

Title: Taking the Leap into Private Practice

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APA: Hello, and welcome to today's webinar, Taking the Leap into Private Practice. This roundtable discussion is part of a new webinar series, Professional Resilience in Changing Times, designed to offer strategies for psychologists facing career shifts, employment disruptions, and supporting clients through job uncertainty. Some housekeeping notes before we get started.

The views expressed in this webinar are those of the panelists and may not reflect the views of the American Psychological Association.

Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes.

A recording of this presentation will be emailed to everyone in two weeks' time.

During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. Have a question for our panelists? Type them in using the Q&A box located on your webinar screen.

Now, for our moderator, Marnie Shanbhag, APA Senior Director in the Office of Independent Practice. Before joining APA in 2023, Shanbhag ran her own practice in Orlando, Florida, for more than 16 years. Her independent practice expertise spans both mental health care practice and applied practice. With a special interest in leadership, immigrant communities, and maternal health. Welcome, Dr. Shanbhag.

Dr. Shanbhag: Thank you very much, Peggy. I'm very glad to be with you all here. Welcome, everyone. Good evening for those of you who are on the East Coast. As Peggy said, I run the Office of Independent Practice for APA. I'm really excited about the panelists you'll be hearing from tonight. Before I introduce them, let me talk a little bit about why we're even talking about this tonight. It's a timely topic because, as you may have heard, the federal workforce is downsizing a little bit right now. The federal workforce has always been a very robust employer for psychologists.

We're also in the post-COVID era, where many psychologists, like many of us, started rethinking our careers. Maybe thinking through our work-life balance, or thinking through work environments, and what we wanted to do in the next phase of our careers. Maybe thinking about autonomy and some flexibility. Some of us went into private practice during that era as well. We're talking about how you make this transition into private practice as a result of those two things that we're still moving through in this next few years.

Before I introduce our panelists, I wanted to acknowledge that what you hear tonight is very specific to private practice in the United States. It's also specific to psychologists. There's a lot of good information that's applicable to experiences that are broader than just those two situations. I also just wanted to acknowledge that making a career transition is scary, no matter what. It's particularly difficult if the decision is not yours and is not a voluntary decision because of a layoff.

I just wanted to make some room for that in today's conversation, if we've got people who are in that situation and are thinking of transitioning to private practice as a result of downsizing. I am really excited, though, that we've got psychologists who are willing to share their own personal stories and talk about the realities of making this transition for themselves. I'm going to introduce them in alphabetical order tonight. If you could just raise your hand, as I'm referring to you.

First, we have Dr. Angela Lawson. Dr. Lawson is a licensed psychologist with Dr. Lawson Consulting in Illinois. During COVID, she started her own clinical and forensic practice where, in addition to forensic psychology evaluations, she provides consultation and psychotherapy services related to reproductive mental health, sexual trauma, and psychotherapy services. She's also a former full professor of obstetrics and gynecology and psychiatry at Northwestern University's Feinberg School of Medicine. Welcome, Dr. Lawson.

Next, we have Dr. Melissa London, who's a licensed psychologist in California and recently transitioned to private practice, where she provides individual and group psychotherapy, supervision, and consultation. She remains affiliated with the University of California, San Francisco, and the University of San Francisco. Prior to leaving her most recent position with the San Francisco VA, she had over a decade of experience working with veterans and their families in specialty clinics for trauma and addiction.

Next, Dr. Steven Norton is a licensed psychologist in Minnesota, providing forensic evaluations for state and federal courts and pre-employment evaluations for law enforcement, correctional, and federal security agencies. Prior to opening his own solo private practice, Norton Psychological Services, Dr. Norton obtained extensive experience working with the Federal Bureau of Prisons, and also has experience working with state and county correctional facilities. Along the way, he even served as the first civilian psychologist assigned to the US Embassy in Kabul, Afghanistan. Maybe a little more dangerous than most of us might face in private practice, but also an example of the kind of opportunities that might be out there for private practitioners.

Last, but certainly not least, Dr. Chuck Ruby is a licensed psychologist from Maryland who's been in private practice for more than 26 years. Providing psychotherapy services focused on humane ways of coping with difficult issues and life circumstances. He's also the executive director of the nonprofit International Society for Ethical Psychology and Psychiatry, and a retired lieutenant colonel who served 20 years in the United States Air Force.

I hope you can see what a distinguished group of individuals we have joining us here today. I can say a lot more about each of our panelists. I've left out their educational backgrounds, their books, their publications, their awards. I didn't want to take more of our brief time together because I really know that you want to hear from them and their stories about life in private practice. With that, I'm going to go ahead and get us started.

As we begin our conversation, I'm going to ask each of them to think back to the year before they went out on their own in private practice. I'm going to ask them to think about the kinds of things they were thinking through as they decided to make that

leap. I'm going to start with Dr. Ruby because I think of our panelists, you might have been in practice the longest. What were you thinking about that year before you decided to take the leap? Dr. Ruby, you're going to come off mute.

