Title

Brain on Display: Teaching Neuroimaging in Psychiatry Through Interactive Progressive Case Conferences

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Joseph Cooper, MD, University of Illinois College of Medicine at Chicago, Kathy Niu, MD, UT Southwestern Medical Center, Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa, Jeff Woods, MD, University of Texas Austin Dell Medical School, Fawwad Khan, MD, University of Illinois College of Medicine at Chicago

Education objectives

As a result of this workshop, the participants will be able to:

1. Appreciate the relevance of integrating neuroimaging into general psychiatric training.

2. Identify clinical scenarios where neuroimaging is indicated, including specific hypotheses which are then tested by practicing viewing actual images.

3. Implement portable open-access educational modules to incorporate neuroimaging education even without local faculty expertise.

Abstract

Scholars in antiquity pointed to the brain as the organ in which cognition, emotion, and behavior are rooted. Despite this transformative revelation, it would be more than two millennia before we would have the ability to peer inside the brain in vivo. The advent of neuroimaging permitted scientists and clinicians to observe what remains one of the most complex structures in the known universe: the human brain. The field of psychiatry has also advanced in that it is not uncommon to utilize neuroimaging in daily clinical practice. From computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), to several other modalities, neuroimaging often proves useful in the assessment and diagnosis of conditions which present with changes in behaviors, thoughts, or emotions. Disorders such as traumatic brain injury, dementia syndromes, epilepsy, and autoimmune syndromes are but a few examples where neuroimaging plays a crucial role in the diagnostic process, helping differentiate from idiopathic psychiatric syndromes. Emphasizing the importance of neuroimaging in psychiatric education, the ACGME includes competency in neurodiagnostic testing and its clinical application as a key medical knowledge milestone for psychiatry residency training.

Despite the importance of neuroimaging in psychiatry, trainees rarely receive high-quality, effective education in this area. This gap leaves many learners uncertain about when and how to order neuroimaging, reducing their confidence in applying it to patient care. Approaches such as lectures, didactics, or bedside teaching may not provide sufficient depth or engagement, leaving learners with limited understanding and, at times, disengaged or bored.

The key to teaching neuroimaging is integrating clinical relevance. One useful approach to achieving this objective is through an interactive progressive clinical case (PCC) format. The PCC allows for connections between knowledge about imaging techniques to their clinical application in assessment and diagnosis. This permits a stepwise and critical consideration of what imaging to select, its advantages and disadvantages, and how the results inform differential diagnosis and next steps. The PCC format is rooted in active learning principles, promoting learner engagement and active application of knowledge. A PCC may also be utilized within group settings, as intended for this workshop, so as to allow small and large group discussion, along with other interactive elements through the application of online technologies, e.g. polling, as well as role play. Additionally, this workshop will demonstrate the ease with which educators can use open resource tools for teaching, removing the necessity of on-site psychiatric neuroimaging expertise.

Note, this workshop was presented and very popular in 2026. For 2027, a novel case scenario, imaging, and expert videos will be used.

Practice Gap

While neuroimaging has become central to modern psychiatric practice, psychiatry trainees often receive limited formal instruction in how to interpret and apply imaging findings clinically. Most residency curricula rely on didactics, lectures, or bedside teaching, which often emphasize technical details rather than clinical reasoning. As a result, residents may lack confidence in knowing when imaging is appropriate, what modality to choose, how to evaluate findings, and how to integrate results into diagnostic and treatment planning. This practice gap is reinforced by the fact that many training programs lack on-site faculty expertise in neuroimaging. Given that the ACGME explicitly includes neurodiagnostic testing as a milestone sub-competency, there is a clear need for practical, scalable, and interactive teaching methods. Interactive progressive case conferences offer a feasible solution to bridge this gap and strengthen residents' competence in psychiatric neuroimaging.

Agenda

10 min – Introduction to psychiatric neuroimaging with built in polling for audience engagement

10 min – In pairs, begin Progressive Case Conference discussion prompts, then return to large group discussion

10 min – Further case history is provided, think-pair-share followed by large group discussion



10 min – Focusing on selection of neuroimaging and hypothesis development, participants will discuss in pairs and then open to large group discussion

15 min- Practice reviewing neuroimaging review individually, then in pairs, then sharing with large group. This is followed by a brief expert video reviewing the same neuroimaging

10 min- Final history of case, neuroimaging review practice individually, in pairs, then sharing with large group followed by a second brief expert video reviewing the same neuroimaging

10 min – Role-play: describing neuroimaging findings and diagnostic implications with the patient and family

15 min – Large group discussion of how to implement such resources locally plus Q&A

Scientific Citations

1. Cooper JJ, Valencia VA, Niu K. Neuroimaging education in psychiatric training. Neuropsychopharmacology. 2025 Jan;50(1):298-304.

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Title

Breaking the Cycle of False Urgency: Rethinking Burnout and the Hidden Curriculum of Academic Medicine

Primary Category

Faculty Development

Presenters

Yekaterina Angelova, MD, Harlem Hospital Center, Omar Mirza, DO, Garnet Health, Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute, Alexandra Perez, N/A, Columbia University/New York State Psychiatric Institute

Education objectives

1. Apply the Emergency/Nomergency framework to distinguish genuine clinical and training emergencies from manufactured urgency in daily practice.

