

How Senior Psychodynamic Psychiatrists Regard Retirement

Douglas H. Ingram and John Stine

Abstract: The variety of personal experiences and attitudes about professional work among psychodynamic psychiatrists who have attained retirement age are explored through semi-structured interviews. Of 21 members of the American Academy of Psychoanalysis and Dynamic Psychiatry interviewed, 6 report fulltime engagement in professional activity, 10 partial reduction, and 5 full retirement from practice. Through direct quotations from the respondents' interviews several matters are considered including the concept of retirement, structural changes in practice, health concerns, dream experience, spirituality and matters of legacy, how others have influenced attitudes toward continued work, and how fears of retirement are manifest among those currently in practice. Among the conclusions is the suggestion that the sense of self-regard and personal satisfaction of those who do retire is far greater than anticipated by those still in active practice.

On one occasion, the two of us, both senior psychodynamic psychiatrists, found our usually pleasant dinner conversation drifting uncomfortably toward the thorny question, To Retire or Not to Retire, with its disturbing existential allusion. Despite our efforts to return to the

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safer territory of books, music, and politics, the question of retirement snared us. How much of who we are is tied up with our work? Would we know ourselves without our work? Is the failure to retire somehow a failure of healthy maturity? What is the role of physical health? Is it safe to retire without having interests to take up? What factors might lead senior practitioners like ourselves either to continue working or to leave the field? And so forth.

We became curious and wanted to know more about how our similarly situated colleagues felt about this question of retirement. Nothing was found in the Psychoanalytic Electronic Publishing Archive (PEP) that addresses this matter. We decided to survey a sample of colleagues who are in the same age range as ours when retirement is considered appropriate in our culture. We sought to learn more about their attitudes toward their work, toward retirement, their fantasies, motives, and other factors. Since we are both members of the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP), we decided to send a general email to its 547 members (Appendix A). The Academy is a national membership society of psychodynamically oriented psychiatrists many of whom are certified in psychoanalysis.

We drafted a list of questions to serve in semi-structured interviews as the means to gather attitudes and concerns from those who responded to our email. We wanted to ask those still working about their view of retiring. We wanted to ask those who had retired if they felt a sense of loss. We chose to rule out queries about sex and marital fulfillment, and to touch only lightly on finances. Both areas might seem intrusive. We preferred to engage in those matters only if an opening in the course of the interview suggested that these matters might be explored. This same thinking applied to questions about fears of diminishing cognitive ability. We knew that in the course of asking about areas we thought useful to explore, others would arise.

Indeed they did. Early on, we found that we were off-base in asking about retirement altogether. The term was so ruefully regarded that we changed the theme and instead asked how "retirement age" psychiatrists deal with their professional work and personal identity. Our respondents were amply aware of the social cues indicating that they had achieved an age when retirement is common. When put in these terms, consideration of practice and career was more readily accessible for review. But whereas we learned "retirement" needed to be discarded, matters about cognitive decline explicitly entered our area of concern. Additionally, we learned that legacy mattered. What clinicians would be leaving behind for others was a concern we hadn't initially included. We also learned that some of our respondents were irritated when they were asked by others if they were "still working." The interests of our

respondents led to gradual modifications to our questionnaire (Appendix B) as our interviews proceeded.

We decided to conduct our interviews with a psychodynamic orientation. That is, in the course of seeking history and attitudes with explicit content, we were alert to the variety of avoidances, spontaneous comments, unbidden denials, idealizations, entitlements, externalizations, rationalizations, and other defensive operations that in combination are revealing of unconscious processes that might illuminate qualities of experience unavailable to less penetrating methodologies. We were appreciative, as we believe our subjects were, that we were performing psychodynamic interviews of psychiatrists who had enormous experience and expertise in performing those same interviews over their lifetimes.

The interviews were conducted by phone and were 30 to 60 minutes' duration. One of us (D.H.I.) has ample experience interviewing clinicians within research protocols and took on the task (Ingram, 2014, 2015). He explained that there would be no recording of the interview and instead, he would be taking extensive notes during the interview. He then entered his notes into a secure file. Each respondent was told that no quoted or paraphrased remark, however disguised, would be presented or published without that respondent's explicit written approval. Hence, each of the following cited comments has been reviewed and approved by its respective respondent (Appendix C). Some respondents were unconcerned if they were identified. Others rendered their responses abstract or opted to use disguise.

RESULTS

A total of ten retirement-age psychiatrists responded to the email solicitation. Of these ten, one failed to respond to repeated efforts of follow-up. Another lived so distant that the cost of a lengthy telephone communication was prohibitive. Eight respondents were interviewed. We decided to recruit an additional 11 respondents from among our collegial acquaintances in the AAPDP. Finally, we also participated for a total of 21 respondents, 17 men and 4 women. Of the 547 members of the society, age data was readily available for 480. We determined that the mean age of these members of the society in 2015 is 67 years. The mean age of the 21 subjects in our group is 78 years. The youngest respondent is 67 and the oldest 90. Since our respondents are either self-selected or personally solicited, we make no claim that the respondents are a randomized group. Rather than drawing large inferences, we prefer to believe the quoted material we collected and would pres-

ent will have some resonance for other psychodynamic psychiatrists of retirement age, or those in their prime looking years into the future, perhaps adding what they locate here to their own considerations.

Of the 21 respondents, 6 reported they were in full-time practice and fully active in other professional activities (average age of these respondents is 75); 5 reported their practice and professional activities were reduced by about 25–50% from levels that characterized much of their professional activity (average age is 75); 5 reported a reduction by 50 to 85% (average age is 78); 5 reported nearly complete absence of clinical activity and regarded themselves as fully retired (average age is 80).

We noted tendencies among some interviewees to meander in their responses. Some were excessively voluble. The interviews understandably served as an opportunity for respondents to announce an affirming relevance. None of the respondents demonstrated more than very mild cognitive impairment as best evaluated through general fluency, coherence of thought, and ease of recall. Infrequent slippages were evident in interviews with some respondents. There were occasional signs among some of regret and a rare hint of bitterness. Nevertheless, the sense of a professional life of fulfillment and personal meaning prevailed through the interviews. Though with an occasional wrinkle, our respondents were fulfilled in their work as psychodynamic psychiatrists.