Dr. Ruby: Hey. Here we go. Thank you, Marnie. It's good to be here. That's a tough question. As I'm getting older, it's hard to remember what I was thinking that long ago. As you said, psychology is a second career for me. I was in the military at the time that I decided to go into psychology. It was about year 12 of my military career where I applied for and was accepted in a clinical psychology program at Florida State University. To get a doctorate degree, go back to the military, and work as an investigative psychologist with the Air Force Office of Special Investigations.

That office does basically felony criminal investigations, counterintelligence, and counterespionage work for the Air Force. I did that. I intended fully after my 20 years to continue in that kind of either forensic or investigative field. I just fell in love with psychotherapy. I never anticipated that, but the experience of doing psychotherapy, working with people, really turned me away from the forensic area. I decided to look into local practices where I lived at the time to see what it was like actually doing the work.

I started out part-time. I was fortunate, which most people aren't, but I was fortunate to find a current group practice, a large group practice, and I joined that group practice. A lot of the issues about starting a practice, I did not have to worry about the reputation, the marketing, and things like that. I just benefited from an existing practice.

Dr. Shanbhag: Can I ask, were you an employee of that practice, or was it like an independent contractor?

Dr. Ruby: Neither. It was a partnership, basically. We worked on commission basis. We still do. It's more of a-- for tax purposes, a partnership. Anyways, I found it incredibly freeing coming out of the military to have my own schedule, to not have a boss, which is one of the benefits of private practice depending on how you're set up. That freedom was incredibly terrifying at the same time, and it was financially unstable. Those two things have to go together, financially

instability with occupational freedom.

I was fortunate, as I said, because I had retired from the military. I already had a financial basis. I already had a retirement coming in. I already had health insurance. I never really had to deal with those kinds of real concerns. I stayed with that practice in order to supplement my income because, at least in the practice that I joined, income wasn't great. It wasn't bad, but it wasn't great. I supplemented that by becoming more involved in the management of the practice. I invested. I'm currently one of the owners. That investment got me into the position to manage and be the general manager of the practice.

Now, I have been since, I think, 2003. Obviously, I get paid a commission for doing that kind of work, in addition to my psychotherapy work that I've done. Long story short, it's been a great move on my part, but I would not say I planned it to happen the way it has. That's one message I would give to all the people who are

participating here. Don't think your plans are going to work out because they won't, but you can be flexible enough to follow and move with the things that happen along the way to get the best out of it that you can.

Dr. Shanbhag: How about for you, Dr. Lawson, because you're closer to that when you have left. The year before you left, what made you go into private practice?

Dr. Lawson: I had been thinking about going into private practice for more than a year before I actually made the leap. I was working in academic medicine during the pandemic. Academic medicine and medicine in general changed in a variety of ways because of the pandemic. It shifted the way I thought about what I wanted to do in the future and what brought me joy. I, since 2004, also had a side hustle, so to speak, working as a forensic psychologist. I had gotten a taste of consulting work while working at the university.

In the year immediately prior to leaving, I knew what my specific timeline was going to be because I was up for promotion to full professor. I had decided that I wanted to wait to see whether I received the promotion and whether or not I received it. I had planned to leave shortly thereafter, and that was indeed what I did. In the intervening year, after I submitted my promotion packet, I talked to all of my colleagues and friends that I knew who worked in private practice. I began to learn about what I would need to start my practice, my LLC.

What everyone's thoughts were about taking insurance, not taking insurance. What note or recordkeeping system they liked. Who was going to be my website designer. A year was plenty of time to do this, but I was able to get everything in place so that by the time I gave my notice, and I gave a three-month notice, a very long notice, I had everything ready to go that I just needed to click a couple of buttons after my last day at Northwestern to start my private practice.

Dr. Shanbhag: Wow. You took about a year to think through it, plan, get ready, and then push go. Dr. London, you've also recently made the transition. You also take a bit of time to put a plan in place?

Dr. London: I did. I also gave a three-month notice, I think. Coming from big settings, when you've got-- I had a full panel, I was saying goodbye to people I'd seen. I'm in the addictions clinic, so we see people for a long time. I was also seeing folks for five, six, seven years that I wanted to have a proper termination with and let them know that this was a really big deal. I had been thinking about leaving the big system I was in for a couple years. A few big things had happened that led me to start thinking about it.

One was a large leadership transition from the top of our hospital and the top of mental health that really changed the culture of all of our teams. I also became a parent. Coming back as a parent, it felt like my priorities had shifted, and wanting to be able to be a full human, as good of a mother as I could be, and a good partner, and just recognizing that my energy was being depleted in so many ways. Having felt some more demoralization from systemic issues really was coming into play a lot more.