2. Describe the neurobiological cost of chronic false urgency and demonstrate brief regulation techniques teachable to faculty and trainees.

3. Identify common cognitive distortions in academic medicine (indispensability, output-as-worth, and mind-reading) that drive overcommitment and are transmitted to residents through hidden curriculum.

4. Explore language for setting boundaries around non-urgent demands without compromising trainee support.

5. Formulate one personal commitment for modeling healthy urgency response for trainees.

Abstract

Psychiatry is the specialty most equipped, on paper, to teach nervous-system regulation. However, the skills we teach our patients and trainees can be remarkably difficult to apply to our own professional lives. Faculty who can help trainees and patients recognize when anxiety is driving an automatic response will nonetheless answer a non-urgent inbox message at 11 p.m., cancel protected academic time for a "quick look" request, and describe their own exhaustion as simply what the job requires. The term “nomergency” describes the myriads of manufactured crises that hijack our attention and physiology without reflecting real risk or importance. Repeatedly responding to these demands can keep us in a state of constant reactivity, contributing to chronic stress and burnout. When everything is treated as urgent, the capacity to recognize what actually is erodes. In a specialty where genuine emergencies exist, that erosion is not only an individual wellness concern; it shapes what residents learn to notice and how they learn to respond.

This workshop introduces participants to the Emergency/Nomergency framework and applies it directly to the pain points of academic psychiatry: after-hours messages, administrative deadlines, and supervisory overload.

Rather than treating urgency management as an individual wellness skill, the session proposes that the way faculty regulate, or fail to regulate, their own response to nomergencies impacts trainees and the workplace culture. Participants will practice a live triage exercise using real-life vignettes common in academic medicine, complete brief cognitive and neuroscience-based regulation exercises, and draft boundary-setting language for addressing administrative demands.

Participants will leave the session with vocabulary for naming manufactured urgency in the moment, a rehearsed script for setting boundaries, and a concrete framework to practice and model for the next generation of psychiatrists.

Practice Gap

Physician burnout remains prevalent, shaped by the demands of clinical, teaching, and administrative roles. In settings where responsiveness is highly valued, physicians may treat non-urgent demands as requiring immediate attention, fueling a cycle of reactivity, chronic stress, and burnout. The consequences often extend beyond individual wellbeing, contributing to the hidden curriculum which has been directly linked to resident burnout and cynicism. Psychiatry faculty are uniquely positioned to interrupt this transmission: they already teach adaptive coping yet report the same reflexive overcommitment and chronic hypervigilance seen across academic medicine, often modeled in front of learners. Programs lack a shared, teachable framework that allows faculty to distinguish real emergencies from manufactured urgency and to model this skill deliberately to trainees.

Agenda

10 min: Overview and reframe of physician burnout through false urgency lens

20 min: Introduction of Emergency/Nomergency framework (application of framework in live triage experience followed by group debrief)

20 min: Presentation of costs of false urgency and common “myths” (limiting beliefs) about urgency in academic medicine

10 min: Limiting belief exercise and pair-share

20 min: Boundary-setting exercise (small group exercise followed by group debrief)

10 min: Q&A

Scientific Citations

1. Holder, K. D., Lee, S. Y., Raza, F. Z., & Stroud, L. R. (2024). Addressing burnout and enhancing well-being among academic physicians: A call for future research and organizational support. 5(3), 199–208. https://doi.org/10.36518/2689-0216.1742

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8. Angelova, K. (2026). NOMERGENCY: Reclaiming focus and calm from false urgency culture. Global Book Publishing.

Title

Creative CBT Adaptations for Consultation Liaison Psychiatry Services and Residents

Primary Category

Curriculum

Presenters

Shamik Mukherji, BS, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Samuel Greenstein, MD, Zucker School of Medicine at Hofstra/Northwell - Lenox Hill Hospital, James Hambrick, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Shivani Mehta, BS, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education objectives

At the conclusion of this workshop, participants will be able to:

1. Identify the key responsibilities and challenges of the psychiatry resident on the Consultation Liaison Psychiatry rotation as it pertains to expectations around bedside psychotherapy

2. Understand how CBT principles can be adapted to the clinical demands and practical limitations of medical hospital care.

3. Describe specific CBT techniques that can be used clinically and taught to residents on CL psychiatry rotations

4. Develop and practice programmatically tailored approaches for teaching and supervising brief CBT-informed interventions, empowering residents to adapt and implement these approaches in CL practice and enhance their psychotherapy skills.

Abstract

Medical hospitalization can bring uncertainty and emotional difficulty to patients, whether from the new challenges of coming to terms with a new diagnosis or health status, or from the impact of medical problems on long-standing and possibly undertreated psychiatric struggles. Psychiatry residents on CL services are often asked to assess these concerns and help patients who often have never interfaced with mental health professionals. In this role, residents must build a strong therapeutic alliance with a patient within the context of a referral question, quickly assess and formulate the patient's concerns, orient them to psychiatric intervention, and develop strategies to help engage the patient with medical care. With an emphasis on collaborative skill-building and a present-focused approach, CBT-informed interventions offer a framework for trainees to apply adaptable bedside psychotherapeutic skills that address distress and support patient goals alongside diagnostic assessment, medication management, and supportive care.