In the following, with our focus on privacy considerations and where there is more than one quotation from a speaker, we decided to omit links that would enable the reader to connect quoted segments and thereby guess at individual identities. To further protect privacy, we omitted the ages of the specific respondents.

For reporting purposes, here, we think it is best to pool the gleanings of our interviews among seven categories: (1) In thinking how it would be for you if your worst fears about retirement were borne out, what is the image you'd have of yourself? (2) How do you find that you react when asked the question, "Are you still in practice?" (3) How does the notion of retirement strike you—maybe another term or phrase would be more apt? When did you first think about retiring? Say something about how your practice has been structured in terms of time—as the years have passed. (4) How did others—mentors, friends, or family members—influence your pulling back or retiring? (5) Has retiring, partially or fully, corresponded with an increase in spiritual involvement and/or religious engagement? Was teaching an important part of your life? (6) How have issues of possible memory loss been a concern to you? (7) How are your dreams?

1. In thinking how it would be for you if your worst fears about retirement were borne out, what is the image you'd have of yourself?

Whereas we imagined that those respondents with interests beyond their professional work would be less inclined to worry about how retiring would impact their sense of self, this turned out to be less the case than we expected. That is, involvement in significant interests outside the profession did not always mitigate concerns about loss of identity. The respondents whose excerpts are cited below had dedicated involvements in athletics, music, religion, and literature. Despite these interests, they expressed concern about how they would react to retirement.

- If I were to stop, it'd scare the s___ out of me. Who would I be if I didn't see patients? What would I do and who would I be?
- I do have that concern, how I'd be if I stopped working. The work I do is so much a part of me, and it takes up so much of my day, that I do fear that without it, I'd somehow lose my sense of compass. The meaning that I find in my work, the experience that my patients value me and the work I do, is so embedded in my sense of self that I cannot feel relaxed that if I were to stop that all would be well. On the other hand, I know I have a stable and strong character. Countless others have retired and gone on to other things—and I certainly do have interests and the curiosity to develop more interests—that I am confident that I'd be okay. Yet, there is this nagging fear (though I'd prefer to downplay it as a fear and prefer to see it as a "concern") that I'd struggle quite a lot with giving up my work altogether.
- Earlier, my identity was tied up with being a psychiatrist. I felt I was nothing without doing psychiatry. Everything else was a diversion. Nowadays, I am seeing fewer patients, but doing the best work of my life and it would be a shame to give it up. Teaching and doing therapy is the real meat of what I like—is what I want.
- I'd say 80 to 90% of my personal identity is tied up with my professional identity. If I am not working, I am not alive. But that is not to say at all that my professional identity is tied up with being Freudian, or Jungian, or what have you.
- I would experience not working as a psychodynamic psychiatrist as an incredible psychological loss. The creative engagement to work with another mind is terrific.

- My worst fears if I stopped working? I'd pull back and six months later have a myocardial infarction followed by cancer.
- If I had to stop, I'd feel lost. I do not have interests aside from my family. It is frightening. I'd have a terror of boredom because I need an external structure. I read and go to movies, but that's different, too passive. I like cooking. I love doing that, but when I think of taking cooking lessons, I do not follow through. That and financial considerations keep me from retiring.

Those who already retired, or who had much diminished practices, seemed to have adapted often by retaining some lesser level of professional engagement. This, often coupled with outside interests, warded off a destabilizing of personal identity:

- My worst fears anticipating retirement were that I'd feel miserable, bored, restless, not knowing what to do with myself and unable to find something to do. Now that I am fully retired, those fears have evaporated. The work that we do becomes so much a part of oneself that I think that this fear is universal. In reality, retirement does involve giving up one's professional identity but I think that the real problem is the individual meanings that we attach to the concept of professional identity. In fact, we all have multiple identities as husbands, parents, community members, friends, scholars, etc. For me, emotionally successful retirement seems to be shifting of our energies so as to enlarge and fill with meaning our other identities and to accept the fact that we can find and develop other sources of emotional gratification...I play the clarinet in a community orchestra, play in a wind ensemble, and clarinet-piano duets with a friend. I recently started to study the jazz guitar and take a weekly lesson. I work out several times a week at the gym in my building and work with a physical therapist/trainer once a week. I practice yoga several times a week. I am an avid reader and enjoy trying to keep up with the psychoanalytic/psychotherapy literature. My wife and I belong to a book club that meets monthly and she and I take a weekly class in the modern novel. We also meet with a friend weekly for coffee and a refresher in French conversation. In addition, I have joined a men's breakfast group and a monthly movie club. My wife and I enjoy going to the opera, classical music concerts, the theatre, and Jazz at Lincoln Center.
- In the course of gradually retiring, I experienced no depression and no problem of personal identity. Recently I started going through my records and throwing them out. I've had no big surprises in re-

tirement. Family, friends, hobbies, the Internet are plenty of stimulation and I still go to some lectures at the medical school. I'm honored to be Professor Emeritus. That fulfills my sense of identity as a psychiatrist, and I still give occasional talks on psychiatry to lay audiences through the Osher Lifelong Learning Institute.

- I have a friend who is a retiring attorney and he is petrified because he doesn't know what he'll do if he doesn't go to the office. I am at the other end: I have so many interests. My work seemed to interfere with my interests after a while. I've always enjoyed what I do professionally, but I also enjoy working around the house, reading, travel, theater, cars (I have four of them), an active social life. We have three grown children and seven grandchildren and that keeps us busy.

2. How do you find that you react when asked the question, "Are you still in practice?"

Somewhat late in the course of our interviews, two respondents spontaneously commented that they react adversely when asked if they are still seeing patients. We then asked this question of subjects whom we interviewed subsequently. The adverb *still* was interpreted by our respondents as indicating variously censure, surprise, disdain, bewilderment, or curiosity.