Usually, I could focus on my patients and really bring joy from my direct team and my patients, but I was finding that the systemic issues were really just adding to burnout. I wasn't being the mom or the partner that I wanted to be. I had actually taken some time off and took some sick leave, some mental health leave, to just think about it and talk to people as Dr. Lawson did. I remember one conversation with a colleague who I had done training with, internship with, where he was also a parent, and he was taking violin lessons.

I couldn't believe he had time to take violin lessons in private practice. Just the notion that you could have hobbies was just something that really pushed me towards finding more about how to get out of the system, I think. Especially this last year with the coming changes in federal government, knowing as a woman of color, as someone who really advocates for patients, for people from marginalized populations, and works a lot in DEI.

I knew that there were going to be challenges ahead, and what was I going to face, what obstacles I would choose to face. I came through similar decisions with Dr. Lawson, really seeking support from the community and finding a lot of folks in community who could help. So many people are more than willing to share documents, to share, "These are the steps I took, and here's a free link to try out this EHR record." That was very helpful for me.

Dr. Shanbhag: That's really good to hear. Dr. Norton, how about you? You also came from a larger system when you went into private practice. When you made that leap, what was it like for you as you were thinking through making it, and then when you made the leap?

Dr. Norton: Well, the Federal Bureau of Prisons is a large system. I had been at the facility here in my hometown for about 11 years. I was at the point where my four children were almost out of the house. I had some offers to go to different institutions. I considered what is it that I wanted to do. I also had to give quite a bit of thought to what did I truly feel I was competent to do. I was able to take the training and experiences that I had received throughout my bureau career. I decided to open a private practice right here in my hometown.

In all honesty, part of the reason, before I left the prison, I had gotten a call from a judge here, a county judge, saying, "We really need somebody to do these kind of evaluations. Can you do it?" As a federal employee, I could not, but that did spark my interest about that there was some possibility for that. I made that decision. There was some changes also at the institution that wasn't real fond of. It was totally my decision, but there was also some factors that were outside of my control that I just said, "Yes, time now to do something different." I was very fortunate to find this path for me.

Dr. Shanbhag: All of you represent different specialties. One of the things that I'm curious about is, for those of you that have brick-and-mortar offices, how did you decide physically where to open up your office? How did you approach who to actually serve? Dr. Lawson, for example.

Dr. Lawson: For me, I had a fairly clear plan to have a brick-and-mortar office. As a forensic psychologist and a forensic psychologist where clients fly in from all over the

US for forensic evaluations, I wanted to have a physical space where I could do those evaluations. I'm also old school enough that I really enjoy in-person therapy, and I knew that some clients would want that as well. I looked for a brick-and-mortar location that was close to a freeway exit, close to the airport for folks who would be traveling in for forensic evaluations.

Somewhere that also had hotels and restaurants nearby for the people who would be traveling in for their evaluation. In that year,

before I left Northwestern, I began looking and looking with a colleague of mine, so that I wouldn't-- I'm a social person, and I knew I would probably feel a little lonely not having someone in an office with me, and so we found a lovely two-office office with our own little private waiting room in a really lovely location.

Dr. Shanbhag: How about you, Dr. Norton? How did you decide where to actually open your office?

Dr. Norton: Well, initially, as we all start private practice, money is not an optimum, so I didn't want to spend a lot of money opening, renting my own space, for example. I was able to rent office space literally by the hour with some other practitioners in the city, and that worked out really well for three or four years. Then I transitioned to renting an actual conference room for a couple of years, so I was able to do a variety of things.

Financial motivation, though, financial means were certainly part of that initial decision. I'm not necessarily the most social person, so I didn't need office mates or anything like that. Working at the prison, I was tired of staff meetings, so I didn't necessarily need that aspect. Again, I just looked at what was available, looked at what my path was, what my financial means were, and fortunately, was able to find some good options.

Dr. Shanbhag: One of the things I'd like to hear from several of you on, when you go into private practice, you really have two jobs. You have the job of delivering whatever psychological services you're going to deliver. When we go into private practice, most of us know how to do that piece already. Then you're in the business of being in business. Most of us got none of that training in graduate school.

I'd like to know where you learned how to be in business. Dr. Ruby, because you actually took on many of those pieces you mentioned in order to actually bring in some extra income, how did you learn the business parts? I'd like to hear from several of you about how you learned to be in business.

Dr. Ruby: That is an incredibly important element, and you're right. I was fortunate in graduate school, we did have a course, and I forget the title, but it was about private practice. It was a very practical, with the nuts and bolts. It never got into taxes and really the financial aspects, but everything else was there. I got a little bit of introduction to it. When I joined the local practice here, as I said, it was already a large group practice that already had a bureaucracy. I just plugged in as one of the providers and did nothing other than that. All the business aspect was handled.