Drawing on literature about CBT training, psychological treatment in chronic medical illness, and integrated hospital care, we will consider the rationale for bedside adaptation and review the available evidence base (Bullock et al., 2022; Scott et al., 2023). Participants will learn how cognitive and behavioral formulation strategies can be applied to common clinical challenges in CL practice, including anxiety regarding medical uncertainty, demoralization, difficulties with treatment adherence, and challenges in patient-clinician engagement (Gostoli et al., 2024; Yost & Cavanagh, 2025). Discussion will focus on how crowded hospital environments, time constraints, patient cognitive deficits, and medical acuity can inform the choice of therapeutic approach. Tools for succinctly providing emotional validation and building therapeutic rapport will be highlighted. Fundamental CBT skills, including functional analysis and guided discovery, will be presented as tools for building alliances, developing formulations, and collaborating with patients to invest in their own care.

A central educational challenge is helping residents recognize which therapeutic interventions are appropriate and how to adapt what they know about CBT to the realities of the hospital. Depending on their stage in training, a resident must make these adaptations with minimal exposure to psychotherapy, much less CBT. We argue the need for increased guidance on how CBT techniques may be adapted to fit the needs of this distinct patient population. Given the heterogeneity between programs with regard to catchment area demographics, psychotherapy training curricula, and supervision resources, we will administer breakout sessions that will allow participants opportunities to identify specific needs and barriers so as to best apply these techniques in both a clinical and training capacity. Finally, we will discuss approaches to supervision and feedback that complement existing models.

Our goal is to help CL faculty make brief CBT-informed care more accessible to residents. In doing so, we aim to demonstrate that bedside psychotherapy is not a superfluous aspect of CL practice, but rather a valuable tool for patients, trainees, and attending psychiatrists alike. Through this lens, we argue that the CL rotation can serve as an ideal setting for trainees to develop psychotherapeutic skills and advance toward therapeutic mastery.

Practice Gap

Consultation Liaison (CL) psychiatrists and their trainees are often tasked to provide bedside psychotherapy for patients in medical environments. This is often met with frustration due to assumptions that bedside psychotherapy is incompatible with the fast-paced nature of medical hospitalization. Though integrating psychotherapy into medical hospitalization is an effective way to improve patient care, there are many barriers that limit such implementation (Sharpe et al., 2024). Patient presentations are heterogeneous and complex, individual time spent with patients is short, and resident psychotherapy training does not often directly address how to adapt skills and techniques to the unique structure of the medical-surgical unit. Furthermore, training resources also vary across different programs, especially when supervision in psychotherapy and other educational resources differ. Educators need practical approaches to help residents adapt Cognitive



Behavioral Therapy (CBT) principles and incorporate psychotherapy teaching into their practice in consultation-liaison psychiatry settings and rotations.

Agenda

0-10 minutes: Audience polling, word cloud, case discussion

10-25 minutes: CBT Adaptations for the Consultation Liaison setting

We will discuss barriers to implementing CBT in CL settings and the clinical and educational rationale for developing CBT adaptations to surmount these obstacles in an evidence-based manner.

25 – 50 minutes: Demonstration of CBT Micro-interventions adapted for CL settings

We will use case-based examples to teach CBT skills that can be adapted for bedside use for myriad medical patients and environments. We will utilize role-play to demonstrate commonly challenging use cases.

50 – 75 minutes: How can I use CBT Micro-interventions within my program?

We will utilize small group workshops, each led by our speakers, and guide discussions on implementation of CBT micro-interventions for different types of programs with varying sizes, resources, and institutional cultures.

75 – 90 minutes: Large group debrief, Questions and Answers, and Evaluation

Scientific Citations

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Title

Direct Observation in Practice: Using Workplace-Based Assessment Tools to Build a Feedback Culture Across Psychiatry Training Programs

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Margaret Hamilton, MD, Columbia University/New York State Psychiatric Institute, Scott Campbell, MD, Perelman School of Medicine University of Pennsylvania, William Smith, MD, University of California, San Francisco, Andreea Seritan, MD, University of California, San Francisco

Education objectives

1. Define workplace-based assessment (WBA), observable practice activities (OPAs), and entrustable profession activities (EPAs), and articulate the role of each within a competency-based GME assessment framework.

2. Describe the principles, features, and formative use of task-linked WBA tools that support both learner development and faculty feedback practice.

3. Identify the goals, benefits, and essential elements of direct observation and real-time feedback in residency and fellowship training.

4. Practice completing a live OPA using a sample WBA tool and compare ratings with peers to explore inter-rater variability and calibration.

5. Recognize potential barriers to WBA implementation across diverse training contexts and identify strategies to address them.

Abstract

Most psychiatry training programs want to do more direct observation and provide better real-time feedback. However, knowing what a WBA is and embedding one into a busy clinical workflow are very different challenges. This workshop is designed to close that gap.

The session is facilitated by program directors and educators from Columbia University, the University of Pennsylvania, and University of California San Francisco, each of whom has developed and implemented a different WBA tool in their local training environment, spanning general psychiatry residency, geriatric psychiatry fellowship, and subspecialty rotations. These tools serve as worked examples throughout the workshop, not as the subject of it. The real subject is the problem every program faces: how do you take a promising assessment framework and make it work in the daily reality of clinical training?

