation to care for family members; some retirees find themselves caring for elderly parents at the same time as supporting young adults with children. If our own health fails at the point of retirement, then the loss of feeling useful in the wider world, of colleagues and of intellectual challenge, may feel particularly heavy. If we're blessed with continuing good health, there's a good chance of enjoying retirement; therapists need to have a lively curiosity to do their work and this may help greatly in the transition to new pursuits.

Illness and death can overcome us in any decade but the odds increase as we age, and if we miss the chance to make a timely retirement, we could put clients at risk

Supervision

Preparation for retirement may be even more important for supervisors because a sudden unplanned ending could reverberate through a wide circle, including the clients seen by their supervisees. Allowing time for an orderly transition is



therefore important. Being aware of our own aging and mortality will also help us respond with sensitivity when supervisees are thinking about retiring, or, more contentiously, when we feel they need to think about it but aren't doing so. We need to be ready to help supervisees reflect on their aging and to fulfil this 'policing' aspect of our work, which for most of us is the part we least relish. This dilemma will be extremely challenging if the supervisee's financial circumstances make it difficult for her to retire. Many self-employed people have not been able to make effective pension provision, and if their capacity to work becomes reduced, there will be a very painful predicament. We may hope that supervisors achieve a way to support supervisees in finding a way forward, while holding client safety as the priority.

In my research I came across only a few people who had felt supported by their supervisor through the process of retirement. Some therapists had felt awkward about raising the issue with a supervisor because she was older than them. A story of muddled supervision came from one therapist who had set about retiring when her supervisor was doing so – she was somehow caught up in the supervisor's own process. She realised just in time that this really was not her choice and reversed the process and resumed full work for some years. Others told of peer groups who found it hard to engage with the departure of a valued colleague.

Conclusion

So often an ending links us back to the beginning; and one supervisee, Patsy, offered a powerful connection, referring to the initial motivation that led many of us into the profession: a hope to repair what has been awry in our own early lives: 'If we have chosen this work to meet our need to be useful, then it will be very hard for us ever to feel that we have done enough.' When we no longer have work to help us fulfil that reparative drive, then there will be the task of mourning and perhaps a new reckoning with that longing to make things right. At the same time, retirement is a rite of passage signalling a beginning as well as an end; it is the entry point to our own unique third age.

Reference

1. Carlisle E. Life-long analysis? In: Junkers G (ed). The empty couch. London and New York: Routledge; 2013 (pp67–78)

*All quotes from interviewees are taken from *Forced Endings in Psychotherapy: attachment and loss in retirement* (Routledge, 2015) and reproduced here with the kind permission of the publisher.

About the author

Anne Power trained at The Bowlby Centre, WPF and Relate. She is a visiting lecturer at Regents University London and has a private practice in London. Her book, *Forced Endings in Psychotherapy: attachment and loss in retirement* (Routledge, 2015), explores the process of closing a practice for retirement or other reasons. She is currently recruiting couples to interview about their relationships and would value contact with possible couples whose relationship originated in romance, arranged marriage or online.

anne.power@gmail.com