As I tend to do, I start getting involved in things I don't like the way they're running. I got involved and eventually took on different aspects of that administrative, financial part of running the business. It just became second nature to me on how it works. It is very tedious at times, but it is incredibly important. That was at the private practice. I also have my own individual practice that I do virtually. In that, I have a separate bureaucracy that I've got to run to keep things going. That is something that the participants ought to know is that you can't let that slide.

You've got to be on top of it constantly. Right now, given AI and other systems that are available to do a lot of this stuff, it's worth paying those like QuickBooks. It's worth paying an accountant and things like that to have that done, not automatically, but with a lot less difficulty than at least as I used to do it back in, I guess, the olden days where you had to physically go to the bank and pay a tax payment, which you don't have to do anymore. It is important, very important, to keep up on that in addition to the clinical part of your work.

Dr. Shanbhag: Dr. Lawson, you came from academic medicine. Did you get some of those business skills in academic medicine, or are you having to learn all of that now that you're on your own?

Dr. Lawson: I would say there's always learning that needs to happen, but it was very, very helpful to work in academic medicine and very helpful to have engaged in prior consulting forensic work before I went into private practice. In the forensic practice, largely learning about the importance of billing and note-taking and report-writing and all those sorts of things. I got a taste of thinking about taxes and some of those structural things that you need to understand how they work.

Being in a clinic, I was documenting in an EHR. I was billing. I was thinking about referrals. I was thinking about advertising and all of these different aspects that would be helpful to have in a private practice. Some of it was. It was not all foreign to me when I started my private practice.

Dr. Shanbhag: How about for you, Dr. London? How are you learning the business aspect of running your practice?

Dr. London: I feel like I'm the baby private practitioner over here. I'm in my first year of this, and I hate it. I'll just be very honest about it.

Dr. Shanbhag: Honest about it. Right.

Dr. London: [laughs] Yes. I think we are taught to be humble and modest, and marketing is the complete opposite. Trying to accept that and work through the anxieties, the imposter syndrome, has been quite an ordeal, honestly, in the past year to actually put my name out there and to say, "Oh, I'll do this panel." [laughs] That is part of the networking and marketing. To make flyers and to meet with people. I think it's all been an on-the-go learning experience.

Particularly, as Dr. Norton mentioned, when I started out, I also didn't have a lot of financial backing to just pay for certain services that are out there that are very helpful. What I did was join different communities. There's clinicians of color referral hubs. There's Northern California. We have lots of different listservs, and that's been

very helpful to introduce myself and then to meet other clinicians as well as prescribers.

I did see in the chat somebody asked about working at a hospital being beneficial in terms of networking, and it was. There's so many people who already have private practices that they're excited to know that you're now available for them to send their private practice clients to. I am still in the growing pains part of it. I think of figuring out how to market myself in ways that feel aligned with my values. I think, for me, it's been a learning process, but more of a building up my confidence process.

Dr. Shanbhag: What about you, Dr. Norton? Any thoughts about where you learned how to do the business portion of your business?

Dr. Norton: Fortunately, I had a pretty good understanding of the marketing-type strategies. I knew who I needed to talk to, who I needed to connect with, where I needed to put my name out, so I was fortunate with that aspect. Now, in terms of the actual business, I can still remember, it had been quite a few years ago, trying to decide, "Well, how much do I bill per hour," because it wasn't a standard rate. Even just some of those very basic concrete challenges are something that I knew I was going to have to do. I wasn't necessarily prepared for how complicated it was.

The business part of it, developing the billing, was a difficult process. I fortunately had a tax person that I'd already been using just for general tax purposes. They were very helpful, not only with their opinions, but also could give me some advice about who else I might talk with. That was a very complicated process. I can't say that it was a smooth process. I took some missteps along the first couple years. That was part of the learning, somewhat exciting, actually, to think, well, I screwed that up. Can I recover from that? I was able, and that was also very encouraging as well.

Dr. Shanbhag: Thank you all. Anyone who would like to weigh in. How did you all decide what you were going to charge initially?

Dr. Lawson: I asked all of my friends who were in private practice, and asked them both from a perspective of, "Are you going to take insurance or not?"

Dr. Shanbhag: That was my next question.

Dr. Lawson: Yes. Some of the specialty work that I do as well in terms of what we call third-party reproduction. Folks who are going to be using donor sperm, donor egg, donor embryos. How much do people charge for the relevant consultations and evaluations, both locally and in the broader US.

Dr. London: Yes. I did a lot of the asking. I think for folks that don't have a lot of people in community, *Psychology Today* has lists of people and their services. What I did was look at different-- I looked at so many profiles, obviously, to see

what were their qualifications, what were their expertise, and what were they charging. Where I felt I landed in terms of my expertise and my qualifications, and found a rate somewhere around that felt comfortable for me.