Participants will begin with a grounded, jargon-free orientation to how WBAs, OPAs, and EPAs fit together and why direct observation matters, both for trainees who want more specific feedback and for programs that need better data to inform milestone decisions. They will then try a tool themselves: completing a live OPA using a sample WBA on their own devices while watching a brief video clinical vignette, with real-time aggregated ratings displayed and discussed as a group.

The workshop then focuses on what presenters across all three sites have found to be the harder challenge: not building the tool but building the culture. Through facilitated breakouts, participants will identify the implementation barriers most relevant to their own programs (faculty engagement, trainee empowerment, technology friction, and the tendency to use assessment tools for documentation rather than feedback) and develop concrete, workflow-friendly solutions they can bring back to their programs.

Practice Gap

Psychiatry graduate medical education continues to shift toward Competency-Based Medical Education (CBME), yet traditional assessment systems continue to fall short. End-of-rotation evaluations rely on global impressions, ratings trend toward inflation, and trainees who routinely request more direct observation and real-time feedback often receive neither. Recent evidence underscores the urgency: milestone ratings show no significant correlation with patient outcomes, demonstrate limited inter-rater reliability, and carry documented risk for racial bias in evaluation. Psychiatry programs are required to complete over 250 milestone ratings per resident per year, often resulting in "box-checking" without meaningful feedback. Workplace-Based Assessments (WBAs) linked to Observable Practice Activities (OPAs) offer a promising solution, but programs consistently struggle with implementation: faculty burden, inconsistent use, and poor integration into clinical workflow. This workshop addresses that gap directly.

Agenda

- Introductions, Framing, and Objectives (5 min)
- Ice Breaker (paired or small groups, 10 min)
- The Case for Change (10 min)
- WBA / OPA / EPA: What Are They and How Do They Fit? (10 min)
- Try It Yourself: Live OPA Practice (15 min)
- What We Learned: Implementation in the Real World (10 min)
- Breakout: Barrier-Busting (20 min)
- Take-Aways & Q&A (5 min)
- Complete Evaluations (5 min)

Scientific Citations

1. Young JQ, Holmboe ES, Frank JR. Competency-Based Assessment in Psychiatric Education: A Systems Approach. Psychiatr Clin North Am. 2021;44:217–235.



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3. Young JQ, Hasser C, Hung EK, et al. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. Acad Med. 2018;93(7):1048–1054.

4. Warm EJ, Mathis BR, Held JD, et al. Entrustment and mapping of observable practice activities for resident assessment. J Gen Intern Med. 2014;29(8):1177–1182.

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Title

Examples and Innovations for the Next Generation of Quality Improvement Education

Primary Category

Curriculum

Presenters

Anne Penner, MD, University of Colorado Denver, Cassie Karlsson, MD, University of Kansas School of Medicine, Wichita, Cassidy McNitt, MD, University of Colorado Denver, Misty Richards, BS, MD, MS, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA

Education objectives

By the end of this workshop, participants will be able to:

1. Describe the ACGME milestone requirements and practice-based learning needs underlying QI education for residents, fellows, and faculty.

2. Review examples of resident and fellow QI project implementation, including strategies for topic selection, project scoping, and faculty mentorship.

3. Discuss how these examples might apply to attendees' own curricular structures, institutional resources, and trainee populations.

4. Brainstorm innovations for engaging trainees and sustaining project quality.

5. Compare methods for delivering QI faculty development.

Abstract

Quality improvement (QI) education is a required, milestone-linked component of psychiatry training, yet many programs struggle to move beyond a compliance-oriented checklist toward a curriculum that residents, fellows, and faculty find genuinely useful. The literature shows that trainee quality improvement projects are better when aligned with real-world clinical realities and backed up by faculty mentorship (1,2). This is something that program directors can implement in their programs with practical guidance. This interactive workshop is designed for anyone who is building or revising their program's QI education and want concrete, transferable models rather than theory alone.

The session will begin with a brief overview of the practice gap and importance of resident participation and faculty development and coaching in QI projects. Presenters will outline the key components of a QI curriculum (3) and share survey data on how QI is currently being taught across programs. The presenters will also share examples of trainee-led QI projects such as discharge medication reconciliation, substance withdrawal

screening, and clinical pathway creation access, illustrating how project topics were selected, scoped, and completed. Emphasis will be placed on practical materials including examples of A3 templates based on different QI methodologies, example timelines, strategies to deal with competing demands, and data collection that participants can adapt immediately. Presenters will also include examples of broader GME initiatives that include institutional supports for residents participating in quality improvement initiatives that could be models to bring back to their home systems (4).

Then, the session will address the importance of faculty development, an often under-considered part of QI education (5). How do programs can support faculty who were possibly never formally trained in QI methodology themselves? Presenters will compare different faculty development examples from their institutions including a structured workshop series, co-mentoring pairs that team junior faculty with experienced QI mentors, and use of institutional QI and patient-safety resources. Discussion will address time and resource requirements.

The final part of the session is a facilitated large- and small-group discussion. Participants will work in small groups to map the examples presented onto their own program's structure, identifying which elements are most transferable given their resources, trainee numbers, and existing QI infrastructure. Groups will then brainstorm innovations, such as ways to integrate QI education with clinical operations, methods for keeping projects alive across resident transitions, and strategies for engaging fellows in subspecialty-specific QI work. The session will close with a large-group share-out of the most promising innovations and practical next steps participants can bring back to their programs.