- In my prime, I worked 60 hours a week. It annoys me and makes me angry as hell when I am asked if I am still in practice. These days, I work about 18 hours in a week. I do one evaluation a week. I no longer do insurance claim work. It isn't something I want to do. But if a trauma victim needs help for PTSD or depression, I am available to do an evaluation.
- I don't like it when I am asked, "Are you still working?" My response is, "Hell, yes!"
- When I am asked, "Are you still working?" I say I am still seeing patients. Initially, I would answer, "Oh, yes." That was as if to say, I am somebody, I am still with it. Now, I sometimes wonder, do they think I need the money? What's wrong with him? So, that question turns out to be more complicated than it first appears.
- Being asked if I am still working somehow carries a realization of being forgotten. I went to a dermatologist who asked me this question, "Are you still working?" I thought, why should you ask that? What I said was, "I hate that question." At a health club a trainer

patronized me, calling me, “dear.” I hate that, also. Maybe I am a senior, but I’m a “junior” senior.

3. How does the notion of retirement strike you—maybe another term or phrase would be more apt? When did you first think about retiring? Say something about how your practice has been structured in terms of time—as the years have passed.

As we noted earlier, the concept of retirement—of a door slamming shut on professional work—had little meaning for our respondents. Rather, “retiring” or “cutting back” or “slowing down” seemed more effective in engaging our interviewees.

- Health concerns seem to lead me to think about retiring. “Retiring” not “retirement” is the way it should be thought of. I’ve been retiring for 15 years. If it weren’t for health, I’d be going full blast.
- The word “retired” is not right. It connotes that your working life is behind you. My self-concept is that I want to see myself as vital, active, engaged, and doing the work I love.

A distaste for the term “retirement” seemed to apply equally well to those who reduced professional involvement because of actual health problems and their consequences, and to those who, while currently healthy, regarded health impairment as inevitable. Significant medical events may spur partial reduction in professional activity even if the sequelae of these medical events do not impair function. Following are those whose health difficulties did not demand substantial reduction in professional activity, but for whom the likelihood of future health issues pointed in that direction:

- I’m a serious climber. I choose mountains that are a bit less challenging than when I was younger. Not K2 anymore, but still rough. I had a fall a year ago and spent two months recuperating. I wondered, how well would I recover from that fall? I did. I have no specific health concerns, but there seems now a possibility that something is going to show up. A high PSA or positive colonoscopy—now, I think, there is a possibility that something will show up. At a certain point you recognize that you are not going to go on forever. I like diving in the Caribbean in the winter and climbing in the summer and still can do it. Gabbard wrote about this, stay-

ing involved with psychiatry, and it is also in one of the psychiatry newspapers. I am thinking that I've been doing this work for 35 years. Maybe I'd do less hospital-based clinical work and private practice and more with politicking in psychiatry. Gabbard talks about not totally stopping because so much of our identity is tied up with our work and I am very much aware of that. But I think of another 5 to 10 years before pulling back, not 1 to 2 years.

- My practice has dwindled since my surgery. I haven't been as involved as I had been. My sources of referral have retired. I talk with others of my same age and find their practices have also dwindled. Also, I left my hospital position which was a source of referrals. Although I am pleased that the work I am doing for a community project is valuable and gives me a strong sense of purpose, it does not lead to new referrals. It was after surgery that I began to think about retirement. I need something to motivate me, stimulation. I play golf four times a week. In the winter I like to ski, but I have to have knee surgery in the fall, so that will be out for now.
- I first contemplated retirement when I was 72 years old, about four years before I completely retired from private practice. At that time, my wife and I had decided to sell our house in a northern suburb of New York City and to move into Manhattan. As we and our friends aged, we found people were moving away from our community and we were becoming increasingly socially isolated. In addition, we were finding that trips into the city to attend the cultural events that we both enjoyed were becoming more arduous, especially in bad weather. My father had died in his early 50s and I had begun to have a series of relatively minor health problems. I decided that I did not want to wait until I was too ill to enjoy retirement and be able to pursue my many interests. Accordingly, I began to limit my practice, accepting fewer new referrals for long-term psychotherapy and accepting more referrals for evaluations. Once we moved into the city, I rented office space and continued to practice on a very limited part time basis, working with patients of mine who either worked in the city or who were able and willing to come in, all with the understanding that I was planning to retire within in the next year. After some increased health problems that accelerated the retirement process a bit, I retired about six months ago, referring those patients who needed continued professional attention to my colleagues. Happily, these referrals have all gone smoothly and I know that my former patients are in good hands. One of my concerns with my increasing health problems was increased fatigue that threatened to impair my faculties and do a disservice to my patients.

- I wanted to get out of clinical work before I fell apart. I retired June 1 of this year [2015]. I was previously in private practice, child psychiatry, and Clinical Professor of Psychiatry at a top medical school. After leaving the military as a flight surgeon I took a residency in psychiatry. Hilde Bruch was an important influence. I did a lot of group therapy and was the hospital's main supervisor of groups. Some colleagues and I started a peer group now in existence for 40 years. Mostly child analysts. We did peer group supervision.

I was busy enough with a large volume of referrals. Since I didn't participate in managed care, there was some fall-off. As time went on—over the past 20 years—I began to slow down. That was okay. I have five active adult children and six grandchildren. Also, as time went on, so many of my colleagues and sources of referral died or retired.

The following respondent cited the health needs of his wife as contributing to his decision to cut back on professional work. Elsewhere in the interview, he mentions a colleague with similar issues and suggests that this may not be an uncommon reason to direct time away from practice.

- Reducing my hours of professional activity is more because of illness, both of a family member and my own. That is the main restriction to my working more. Another of our colleagues has a similar problem—the restrictions created by need to care for a sick family member. And since we have no other close family member out here, it falls to me now that I am almost entirely recovered from an accident that put me out of commission for a few months.

I am happy with the reduced hours and in fact turn away work away even though I have time. The situation has limited not my work interests or potential but my recreational interests—such as being away from home and travelling with friends. I am happy to be working less and settled into a situation that was precipitated by an emergency but has turned out to my liking. I continue to work because it is not overbearing, I have time for activities, and I love my patients and colleagues. I feel the pressure of age and time and want more alone time with my spouse before we both pass away (which I hope is long in the future). Our illnesses bring the sense of limited time.

Health concerns were less significant for some who, instead, cited the wish for more personal time for family or to pursue other interests. Health issues, or the expectation that health would become impaired overlapped with the wish for more personal time.