Dr. Ruby: It makes a difference whether you're on the insurance panels or not, also, because whatever you charge, the insurance companies don't really care, and

they're going to pay an allowable amount. For my situation, as I said, a couple of times already, I've moved into a system that was already there. We already had a fee, a usual and customary fee, and we try to increase it each year according to CPI, the consumer price index, and stay with that.

As I said, the insurance reimbursement rates don't go along with that as well. They have increased over 20 years or so, but not greatly. It seems like the difference between what we charge and what the allowable insurance rate is getting bigger and bigger as we go through.

Dr. Norton: Now, for myself, almost none of my work is based on insurance. I'm not part of any insurance groups. The first year I was, it was really a challenge. I did not like it at all, and I just made the decision to go non-insurance where everything is paid. A lot of it is state-mandated service fees, but I'm not part of any insurance panel at all, and I am quite thankful for that. I don't have to concern myself with that aspect at all.

Dr. Shanbhag: One of the reasons I'm asking a few questions about the finances here, because, A, we get a lot of questions in private practice about money from people wanting to go into private practice. B, I often joke that money is actually the taboo subject for psychologists. It's not sex. We will talk about sex with a lot more comfort than we will talk about money, and yet it's crucial for psychologists who want to go into business for ourselves to be able to talk about it.

One of the questions we got a lot was, is it crucial to set aside a pot of money when you're going to go into private practice to carry you through the first year or the second year and things like that? Do any of you have any thoughts that you want to weigh in on that? Do you need to set aside a pot of money to carry you through? I'm happy to share from my own experience.

What I often encourage people who are thinking of going into private practice to do is you have to know yourself a little bit and what your psychological risk is, and what you can, as I say, the stuff that will really keep you up at night, because it's not always a math problem. Sometimes it's not really about the math. It's about the stuff that will keep you up at night. If there's something that's going to keep you up at night, then you've got to think about that particular thing in advance.

In my case, I wanted to make sure I had the mortgage payment locked away for a year, and I made sure I had a year's worth of mortgage payments. That made me feel a little comfortable to get through the days when I went home and thought, "I don't know if this thing's going to work or not. I may have to go get a day job," as I called it. In your case, how did you handle those money anxieties. Is it necessary to have a pot of money set aside?

Dr. Norton: I can remember in the beginning of school having this perspective that if you want to make a lot of money, you go into private practice. That's just not really how it works. Now, maybe eventually you'll have that higher income, but you have to be willing to-- those first couple years are not going to be a huge income stream.

Again, that was not the message we received, or at least I received as graduate students. It would have been nice if I had more foresight about setting off a pot of

money for that. I didn't, so that was just another part of the challenge. It would be important, and I would certainly encourage people to do that if they have that opportunity.

Dr. Shanbhag: That's one of the money myths you might want to bust, meaning don't think that instantly, the third month necessarily, that the rainbow money starts pouring in. It might take a little longer than that.

Dr. Norton: Very true.

Dr. Ruby: Especially if you are accepting insurance payments, because there's a big lag sometimes between a session, filing the claim, and then eventually getting some payment in return. It doesn't happen, in most cases, too quickly.

Dr. London: I actually have had a little bit of a different experience with insurance that's helped me with both. I do believe having some savings. For my own anxiety, I needed some savings in order to actually step out from a system that was paying me on a regular basis. I also did start off with insurance, but I started through Headway, which I'm not endorsing or whatever.

It's a system that helps credential and bill, and they pay you on a regular basis. That helped me know that I was going to get insurance patients, which were much more available and accessible right away, and of the population more like who I'd been serving at the VA for quite some time, while I was trying to figure out how to get more private pay. That allowed me to have a little bit more sense of security.

Dr. Shanbhag: You mentioned something that I'd like to hear from you all next. When you are stepping away from an institutional setting, you are used to getting an array of benefits. There's a retirement plan. There's an insurance plan. There's something weird called paid time off, where your paycheck still comes, but you're on vacation. How did you navigate that in private practice? If you're willing to share, how do you source your health insurance? Because that's a big expense for people in private practice.

Dr. Norton: I have heard that word vacation before. I'm not sure I really remember that, but it is a new reality. You are not getting paid to not work. That is something you have to factor in literally right away. You have to be willing to make that decision, make that commitment. Have that understanding that if you're not working, you're not going to get paid, which is just how private practice runs. It was a challenge initially to realize that I do have to work. I didn't, obviously, in working for public institutions, but it's a much different setup in terms of pay.

Dr. Shanbhag: Just so there's no confusion, it doesn't mean you don't get to take a vacation. You absolutely do still get to take a vacation. It's just that the math is a little different on how that works.