By the end of the workshop, participants will leave with a deeper understanding of QI curricular structures and faculty development models alongside implementation steps.

Practice Gap

The ACGME identifies quality improvement (QI) as a core element of the Practice-Based Learning and Improvement competency, and residency and fellowship milestones require that trainees participate in real or simulated QI activities and that both residents and faculty receive data on relevant quality metrics. In practice, psychiatry programs vary widely in how they meet this requirement: a recent survey found that only about two-thirds of Canadian psychiatry residencies deliver a structured QI curriculum, and programs that do often rely on isolated didactics rather than a model linking coursework to applied trainee projects and faculty mentorship. Faculty frequently report limited formal QI training themselves, which constrains their ability to mentor high-quality projects and to sustain momentum across academic years. This can also be a concern on ACGME faculty surveys. Training directors would benefit from practical examples of programs that have built QI curricula that include applied projects and faculty development initiatives.



Agenda

- Introduction, review of the practice gap, and survey results (10 minutes)
- Three programs give specific examples of their QI curriculum including projects and how they are scoped and implemented. (30 minutes and 5 minutes for questions)
- Comparing specific curricular options for faculty development and project mentorship. (10 minutes)
- Table discussion: using a short, structured worksheet, participants will apply ideas to their own programs. (20 minutes)
- Large group share-out: each table will focus their report on innovations identified from each table (10 minutes)
- Evaluation (5 minutes)

Scientific Citations

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Title

From Instructor to Professor: Navigating the Journey for Academic Promotion

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Narpinder Malhi, MBA, MD, Christiana Care Health System, Julia Shekunov, MD, Mayo School of Graduate Medical Education, Raman Marwaha, MD, Hackensack Meridian Health-Ocean Medical Center, Consuelo Cagande, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Dorothy Stubbe, MD, Yale University School of Medicine

Education objectives

1. Identify common barriers faced by program directors and faculty in pursuing academic promotion across academic and community psychiatry training programs.

2. Describe the distinct roles of mentorship and sponsorship in building scholarship and strengthening an education portfolio.

3. Develop a personalized action plan to build a sustainable education portfolio that supports academic promotion.

Abstract

Academic promotion is a critical milestone in an academician's career, providing formal recognition of growth as a clinician, educator, leader, and scholar. Advancement can open doors to expanded leadership roles, increased compensation, and greater institutional and national impact. Although most institutions publish promotion criteria, many early- and mid-career faculty find themselves stalled on the path to advancement.

These challenges are amplified in community-based psychiatry training programs that are not directly affiliated with major academic centers, where faculty may lack protected academic time, access to mentorship and sponsorship networks, and institutional infrastructure to support scholarly productivity. Faculty in these settings frequently balance substantial clinical, administrative, and educational responsibilities, leaving little time for scholarship, academic networking, or promotion-focused career planning. Consequently, curriculum vitae (CV) may not be consistently maintained, scholarly contributions may go unrecognized, and opportunities for advancement may be missed. Across institutional settings, recurring themes emerge such as limited mentorship, heavy workload demands, unfamiliarity with promotion criteria, and underappreciation of educational work by promotion committees.



Despite the high impact of this work– including administrative oversight, resident support, faculty engagement, curriculum development, and accreditation compliance – many PDs struggle to identify viable promotion pathways, document educational achievements in formats recognized by promotion committees, and translate leadership and educational contributions into a cohesive scholarly portfolio. These challenges cut across career stages and institutions, and are deepened by limited familiarity with promotion criteria, limited access to mentorship, and the systemic undervaluation of education scholarship in traditional promotion frameworks.

This workshop provides practical strategies for PDs and faculty to identify and leverage their existing work for academic advancement. Using the AAMC's five educator activity domains as an organizing framework, participants will learn how to systematically document their contributions, build a promotion-ready educator portfolio, align accomplishments with institutional criteria, and cultivate mentorship and sponsorship relationships that support career growth. By increasing awareness of the academic value of routine educational and clinical work and offering actionable tools for promotion readiness, this workshop aims to empower faculty across settings to successfully navigate and self-advocate for their promotion pathways.

Grounded in the themes of creativity and generativity in education leadership, this session tackles common barriers to advancement, from navigating unfamiliar promotion criteria, to finding the right mentors and sponsors, and making the case for recognizing educational leadership as scholarship worthy of promotion. This workshop will also provide participants with practical handouts and resources to support the development and planning of their educator portfolio.

Practice Gap

Program Directors (PDs) and teaching faculty across psychiatry training programs face persistent barriers to academic advancement, regardless of institutional setting. The demands of program leadership often leave little bandwidth for long-term career planning leaving academic promotion sidelined. Feedback gathered from AADPRT 2026 career-stage workshop discussions highlighted the need for practical guidance on academic promotion, particularly for educators whose work centers on teaching, supervision, curriculum development, quality improvement, mentorship, and program administration.

This workshop addresses these gaps by equipping participants with practical strategies to feel empowered and leverage their educational and leadership work for academic growth. It also raises a broader question: how do we ensure that the creative, generative, and deeply human work of psychiatric education leadership is not only sustained amid growing pressures, but formally recognized and valued?