- I retired completely in 2013. I've been cutting back for nearly 15 years. For the past year or two before I retired, I had 8 hours per week of patients. Nowadays, I exercise and play the trumpet. I go to doctors a lot—but nothing serious: dermatology, dentistry. I keep up my membership in the Academy and in a local psychoanalytic society. I try to see one or two friends for lunch each week. I am going to take a course in fiction writing. I am thinking of a science fiction novel I'd like to pull together.

I never suffered from lack of referrals. It was a decision to have more time. When my father died—I was his sole caretaker—I wanted more time for myself. . . . If he had stayed well, or died suddenly, I might have gone on. But I was worn out. These days, I play online bridge and I am active in a local bridge club. I had no loss of identity when I gave up my professional identity. Money is okay—pensions and what-not. A small inheritance helped. That will help me to help my daughter.

- Starting about 2003, I began tapering my practice a bit. Instead of seeing seven patients a day, I cut back, declining referrals, retiring fully in 2006. I have a lot of interests—music, languages, fitness, and am never bored. I have a Master's in Public Health—took an M.P.H. after psychiatric residency. Family and couples therapy interested me, as did family planning and sex education as a form of preventive psychiatry. I supervised residents at a local medical school. Also, I enjoyed working with elderly patients on Medicare, and this got me thinking whether I want to stay in practice or leave and do other things while I still could. In my prime I worked 35 or more hours a week. There were no health-related issues and finances were good enough, comfortable. Now, in the past year, I have some memory problems, and could not function confidently in clinical practice.
- In 2004, my four kids all ended up in Chicago with the grandchildren. It was a hard decision because two years previously, I was given an important position at my medical school. That enabled me to do many things. But at the same time, we started visiting our kids and grandkids very often. We had once lived in Chicago

and I had a license to practice there. Ultimately, we bought a house near one of our kids. We built an office where I could see patients. I always had a full-time academic position. I was director of a neuroscience research lab. I wrote a book on brain physiology. And I also always had a part time private practice. My wife also had a very successful professional administrative position. Financially, we were okay. About two years into my new position at the medical school, we left and went to Chicago.

Declining referrals perhaps associated with shifts in career or health concerns contribute to retiring from practice—or the anticipation of retiring.

- I am not intending to retire and am doing nothing to speed retirement along. I assume I will have a certain amount of attrition over time. Practice tends to decline when people get into their early 70s. I assume my connection with others will reduce. People may want to hook up with younger psychiatrists and therapists. But maybe, too, we get a little less hungry and do not work so hard at practice maintenance. Maybe I am a little less willing to put up with the difficulties of clinical borderline patients. I take a little more vacation than I used to. Otherwise, there has been no decrease in my practice hours.
- I've never had to say to a patient that I cannot see anyone anymore. Referrals have gone way down because I am no longer at the hospital. And I do see new patients who come my way. I've had some serious health problems: broken hip, polycythemia vera with phlebotomies every six or eight weeks—but though it's a serious condition, it doesn't interfere.

Some interviewees rejected retirement out of hand, regarding it as simply not on their radar. Similar responses will be found below, under #4.

- I keep working. Why, you ask? Why not? My practice has not changed very much in the last many years. I get more referrals because I get to know more people. I accumulate more contacts. I am now and again happy to accept patients of older colleagues and mentors who are retiring, usually for reasons of illness. Their trusting me with their treasured patients, some treated for lengthy

periods, affirms that my respect for these doctors is reciprocated, and I feel especially useful.

One of the things that brought me to psychiatry was that you don't have to retire. Additionally, (1) older doctors in psychiatry are valued—age counts as valuable unlike other professions, (2) overhead is low, (3) if there is no decline in mental competence, there is a gain in judgment.

- I work 25 to 30 hours a week. All I do is psychodynamic psychiatry. I decided I would not do split treatment. I prescribe only for my own patients. In my earlier days, I worked 40 to 50 hours a week. I model myself on the old shtetl Jews who never retired. My father made money until the day he died.
- I had the good fortune to have patients contribute to our research and we were able to open an entire floor. The people I am working with are PhDs and MDs and we have half a dozen projects, all in psychosomatic medicine. We are often interviewing post-docs for our programs. We have grants and it is a going enterprise. I also have a busy practice. I just got one of my colleagues an endowed professorship. We have programs, among others, in which mothers write a lullaby for their unborn children. It is a program we have with a grant from Carnegie Hall [You've been drawn forward—not petering out.] Exactly. [The pace of your work, from your description is accelerating.] Yes. I want to add that telepsychiatry—I use Skype a lot—is an important evolution in the field, both for teaching and practicing.

4. How did others—mentors, friends, or family members— influence your pulling back or retiring?

- My father, an attorney, had no retirement plans and did not retire. He worked as long as he had breath in him. He died at 82 and had calls coming in on his deathbed. Like him, I also did not think about retirement. That was before I got ill at 66.
- My father was a doctor and worked to the last weeks of his life. That is my only model...I think of my father every single day... Like my father, who was very ethical, I take low fees when necessary...I feel absolutely more like a healer and I remember my father talking about that, being a healer. It is a cause. What we do is more a cause than a profession. I am very happy when someone is better. I feel that more than I used to.

- My mentors were at the Psychoanalytic Institute of New York Medical College—Walter Bonime, Marvin Drellich, Ian Alger, Irving Bieber—worked until serious health issues intervened, or they died.
- My thoughts about retirement have been shaped by my friendships and my observation of choices made by senior colleagues practicing psychodynamic psychiatry. From my senior colleagues I learned that with experience their practice can become more flexible and more creative. I could see that they gradually devoted more time to other aspects of their careers such as writing and teaching. They pursued personal interests with greater vigor. I learned from them the pioneering use of the telephone for sessions when patients needed to travel, or when they, the psychiatrists themselves, needed to travel or relocate for extended periods of time. This has led me to slowly transform my practice so it has become more manageable and allows me to dedicate attention to other areas beyond my professional work. As a result I continue to have a viable practice and yet can pursue my other interests. I intend to work with patients as long as I can.
- About 12 years ago, when I was 60, I thought I'd begin retiring. Instead of starting at 7:30 each morning, I began rearranging my schedule so that I'd start at 8:30. Then, a few years later, at 9:30. Now, I start at 10:30 each morning. I've made up for the lost time by working through lunch hours, but I still do take 10 minutes between patients—and I work until 7 p.m.