Dr. Ruby: Well, you have to up front. You have to calculate out a year and think if you want four weeks. I used to get four weeks off every year in the military. Unlimited sick time off, too. If I want four weeks now, I've got to budget that into the program so that I have money in the bank when I take those weeks off. When you have money in

the bank, it's tempting to spend it, but those are the things you have to keep in the bank for your own benefit.

Dr. Lawson: That's what I did before I left Northwestern, is I did the math, literally, and calculated how much I needed to bill on a weekly or monthly basis so that I could take vacation, I could have sick leave. I had done that math beforehand so that I could go to academic meetings that I still go to. I will say I'm married, and so for me, insurance was not stressful. I am on my husband's insurance, which was very helpful to not have to think about. I know it is figureoutable, but it's a little stressful for folks who are not in that situation.

Dr. London: I agree. I have the same privilege of being married to someone who is in a system with health insurance, and that also pays them for sick leave and time off. There was also conversations with them in the beginning about who's going to take the sick leave. [laughs] Well, at this point, you get paid for it, and having a family agreement on that as well. Especially with children in the picture who will get sick all of the time, that it's something that you have to account for and do the math for ahead of time.

Dr. Shanbhag: Working in private practice can be isolating. You're by yourself, you're in a small group. Especially when you're coming from a larger work setting, how do you find community and connection? Dr. Ruby, I know you've been very intentional about this, so I'm going to start with you. How have you gone about building community?

Dr. Ruby: There are typical ways, obviously, to do that. Stay in touch with different groups in your area, different kinds of providers who do the same kind of thing you're interested in. I have a particular issue in that I'm considered somewhat rebellious within the profession. As Marnie mentioned, I'm the executive director of the International Society for Ethical Psychology and Psychiatry. That organization is misunderstood a lot, and many times we get called anti-psychiatry, which we aren't.

We're basically questioning the medical model that is used in conventional mental health system. Given that, we tend not to be welcomed by our

colleagues in the area, and we are considered less than. That's one reason we have the organization, the nonprofit, is so we do have a group of people all around the world who are similarly minded. We maintain support that way with an annual conference and webinars, and things like that, that we get together for.

Especially if you're isolated in your area, it's really frightening if you're in private practice, and the way you do it is questioned by the mainstream. That is my challenge in particular, is to maintain that kind of connection. It works, and it's a very helpful support system.

Dr. Shanbhag: How do the rest of you maintain connection?

Dr. Norton: For myself, I had already been a member of Division 18 of APA, Psychologists in Public Service, while I was working at the prison. I was fortunate to be on some committees before I left the prison, and I actually just continued that work. I found that to be a very fulfilling home, not only professionally, but also with

those colleagues and that connection. I was eventually able to be president of the division at one point. That's how I maintain connections, is having that connection to APA.

Now, I know APA is not the whole avenue for everybody, but for me, it has actually worked out quite well. I maintain that connection. Myself personally, I don't have a lot of other connections locally. The town I live in is relatively small, so there's literally one or two of us that do what I do. There's not that community here. Having that Division 18 backing is really important for me.

Dr. Shanbhag: If I can interject, although you might find it surprising to hear, given that I'm an APA employee. I've been in APA forever, but I found community actually in my state association because we're all over the United States. The people in your community may be in APA, they may not, but the local psychologists are often in your state psychological association. That may also be a place to find community. I could connect with other psychologists who were in an independent practice, right in Orlando, which was a good place to me.

Dr. Ruby: There's also many community psychological associations too. For instance, there's a Psychological Association of Southern Maryland, that kind of a thing. They are out there and available for people.

Dr. Shanbhag: I do find staying connected is really important, especially when you have a tough case, because it's that kind of real-life, hey, can I check something out with you that keeps us all out of trouble when you need to check something out on a case. Sorry, Dr. Lawson, I cut you off.

Dr. Lawson: No, no. I was going to say, it's also one of the things that I've enjoyed. Working in reproductive medicine now for over 16 years, and given that I'm the social butterfly that I am, I'm still connected in all the ways that I was at Northwestern. I still teach, I still do research, I still run a training program for psychology grad students, and still go to academic meetings. One of the things that I have been a part of since before I even left is I'm on a text chain of about--

I don't know how many of this there are now, but there's at least a dozen of us psychologists, mental health professionals who work in the field of reproductive medicine. HIPAA-compliantly, we do exactly that. We say, "Hey, can I talk to somebody about this particular case I have, or I have a question about this?" It's an automatic go-to that when folks see the text chain, if they can respond, they'll respond, and it's been very helpful.

Dr. Shanbhag: I'm curious, before we get to a portion where we have some time to answer audience questions, I'm wondering if you have any advice for folks. Or if you could go back, and if you wish you would have known something then that you've since learned by being in private practice, what would that be? I'm curious what comes to mind. If you knew then what you know now, or a piece of advice that you have for our audience members, I'm curious what comes to mind. I'm going to go around whoever would like to go first.