Agenda

5 mins: Introduction with interactive audience polling exploring their role and where they are in the promotion process

10 mins: Barriers to Promotion in Community and Academic Programs



5 mins:Pair-and-Share activity discussing barriers to promotion and identify a strategy used at their institution: brief group debrief.

10 mins:Building an Educator Portfolio: Overview of the five AAMC educator activity domains and approaches to documenting contributions with evidence of impact, quality, and scholarly engagement.

15 mins:Large-group activity using vignette to map PD/faculty activities to educator portfolio domains to identify strengths, gaps, and opportunities for growth.

10 mins:The Power of Mentorship and Sponsorship: Career reflections from a senior faculty leader on finding mentors, building networks and creating visibility

15 mins: Large-group activity using a faculty vignette to develop a personalized 12-month promotion action plan, including priorities, mentors/sponsors, and a scholarly project to pursue.

20 mins:Q&A, Takeaways, practical resources

Scientific Citations

1. Murphy EA, Holmes-Maybank K, Burger A, Harrison R. Pathways to promotion: A road map for growth and impact in academic medicine. J Hosp Med. 2026 Feb;21(2):205-206. doi: 10.1002/jhm.70211. Epub 2025 Nov 4. PMID: 41189292; PMCID: PMC12865234.

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Title

From Vision to Practice: Crafting Creative Models of School Psychiatry Training Experiences

Primary Category

Curriculum

Presenters

Rebecca Klisz-Hulbert, MD, Detroit Medical Center/Wayne State University, Khushbu Shah, MD, McGaw Medical Center, Northwestern University, Molly Wimbiscus, MD, Cleveland Clinic Foundation, Kristie Ladegard, MD, University of Colorado Denver, Tiffany Ogundipe, MD, Cleveland Clinic Foundation

Education objectives

As a result of this presentation, participants will be able to:

1. Describe multiple models of school psychiatry training experience.
2. Identify existing school psychiatry resources and opportunities within your own program.
3. Design a proposed school psychiatry experience for your own program complete with a sample curriculum.

Abstract

School staff, families, clinicians, and policy makers are increasingly calling for the integration of mental health services into the school setting. CDC data suggests that up to 75% of students with poor mental health receive no treatment or inadequate treatment. School-based mental health services have demonstrated benefits on internalizing and externalizing mental health problems in multiple studies. Such programs include universal, selective, and targeted interventions. Furthermore, partnerships with healthcare providers, including child and adolescent psychiatrists, through school-based services expand access to needed mental healthcare and improve the lives of young people living with mental illness. The national CAP workforce shortage increases the need for training models that broaden trainees' understanding of community-based care and prepare future doctors to work effectively across youth-serving systems. As child psychiatry seeks to engage with interdisciplinary teams to improve mental health access and outcomes, we must prepare trainees at all levels to collaborate with schools.

This highly interactive workshop will help training directors, faculty, fellows and other educators develop scalable school mental health (SMH) training experiences tailored to their communities, local schools, and institutional resources. A brief pre-workshop survey will characterize participants' current school-related clinical and training experiences, resources, and challenges. Presenters from four programs will provide concise examples spanning a continuum of implementation, including school consultation, educator wellness and other

professional development, classroom curriculum led by CAP fellows, direct patient care models within school systems, re-entry and transition supports for student, mental health navigation, virtual access services, and integrated school-based health centers. Trainees will contribute perspectives on the educational value and practical realities of participating in these models.

The core of the workshop will use four rotating small-group stations. Facilitators will guide participants to creatively identify existing resources and simplify logistical concerns (including GME and legal) of developing an ACGME-required experience. At each station, participants will examine one SMH model, identify transferable components, and apply an implementation exercise to their home program that is appropriate in scope and optimizes the training experience. Pre-trained generative artificial intelligence will be used as a structured planning tool to help participants synthesize their local resource inventory, training goals, constraints, and potential partnerships into an actionable draft blueprint. Simple, AI-generated plans will be critically reviewed and refined by participants and facilitators. By the end of the session, each participant will have developed a practical next-step plan for a small, intermediate, or more comprehensive school psychiatry experience. Plans may range from a focused consultation or didactic experience to longitudinal clinical, navigation, re-entry, or integrated school health models. The workshop will demonstrate that meaningful school psychiatry training does not require a single standardized model or extensive new infrastructure. Programs can build from existing community relationships and scale deliberately over time.

There is a need for creative development of school psychiatry experiences based on each program's resources in order to fulfill ACGME requirements, increase interest in CAP careers, directly address workforce shortages, provide essential care within community settings, and better prepare future psychiatrists to work across youth-serving systems.

Practice Gap

The ACGME requires Child and Adolescent Psychiatry (CAP) training programs to provide organized clinical consultation experiences, including "supervised formal observation and/or consultation in schools" yet the implementation of this is wide-ranging. Workforce shortages and limited resources severely limit access to CAP faculty in these settings, causing difficulty in creating meaningful experiences that expose trainees to school-based consultation and develop skills needed for effective collaboration with child-serving systems, as mandated by ACGME.