Most recently, my thoughts about retiring crystallized when a friend announced his intention to retire fully. I was going to follow suit. But I do this sort of thing. When a patient and another friend reported that their hearing was less than it had been, that they were getting hearing aids, I decided I also needed hearing aids. I tried them and found that my hearing was not so impaired that hearing aids were a benefit. The same happened when a couple of friends had prostate work done. Then, too, I figured I needed an evaluation for prostate. And, then, as with the hearing aids, it made no good sense to pursue that. I jumped the gun with hearing aids, with prostate, and now with retirement. True, I had some back problems, some slight loss in hearing fricatives and sibilants, some diminished physical stress tolerance—but nothing quite enough to justify retirement, only enough to justify a cutting back.

- Models for work and retirement? Marianne Eckardt and Walter Bonime—they never retired. Psychiatry lends itself to low energy, which I have. But I also don't want to work 40 hours a week, which I could do. I have enough energy for that. Teaching had been im-

portant for me but not in recent years. I stopped supervising residents about five years ago.

5. Has retiring, partially or fully, corresponded with an increase in spiritual involvement and/or religious engagement? Was teaching an important part of your life?

We found that spirituality, creativity, and sense of legacy seemed to fall together in associational sequences. The significance of legacy was another area that we had not anticipated when we composed our initial set of questions. Much as we learned that “retirement” was not useful to incorporate in our queries, we learned that “legacy” was useful to consider.

- When one gets to this age, one gets to the matter of legacy. How much you work or don’t work takes that into account. What are you doing with your life leaves a guideline for others? I bring that to dance, which I still enjoy. And I teach dancing. Many people retire because they want to work on legacy. It involves many things, such as spirituality. The spiritual side is important and has to do with retirement. You want to have a relationship with God. I say four prayers every morning. Sometimes I share this with patients of all religions if they ask and they find it very meaningful.

Creativity is also important. The time for creative activity in older persons is under-appreciated. Creativity is newly discovered in the older person. It is different than the creativity we find in younger people. E. Jaques (1999) uses the concept of “sculpted creativity” to refer to the kind of creativity we can have in later life when experience, understanding, and application over many years enables an enlarged quality of insight.

- As for legacy, I sense that my work has had a beneficial effect on the people whom I helped. I don’t feel a need for leaving my name attached publicly to that legacy. That I have helped and that many of my patients know that is enough.

As for mortality, I have more time to think about it, but it is not generally associated with anxiety. Still, I am not looking forward to death. With age and retirement, I am increasingly aware of separation and endings. In my retirement, years seem to go by faster when I think back, but the actual experience of time, day by day and week by week, is slower. Experienced time feels slowed, but remembered time feels sped up.

- We are in high demand among the residents. We have to keep doing this. This is a responsibility we have to keep going. This is very important. This is the generativity aspect that Erikson speaks about. We have to give back. We can really help younger people. Mentoring is very important, even when one is no longer seeing patients. It is important to want to heal...I feel more positive and optimistic and spiritual as I get older. It's a nice lovely warm feeling. But I don't feel more religious.

Partial retirement can provide the opportunity to pursue religious studies:

- I call myself semi-retired. That means that I preserve Monday's and Wednesday's for myself—I make no exceptions. I just don't work those days. I find it in a way liberating, but I have plenty to do on other days. I take it easy in the morning, go to the gym for one-and-a-half hours, shop, edit my photographs, and so forth. I schedule things like dental appointments. On Wednesdays I study religious texts with a friend and have a massage. My personal scheduling has a lot of flexibility. It is loose and doesn't have the same rigidity that office scheduling requires.

Spirituality can take a different orientation though not explicitly because of retirement:

- I identified myself as Catholic growing up. I stopped pretty much and now I have joined the Ethical Culture Society in this area. So that has become quite important to me. It is a community similar to me age-wise.
- I am a member of the Center for Inquiry, a secular, critical thinking science oriented group. I read the literature. I have gotten interested in science-based medicine. I am reading in philosophy and physics. I have not gotten interested in organized religion, but I do regard myself as a spiritual person in the widest terms.

The sense of personal legacy with respect to one's family was generally implicit for all respondents:

- In terms of legacy, I certainly feel that in terms of my children, as someone who has been a loving and supportive father. I am still ac-

tively writing papers. I'd like to live on in a body of work, e.g., collected papers. I am writing an autobiography, but just for my family.

- While I enjoy other creative pursuits (writing poetry, editing family pictures, creating personal narratives for family members) nothing compares to the joy and challenge of engaging another human being in the discovery of their psychological selves.

6. How have issues of possible memory loss been a concern to you?

Only in the course of the interview process did this question arise. As with "retirement" and "legacy," it was not on the original list of questions we intended to ask. It arose because the respondents were concerned about it. They were either aware of memory difficulties or anticipated that memory difficulties were likely to occur in the future.

- I notice that my memory is starting to slip a little. I am not as sharp as I used to be. I went into the office this afternoon and forgot that I had taken the afternoon off. Now, I have 12 to 15 hours a week of private patients and I work for Project T___ three mornings a week. My current total hours of PT care is 30 hours. At my peak, I was at 50 hours plus another 10 of practice administration.
- Some of my mentors had cognitive problems. I do worry about that. How, when, and who will tell me when to stop. My father retired and died a year later. That may have had an effect on me. Ageism is alive and well and there is a prejudice against people of a certain age, that you're over the hill.
- A few years ago in connection with treatment I needed for prostate cancer, I underwent some testing, including cognitive testing, and was found to be perfectly competent. I passed with flying colors. I felt that I wanted to get out of this work while I am still on the top of my game. I started to think about retirement seriously two years ago. When I decided I'd retire, I was at about 20 hours of patient care. In my prime, I was at 60 hours of professional involvement. About a year ago, I was down to about 5 hours of therapy a week.

7. How are your dreams?

Inasmuch as the respondents are analytically oriented and dreams figure significantly, we wondered how they experienced dreams and if

they sought to interpret them. Three respondents reported no dreams when specifically asked. Respondents other than those below either were not asked about their dreams or bypassed the question.