Dr. Norton: Well, I'll jump in. I think, for me, it was really important to recognize what I had training in. What I had been provided training for, both academic and just

experience. Where I worked, I received a lot of training. I was part of the training committee, so I had that knowledge, I had that training, and I was able to take that and transition it into my practice.

Now, I do have colleagues who totally switch careers. That's certainly possible. When you do that, you have to be willing to say, "Well, I need this training in order to make that career switch." For me, I had a lot of that training, I've certainly kept up with it, but I built on what I had already been taught, and for me, that was important.

Dr. Lawson: For me, what I would say is, in my experience, and maybe this isn't the same for everyone, but in academia and in academic medicine and in my training. The messaging I received was that being a clinician, being in private practice was somehow less than working for one of these larger institutions. I wish, going back, that I had thought about what that messaging was that I was hearing.

That if you leave me, you will be unhappy. You won't be good enough if you leave me, you won't be doing enough if you leave me. That, from my perspective, it could sound a bit like a toxic relationship to be in, and that the work you do in private practice is worthy. It is not less than. It is important work, and if you choose to do that work, you are contributing in a amazing, and important, and vital way in society.

Dr. Shanbhag: Thank you, [inaudible 00:46:37]. Other thoughts?

Dr. Ruby: For me, one of the things that bothered me the most when I started was that I didn't feel like I had a specialty. I took on every case I could take on so I can have a full schedule. I almost felt like a phony in some way doing that, but that was just what was necessary early on in any career, I think, is to do whatever you have to do to keep things going. Eventually, things do settle out, and we do find our place in this project that we call psychotherapy. We settle into it. Just like dust settles, we do the same thing.

Don't expect that if you start a practice, you're going to specialize right away and get every case you want. Don't, by all means, don't only accept certain cases because you're going to shoot yourself in the foot financially.

Dr. London: I feel like mine is a little bit different, but in line with a little of what Dr. Lawson said. I really appreciate what you said around the toxic relationship systems can place us in with the reliable income source and the focus on one specific thing. I think something that I would have benefited from hearing earlier is, you can do a lot, you don't have to. I think that was something that spanned from the anxiety of having this stable income to now I have to build up the same exact income all at once and take every patient.

I know that I can work with the hard ones, so I should do it. No, that you don't have to, and that you don't have to do it alone. There are endless opportunities to work with the patients that you want to work with, to help the communities that you want to work with, and to connect with others. I think that was something that felt unreal that I wasn't going to be able to see. I was working with a very specific population, and I wasn't going to be able to see them, and there are ways to see them. Just remembering the opportunities are there, and it might take time.

Dr. Shanbhag: I think that's really good advice. I'm going to add one thought to that as I was thinking as you all were talking. It's a piece of advice I was given early on, and it's a version of what you were saying. That is that just because the phone hasn't rung in a while and you might be hungry, don't take a case that you're not right for. Don't get ahead of your skis, so to speak. I remembered that because in the early days-- you're right, Dr. Ruby.

You can't be picky in the sense of just waiting for your ideal case, but you do need to remember what you're competent in and what you're not, and make the appropriate referrals. Otherwise, you'll get in trouble. I remembered that, and there were cases that I was absolutely not the right fit for, and I would send those folks to the folks who I knew were the right people. I wouldn't think twice about it, even though I really could have used the income.

Years later, people would call me,

and they would say, "You won't remember, but I spoke to you seven years ago, and you sent me to so-and-so. I always remembered that you took the time to talk to me, and you didn't take the case, and you sent me to the right person. I thought you must have had some integrity to have operated that way. I remembered what you did do. Then, when I needed that case for my family member, I called you back." I thought that was very interesting.

I never thought that at the time, never made those links. Doing the right thing can pay off in ways you may not envision at the time. Don't take a case that's not the right case for you on that. We're going to open it up and have some time for our panelists to answer some of your questions. Some of you submitted some of those questions in advance. I'm going to throw out a few that had caught my eye ahead of the time. Then I know Peggy and I have been looking in your Q&A as well.

One of the questions people wanted to know is, what is the most challenging part of being in private practice? Anyone want to take a crack at that? What's the most challenging part of being in private practice? Along the way, does it get easier or does it get harder? Any thoughts about that?

Dr. London: I think, for me, it's been the waiting. [laughs]

Dr. Shanbhag: [unintelligible 00:51:13].

Dr. London: Yes. Coming from the system where I was constantly overwhelmed and never had a moment where I wasn't getting a referral to then just waiting for people to know that I was good at what I do, and to send me referrals or to email me and reach out. Because of those moments where there are lulls, it comes up and goes down. That's been very challenging.