Agenda

- Introduction, objectives and participant survey (10 minutes)
- Speed presentations on building SMH programs from faculty and trainee perspectives (10 min)
- Audience share about their experiences developing, refining and achieving ACGME requirements (5)
- Small group rotations: Rotate among four stations for direct learning and blueprint making using generative AI with critical and creative thinking exercises to optimize implementation for one's own program (4 stations, 40 min total)



- Large group share-out about blueprint making and next steps (10 min)
- Questions and discussion (10 minutes)
- Survey completion (5 minutes)

Scientific Citations

1. Richter, A., Sjunnestrand, M., Romare Strandh, M., & Hasson, H. (2022). Implementing School-Based Mental Health Services: A Scoping Review of the Literature Summarizing the Factors That Affect Implementation. International Journal of Environmental Research and Public Health, 19(6), 3489. https://doi.org/10.3390/ijerph19063489

2. Ryst, Erika, and Shashank V. Joshi. "Collaboration With Schools and School-Based Health Centers." Child and Adolescent Psychiatric Clinics of North America, 2021.

3. Hoover, S., & Bostic, J. (2021). Schools As a Vital Component of the Child and Adolescent Mental Health System. Psychiatric Services, 72(1), 37–48. https://doi.org/10.1176/appi.ps.201900575

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5. Cortese, Samuele, et al. "Child and Adolescent Psychiatry: Challenges, Solutions, Opportunities, and Future Directions." World Psychiatry, 2026.

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Title

Harmony without Uniformity: Creative Approaches to Building a Psychotherapy Training Program in Diverse Residencies

Primary Category

Curriculum

Presenters

Alyson Gorun, BA, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry, Sindhu Idicula, MD, Baylor College of Medicine, Jessica Khan, MD, University of North Carolina Hospitals, Aimee Murray, PsyD, University of Minnesota, Erin Seery, MD, Medical University of South Carolina

Education objectives

Upon completion of this workshop, participants will be able to:

1 Describe current ACGME requirements and milestones for psychotherapy training, including their historical development and the standard components of a comprehensive psychotherapy curriculum.

2. Evaluate their program's psychotherapy training by comparing its current structure, resources, and gaps with diverse models used across residency programs.

3. Develop an actionable plan to strengthen psychotherapy training at their home institution using available faculty and program resources, adaptable educational strategies, and relevant AADPRT resources and consultation opportunities.

Abstract

Psychotherapy education is a core component of psychiatry residency training, yet programs can vary considerably in how they interpret ACGME requirements and organize psychotherapy curricula, clinical experiences, and supervision. Programs may also face challenges related to limited faculty expertise, competing curricular demands, insufficient supervision, and uncertainty about how to create advanced training opportunities and questions related to the value added of psychotherapy education for trainees. This workshop will provide participants with a practical framework for understanding the components of psychotherapy training and strengthening psychotherapy education within their own institutions.

The workshop will begin with an overview of the history and evolution of ACGME psychotherapy requirements and milestones, the standard components of a psychotherapy education program, and relevant literature on psychotherapy training requirements in psychiatry residency, as well as the recent consensus article on the perceived value of psychotherapy training. Presenters will then describe diverse approaches to psychotherapy training, focusing on the timing of training across postgraduate years, creative approaches to didactics, split



treatment versus combined psychotherapy and medication management, use of psychotherapy skills in diverse clinical environments, and opportunities for advanced psychotherapy education. Small and large group discussions will help participants compare their own program structure and identify meaningful similarities and differences across institutions, including sharing strategies and perspectives from rural to urban environments and well-resourced to under-resourced programs. Participants will assess the faculty, supervision, clinical, and curricular resources available at their own programs; identify gaps in meeting required and aspirational training goals; and consider feasible strategies for improvement.

In keeping with the meeting theme, this workshop will help training directors apply creative strategies to reduce the stress of meeting psychotherapy training requirements and develop sustainable (and generative) training models tailored to their programs. The workshop will conclude with a review of existing AADPRT resources, including the Virtual Training Office, Psychotherapy Training Consultation Group, and Psychotherapy Committee initiatives. Participants will leave with an individualized framework for improving psychotherapy training at their home institutions and will have an opportunity to provide feedback on additional resources AADPRT could develop to support programs facing challenges in this area.

Practice Gap

Psychiatric residency programs must satisfy Accreditation Council for Graduate Medical Education (ACGME) psychotherapy requirement for instruction and practice competency in supportive, cognitive-behavioral, and psychodynamic psychotherapies. Program implementation of these requirements is heterogeneous and may lead to inconsistent outcomes. One of the primary drivers of the variation is the vagueness of the ACGME wording, which is necessary to avoid specific mandates that would be unrealistic for the diversity found in training sites. Other drivers include differences in resource availability, distinct operational infrastructures, and sparsity of literature. Consequently, program directors lack clear operational blueprints for didactics, casework, and supervision. These gaps are further complicated by the ACGME's ongoing 10-year major requirement review, expected for public comment by late 2026 (Sudak, 2026). To navigate these challenges, residency directors need adaptable frameworks and resources that can accommodate upcoming regulatory shifts while ensuring feasible, individualized, high-quality clinical training.

Agenda

- 5 minutes: Introduction.
- 20 minutes: Didactic. Introduction to and history of psychotherapy milestones and ACGME requirements, as well as standard components of a psychotherapy education program.
- 10 minutes: Think-Pair-Share. Participants describe their program's psychotherapy training.
- 5 minutes: Large group discussion. Participants share what surprised them and major differences between programs.