- In my dreams at night, I sometimes revisit the various settings in which I did clinical, teaching, and administrative work throughout my career, including my rotating internship, my residency, and, especially, my experiences with indigenous peoples. My dreams also include meetings of the Academy where, in these dreams, I'd run into dear old friends, most now deceased. In Academy meeting dreams, I am sometimes asked to give a talk and, of course, I am usually unprepared in some way!
- I dreamed the other night that I was casually dressed at a medical school reunion. I was very youthful in appearance and walked through the tables and lounges of elderly men in suits, my classmates. I hadn't kept up with any of them. I had been recovering from some procedure and had been out of my practice for a while. I had just phoned a colleague. But he was hesitant, and I surmised that he had done well enough without me and perhaps I didn't need to come back. I was apprehensive.
- I have night dreams in which from time to time my parents appear and I am faced with them aging and in decline. Those are dreams of mortality. I remember my first dream: I saw a tombstone with my name on it. I awoke terrified and my mother comforted me. I've always had this counterphobic orientation.
- I have recurrent dreams of being in a building or house. It feels comfortable. But I am looking for a way out so that I can have more time outside. What does the dream mean? Maybe although my life is comfortable, age and health limitations create a sense of restriction. I would like more time in nature, in recreational activities, to enjoy the brotherhood of men and colleagues. Yes, the aging thing bothers me. I used to travel to Europe and Asia alone for weeks or even months at a time or be off on an outdoor adventure with a group of like-minded people, but I don't do that now. My brother chuckles and says, "What do you want? You're an old guy!"
- My dreams are very mundane. I have them, but I'm not inclined to dwell on them. When I was in analysis and at an earlier point in time, I'd think long and hard about them. I don't feel like doing that anymore, so I don't think about them much...I have a second thought: my dreams are not really mundane. I tentatively look at them and attribute some meaning relating to relationships and life, and occasionally to clinical work. I suspect that I am hesitant to

explore them more perhaps because I know that they will deal with my mortality.

DISCUSSION

In the tradition of narrative medicine we are satisfied to enable the voices of these retirement-age psychodynamic psychiatrists to speak. We think it is sufficient to suppose that their experiences might provide resonance and even instruction to those in similar circumstances. Insofar as the respondents in this study either volunteered to be interviewed for this project or were colleagues of the authors, any generalities drawn are uncertain. What can we say about those we did not interview, those who are not represented? For example, any psychodynamic psychiatrists and psychoanalysts who fled the profession out of bitter disillusionment are not represented. The lack of salience of the topic or the wish to avoid self-disclosure would lead others to decline participation. Also omitted would be those whose professional identities were so critical to their sense of self that speaking about their experiences might be unacceptably painful. Regardless, those who relinquished membership in the AAPDP for whatever reason were not consulted.

Nevertheless, our consideration of the matter led to our postulating motives for retiring, or not.

Somewhat arbitrarily, we name nine factors in favor of remaining clinically active: (1) By contrast with most medical specialties, the private practice of psychodynamic psychiatry requires lower cost overhead and entails less physical vigor. (2) Staff may be minimal or absent. (3) The space for waiting and consulting rooms is likewise minimal. (4) Instrumentation is nil. Not even is a couch necessary. (5) Even professional liability insurance rates are far less than other medical specialties. (6) Significantly, patients are seen by the hour enabling the psychiatrist to expand or contract practice based on desire and circumstance. (7) The satisfaction of helping, or, more precisely, of applying well-wrought skills to benefit others may be substantial. (8) There may be a status factor in continuing to work, in remaining relevant and productive as others in one's circle move to leave work. (9) The structure imposed by continuing work may ward off various dysphorias that may occur when time might otherwise seem relatively empty.

At the same time, the practice of psychodynamic psychiatry has become increasingly more difficult for many clinicians. Again, in a neat symmetry, we name nine factors that favor retirement: (1) Psychiatrists, as with physicians generally, are encountering increased administrative demands arising from new government regulations. Most recently, in

New York State, for example, mandatory electronic prescribing of controlled substances with two-factor identification sets a new administrative hurdle. (2) Obtaining adequate reimbursement may prove difficult when third party payers favor treatments that emphasize fast results rather than introspection and self-awareness. (3) The flow of referrals is impacted by the fact that psychoanalysis and psychodynamic psychiatry are under increasing threats of marginalization by advocates of cognitive behavioral, neuroscientific, and psychopharmacological approaches to mental illness. (4) Health concerns and diminished vigor point to retirement, or at least an easing up. (5) Caring for a spouse or other family members may suggest exiting professional work. (6) Pursuing long-neglected interests may call on the clinician to relinquish practice in order to engage these interests. (7) The sense of been-there-done-that or what passes for burnout may lead to reduced interest in work. (8) For clinicians who have planned well financially, the financial gain of working has less incentive than it did earlier in one's career. (9) Finally, as others in one's circle retire and engage in more leisurely activities, the attraction of joining them may lead one to relax professional practice.

Our original endeavor had been to determine a wide range of factors—the how, why, and when psychodynamic psychiatrists choose retire, or not. The sour regard our respondents had toward the notion of retirement led us to revise our goals. We shifted direction. We decided to ask how retirement-age psychodynamic psychiatrists regard their work and themselves. Employing a psychodynamic interview approach, we were alert to the variety of avoidances, spontaneous comments, responses to unasked questions, unbidden denials, idealizations, claims, externalizations, and rationalizations that are revealing of factors that we care about. These are factors that may not be evident through reliance on a straightforward questionnaire.

How, for example, do retirement-age psychiatrists process the emotion-laden issue of professional self-image and self-regard when their practice begins to shrink because of waning referrals? In some cases, we speculate that at least some respondents use adaptive defenses against the loss of professional self-worth that involve turning passive into active. They say, in effect, "It is not that people are seeking my help less often but rather that I am reducing my practice for reasons of health or to pursue other interests." In other cases, however, the respondent may be using good reality testing, acknowledging the fact that there may be a general falling off of referrals because of increasing numbers of competing mental health practitioners offering competing therapeutic approaches. Or, the respondent may correctly recognize how decreasing third party insurance coverage for psychodynamic therapeutic ap-

proaches is impacting the economics of practice. Finally, there is good reason to suppose that the patient population that is interested in pursuing an introspectively oriented therapy is shrinking. Whether the retirement-age psychiatrist employs turning passive to active or good reality testing, or—as might often be the case, some combination of strategies—we feel that these constitute constructive, adaptive psychological reactions.