Dr. Lawson: I will say from my perspective that, Dr. London, the time period that you were in was the hardest period for me. It was the exact same wondering and waiting, how is this going to go, and it does get better. It does get better, but it is anxiety-provoking initially to go from a system where you get a regular paycheck, you get insurance, you get days off. It's all figured out. You've probably been working there

for years. Now there's this new learning curve and this worry of, "Am I going to have to get a day job?" [laughs] It does get better.

Dr. Shanbhag: What surprised you the most once you were established?

Dr. Norton: Well, for me, and this is probably true of forensic systems across the US, when I first started the first probably 10 years, it was good steady income, but these last five or six years, the forensic caseload has really exploded. Now I find myself turning down referrals, and that is so anxiety-producing. I cannot yet get over the hump thinking that if I decline one case, I may never get another one. When I know logically that's not the case, but I still have that in the back of my mind. I can't take all the referrals. Again, that's been a big change over the last five or six years.

Dr. Lawson: I'd say the same thing. It's surprising that people keep calling, [laughs] that you keep getting new referrals, you keep getting new cases, and yet they do keep coming. You build your referral sources, there's a lot of word of mouth, and it just grows.

Dr. Shanbhag: One of the questions that came in from the audience, do you have to worry about burnout, or what do you do in private practice to manage burnout or reduce the risk of it?

Dr. Lawson: I mean, it's just so much better being in private practice than working in the system that I was in. That in and of itself dropped my risk of burnout. The freedom that I think Dr. Ruby talked about in being your own boss and not having to go to meetings that you don't want to go to, or really setting up your daily schedule to look like you want it. You can take violin lessons.

Dr. Shanbhag: You really can.

Dr. Lawson: Yes, you can do these things that promote work-life balance in a real way.

Dr. Ruby: There is a temptation to fill that gap with something, especially something that generates money. It depends on our personalities and what we think of ourselves. Not working a full eight hours or so a day. It can get out of hand very quickly, especially if you're a so-called Type A person and you want to take advantage of the time to do your work and to generate income.

Dr. London: Totally. I definitely want to just hop on the, you can overextend yourself very easily because the opportunities are endless. Just getting comfortable with having time to take my lessons-- I haven't taken those, by the way. To do something for yourself and to not be constantly busy, it's different. It's something that needs adjustment when you're coming from a place where you're constantly busy.

I think the burnout is so different where even if I'm overextending myself, I'm doing all these things that I love, and I'm not doing things for a reason that I don't feel aligned with. A reason that doesn't seem to make sense with me. It's a different quality even when it's overextending.

Dr. Shanbhag: Any final thoughts before we wrap up for tonight?

Dr. Norton: I've been very fortunate, and I think most people in private practice enjoy the work that they do. It is a challenge those first couple years. I do hear this sometimes from younger colleagues who are contemplating that private practice change. The first couple of years are challenging, and they have to be ready to accept that challenge and have a backup plan. Proactive is always better than reactive. That's something I encourage students and younger colleagues all the time. Have a plan. Don't just say, "Well, this is going to work." Might, but have a plan.

Dr. Ruby: It sounds like, as we've been talking tonight, that plan has a lot to do with money. A lot to do with that. It ought to give you, like we talked earlier, setting time aside, but budgeting that in. Not just thinking I'll take time off when I find the time to take time off, but to schedule it. Put it on your schedule instead of just doing it spontaneously, but budgeting for that. If we all got paid very well, a lot of these problems wouldn't occur that we're dealing with, but that's not the reality.

Dr. Lawson: I would say talk to your friends and your network who are already in private practice and learn from them, research from them, whether or not you think this is a viable option for you. It probably is, but yes, there is a little bit of work that you need to do in advance to set it up. Yes, money matters, and it would be helpful if possible to have some money saved up and to have a partner that has insurance. Take your time, do your research, but it's highly likely, I think, that it could work, especially with telehealth nowadays.

Dr. Shanbhag: I would absolutely underline that. I wouldn't have done it any other way. It was a fantastic time and I enjoyed it. I encourage everybody who is interested in that to really think about it. Peggy has put two resources in our chat for you. One is a free resource. It's an e-booklet that takes you step by step on how to think about going into private practice. One is a paid course that APA has. It's a two-fold day course on how to go into private practice if you're interested.

Those are not the only resources out there. There are many if you want to look into it. I'm going to turn it back over to Peggy, but before I do that, I would like to thank our four panelists so much for being open and sharing part of their own journey with all of us tonight. It helps so much to hear from people who've actually done it and are doing it. I wish all of you out there who have heard a little bit about their stories all the best of luck as you go through your own journey. Thank you again, and Peggy, over to you.

APA: Thank you so much, Dr. Shanbhag, and doctors Lawson, London, Norton, and Ruby. Thank you to all our listeners for your questions. We're sorry we didn't get to all of them. A recording of this discussion will be emailed to everyone in two weeks time. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. That's it for now. Have a pleasant evening.

[00:59:35] [END OF AUDIO]