Sometimes, our respondents showed circumstantiality and volubility. At times, the interviews were evidently opportunities respondents employed to announce and affirm their relevance perhaps suggesting to us concern about existential diminishment. There were occasional signs in our respondents of skittering close to the edge of bitterness and despair. Professional regrets and concerns about the profession were present. Nevertheless, generally, the sense of a professional life of fulfillment and personal meaning prevailed through the interviews. At no point was the interviewer concerned about any of the respondents' cognitive or emotional competence.

Of the 21 respondents, we found that 6 had rejected retirement in the present or near term. The remaining 15 seemed to be evenly divided three ways in their primary stated reason to retire. They either had (1) health concerns involving themselves or a family member, (2) wished to relax at a stage in life when that seemed a legitimate option, or (3) had interests they wished to pursue. Understandably, these explicitly stated motivations overlapped.

Three of the five respondents who retired completely gave health considerations as primary. The remaining two wished to engage other interests. The average age of those who retired completely (80) was four years higher than all others (76). Another interest emerged for us as the project advanced: how did mentoring contribute to attitudes toward retirement? This factor was striking for some respondents, but most reported little recognized influence by mentors in connection with retirement. The names of two eminent analysts, Marianne Eckardt and Walter Bonime, recurred. Two respondents cited their fathers as serving as a model for deferring retirement.

No evidence emerged that retirement and the presumably amplified sense of mortality brought our respondents into closer relation with organized religion. Yet the sense of transcendent communion and beneficial engagement with humanity is evident in the interviews—sometimes expressed explicitly, sometimes not. Many of the respondents emphasized a view that the profession of psychoanalyst-psychotherapist-psychiatrist is a calling, a true profession as intended in its original sense. These respondents regarded themselves as healers. For them, in its broadest interpretation, professional engagement has a spiritual

component. While there is little to suggest that our respondents became more committed to religious involvement than they had been earlier in their professional lives, their sense of themselves as teachers and mentors is evidently a critical and continuing component of self-identity. All but one of the respondents interviewed cited teaching as a major factor in their professional lives.

We had four surprises:

1. We were surprised by the resentment and possible defensiveness when we asked respondents, "How do you find you react when asked the question, 'Are you still in practice?'" We did not query all or even most respondents on this point so we cannot comment on how frequent retirement-age psychodynamic psychiatrists share this feeling. Surely, the reported reactions were not universal. So, does the anger and resentment trigger a healthy, assertive, and essentially normal reaction to implied age discrimination? Or, does it show a defensive posture taken by someone who cannot accept that aging is normative, at least statistically. And, to take it one step further, does the self-righteous resentment imply that they view those who do retire as having accepted a second-class level of existence. Does this resentment effectively reflect and approve our society's cultural assumptions that only those who work are productive and that earning money is needed to have a worthwhile existence?
2. We were surprised at how different were the attitudes of those who had already retired from those only considering retirement. Those respondents who had completely retired reported little difficulty with existential concerns, the structure of their lives, or a sense of personal meaning. By contrast, several respondents still in active practice worried about how it would be for them without the structure and engagement they found in their professional responsibilities. "If I had to stop, I'd feel lost." Perhaps the biased sample selection accounts for this difference in the two groups. More reassuringly, however, is the possibility that the relinquishing of professional activity and adapting to retirement is far more manageable and satisfactory than expected by those still working.
3. Another unexpected finding was concern about cognitive diminishment. For some this was explicit. For others, the spontaneous denial of cognitive difficulties was notable. In a word, the sense of cognitive loss was a shadow hovering over these clinicians, present enough for them to respond to an unasked question about it.
4. Finally, we were surprised that these analytically trained retirement-age psychiatrists showed little interest in exploring their

dream life. Earlier in their training, the utility of dream analysis would have played a major role in their introduction to psychoanalytic theory and practice. Yet, now, at this stage in their lives, the analysis and exploration of their dreams was relatively meager.

CONCLUSION

In a more general way, our findings indicate there was very little evidence of burnout or job dissatisfaction among our respondents. We hasten to qualify this comment by again noting how non-random this sample is. Colleagues in full or part time practice made it clear that they found their work to be gratifying and of value to both themselves and their patients. None of the roughly 25% of our sample who are fully retired attributed their retirement to dissatisfaction with their work. Instead, their retirement seemed more related to health issues, changing patterns of practice in the field (fewer referrals, the economic problems of dealing with third party payers), and the wish to explore other areas of interest or to spend more time with family.

If burnout is indeed less frequent among psychodynamic psychiatrists, generally, what might account for this possibility? Perhaps the gratification of long-term dyadic engagement with patients and of working within the proud intellectual tradition of psychoanalytic theory form a sense of intellectual community and, in so doing, plays a protective role. Again, those who responded to the general solicitation and those colleagues whom we personally solicited may well represent a group that throws a particularly favorable light on the matter we are considering.

What emerges as a final instructive note for the retirement-age psychiatrist is that possessing interests other than psychiatry are protective as practice and professional engagement generally begin to slow. Those interests may be intellectual, musical, athletic, artistic, spiritual, or directed to enhancing legacy. This exploratory project suggests that the variety of interests that were subordinated to professional activity during work life tend to surface during retirement and serve to affirm character structure and personal identity. Yet, perhaps a more accurate view is that beyond exercising existing interests during a time of professional slowing, it is the fertile capacity to develop or enlarge interests, those existing or those newly conceived, that is protective and that enhances generativity and personal meaning.

APPENDIX A

Dear Colleagues:

We are interested in learning more about the issues raised by retirement from practice for dynamically oriented psychiatrists and psychoanalysts, a group typified by the members of our Academy.

If you are contemplating retirement, are in the process of retirement or have recently retired, we would welcome the opportunity to talk with you. One of us (J.S.) has recently retired from practice. The other (D.H.I.) is considering the same move through a gradual reduction in office hours. We wish to learn more about how other colleagues think about and manage this process. Consequently, we plan on interviewing all colleagues who respond to this solicitation.

Each interview may be carried out by either one of us by telephone and should take about 45 minutes. We will, of course, respect any time limitations that you suggest. The interviews will not be recorded but we will take extensive notes.

We are more interested in exploring experiences, fantasies, motivations, plans, and related factors, in short, the existential and psychodynamic dimensions, than in exploring demographic statistics. In the aggregate, we expect these interviews to provide a rich overview of the meaning of retirement for our professional community. It appears that little has been written about this important life cycle event for our professional group. We feel that an exploration of this issue through personal narrative would be illuminating and relevant for psychodynamically oriented psychiatrists and psychoanalysts.

Please note that this project has not been presented for consideration or sponsorship by the Academy.

If this is of interest, please reach me (D.H.I.) by phone (212-289-4022) or email (DHIngramMD@aol.com). We will take your participation in our project as informed consent. We will protect the confidentiality of all discussions. Under no circumstances will identifiable personal data be revealed in any presentation or publication. Narrative material will be disguised by us and then reviewed by each subject prior to eventual publication or presentation. Each subject will be able to veto any material provided in the event that he or she has second thoughts about its inclusion. Only after a subject is satisfied with material that he or she has reviewed will we request consent to present or publish it and we will only publish material for which consent has been provided.

We look forward to hearing from you.

Sincerely,

Douglas H. Ingram, M.D.

John Stine, M.D. (retired)

Dr. Ingram is past-editor of the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, former president of the Academy, Fellow of the American College of Psychoanalysts, and Clinical Professor of Psychiatry at New York Medical College. He is a Life Fellow of the American Psychiatric Association.

Dr. Stine is a Fellow of the American Academy of Psychoanalysis and Dynamic Psychiatry where he is serving as Trustee. He is a member of the New York Psychoanalytic Society, the American Psychoanalytic Association, the American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry. He is a former Associate Professor of Psychiatry, Cornell Weill Department of Psychiatry, Westchester Division.

APPENDIX B

The following lists the general framework of queries to include in the interviews of respondents:

- How do you find you react when asked the question, “Are you still in practice?”
- How does the notion of retirement strike you—maybe another term or phrase would be more apt?
- When did you first think about retiring? Say something about how your practice has been structured in terms of time—as the years have passed.
- Prior to any movement to retire what would you say are the usual number of hours per week you would work in direct care of patients in your practice? And how has that changed since you moved in the direction of reducing your practice?
- Do you take off more time? Vacations?
- If you are still practicing, in thinking about giving up your practice do you have concerns that you will lose your identity, that you won’t be sure of who you are?
- How did your parents or other family members manage their careers and face retirement issues?
- In thinking how it would be for you, if your worst fears were borne out, what is the image you’d have of yourself?
- If you’ve stopped practicing, how did you go about terminating practice? Or, if you have reduced your practice, how has that come about? For example, did you experience a natural decrease in reduction of referrals perhaps because patients moved away or died? Have you lost contemporaries who were sources of referral? Or, have you taken active steps to reduce your practice? Some combination?
- If you’ve stopped practicing, or are on your way to slowing down, what new activities if any have you taken up, or what interests are you pursuing that previously were blocked by the hours of work?

- If you have ceased practice, how are things different from the way you imagined it would be? How long ago did you cease practice?
- Age? If fully retired, how long?
- What has led you to retire or think about it? (Health? Finances? Decline in practice as referrals diminished? The wish to have more time for other pursuits? Combination of above, etc.)
- Was teaching an important part of your professional life? How has that changed?
- Was administration an important part of your professional life? How has that changed?
- Dreams?
- Personal professional regrets? Concerns about how the profession has changed from the vantage of your current age?
- Has retiring, partially or fully, corresponded with an increase in spiritual involvement and/or religious engagement?
- Has retiring, partially or fully, corresponded with an increase in creative involvement (music? art? dance? athleticism? etc.)?
- Do you occupy yourself with matters of legacy? That is, arrange things you've done or work on matters with an eye to how you will leave family, friends, community, or the world a better place. (An example might be charitable work, or, closer to home, collecting and cataloging family pictures.)
- How have the changes in psychiatry impacted your practice or your willingness to continue practice?
- If you had a colleague with increasing cognitive problems, what would you do?
- What advice would you have for a colleague who is thinking about retiring?
- Why did you choose to respond to this summary?

APPENDIX C

Dear Dr. A:

You may recall that we spoke earlier this year, exploring your experience as a "retirement-age" psychiatrist. We are about to begin the next phase of our project. This entails checking out and perhaps modifying the quotes or paraphrases of each of our 21 respondents.

We want to quote from notes of our conversation. As I said earlier, I would check with you before we included anything from that conversation. We have submitted an abstract of the paper for possible presentation at the May, 2016, meetings of the Academy. We also intend to submit the paper to the Academy Journal.

In reviewing what is below, please keep in mind that the paper is likely to live indefinitely on the Internet. You need to imagine the possibility that it will appear in the *New York Times* and who knows where else. Although your name does not appear, those who know you and others who may put two-and-two together may guess at your identity. You may not care, or you may. If you wish, please recommend changes that would effectively disguise your identity. Below, I will offer some disguise possibilities. We need your approval to use what we finally arrive at. I will be happy to speak with you by phone to go over any part of it that deserves our joint attention. Please allow that we may make changes in sentence structure to conform with syntactical and grammatical usage.

Although I took extensive notes from our conversation, space limitations dictate restraint in what we can include. Here are the sections we would like to incorporate:

[one or more quotations from interview notes]

You may be highly identifiable in these segments. If that is acceptable to you, we can keep it as it is. Nowhere do we indicate your age, so that doesn't enter into it. By way of suggestion changes, we can omit _____ in the quote. We can substitute _____ for _____ at another point in the quote. Please let me know if what I have is acceptable, as is, or make suggestions as to how we might change it. What we seek to publish of this is entirely up to you. We very much look forward to hearing back from you.

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