- 10 minutes: Didactic. Description of diverse psychotherapy training programs, including when psychotherapy curriculum/patients start, creativity in didactics, split vs combined treatment, training in rural or underresourced programs, and advanced training.
- 10 minutes: Small group discussion. Participants outline their programs' psychotherapy training resources and deficits.
- 5 minutes: Didactic: Common gaps in psychotherapy training.
- 15 minutes: Small group discussion. Discussion of what both aspirational improvements and improvements to meet the psychotherapy training requirements.
- 5 minutes: Didactic. Review current resources within AADPRT to create/improve psychotherapy training
- 5 minutes: Conclusion and discussion of what resources would be helpful for AADPRT to create.

Scientific Citations

1. Sudak, Donna M. 2026 Specialty Updates: Psychiatry Update. ACGME Annual Educational Conference, Accreditation Council for Graduate Medical Education, 2026. PDF download. www.acgme.org/globalassets/pfassets/presentations/2026-specialty-updates/aec-psychiatry-update-2026.pdf.

2. Sudak DM, Brenner AM. The future of psychotherapy training. Acad Psychiatry. 2024;48:511–55.

3. Potash, J.B., McClanahan, A., Davidson, J., Butler, W., Carroll, N., Ruble, A., Yaden, M., King, D., Torous, J., Zandi, P.P., Kennedy, K.G., Smith, T.E., Waghray, A., Trestman, R. and Wills, M. (2025), The Future of the Psychiatrist. Psych Res Clin Pract, 7: 80-90. https://doi.org/10.1176/appi.prcp.20240130

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Title

Legacy by Design: Creating Rituals and Traditions that Foster a Culture of Connection in Your Program

Primary Category

Learning Environment

Presenters

Samuel Dotson, BS, MD, Northeast Georgia Medical Center Program, Rahel Bosson, MD, Mass General Brigham/Brigham and Women's Hospital/Harvard Medical School, Ann Schwartz, MD, Emory University School of Medicine, Joseph Stoklosa, MD, Mass General Brigham/Brigham and Women's Hospital/Harvard Medical School, DeJuan White, MD, Emory University School of Medicine

Education objectives

Through participating in this workshop, attendees will be able to:

1. Describe the role of organizational culture, psychological safety, and belonging in shaping the residency learning environment.

2. Analyze the residency lifecycle to identify key transition points and opportunities for strengthening community, professional identity formation, and stakeholder connection.

3. Design at least one new ritual or tradition that aligns with their program's values, supports its mission, and reinforces a culture of connection.

Abstract

Residency program culture is widely recognized as a critical determinant of the learning environment and is regularly assessed through mechanisms such as the Annual Program Evaluation and the ACGME Annual Survey. Yet culture is often treated as a passive characteristic of a program rather than an organizational asset that can be intentionally designed by leaders. Established residency programs frequently possess traditions, ceremonies, and rituals that appear to have emerged organically over time. Closer examination, however, often reveals generations of leaders, faculty, and residents who deliberately created moments of connection that reinforced the program's values, mission, and identity. Over time, these traditions accumulate into social capital that helps transmit culture across resident cohorts, faculty turnover, and leadership transitions.

As new residency programs continue to emerge and leadership transitions occur within established programs, program directors have opportunities to intentionally shape and reshape their program's culture. Drawing from scholarship on liminality and rites of passage in the anthropology literature, organizational culture in business, and a pedagogy of connection in education, this workshop provides participants with a practical framework for creatively designing culture-building experiences throughout the residency lifecycle.



Participants will first explore the values and cultural attributes they hope to transmit within their own programs. Through guided reflection and interactive activities, they will identify strengths, gaps, and opportunities within their program (or planned program for new program directors). Attendees will then examine three categories of culture-building interventions. The first are rituals of transition ("Who are we becoming here?"), which mark important liminal moments such as orientation, Match Day, chief resident transitions, and graduation. The second are rituals of recognition ("What do we value here?"), which celebrate behaviors and accomplishments that embody program values. Attention is also paid during this portion to what or whom our awards may inadvertently leave unseen. Finally, rituals of routine ("How do we behave here?") infuse recurring events such as grand rounds, retreats, committee meetings, and didactics with greater meaning and connection.

Throughout the workshop, participants will use break-out groups and polling software to share examples and learn from one another's experiences. The session concludes with the development of an individualized culture-building action plan, including at least one concrete intervention that participants can implement within their own programs during the coming academic year for each of the three ritual phases. By the end of the workshop, attendees will leave with a practical framework to strengthen belonging, reinforce shared values, and create lasting cultures of human connection within their institutions.

Practice Gap

While organizational culture is one of the strongest predictors of success in both business and educational settings, many residency leaders struggle to intentionally create cultures that foster connection, belonging, and psychological safety. Established programs often possess traditions and rituals that have been passed down over generations of trainees and faculty, helping to reinforce community and transmit institutional values. In contrast, many newer residency programs must build culture from the ground up yet receive little guidance on how to do so. Culture is not created through a mission statement, strategic plan, retreat, or single wellness initiative. Rather, culture emerges through repeated interactions and meaningful rituals that occur at pivotal moments throughout the residency journey. Program directors need practical, evidence-informed approaches for creatively designing these experiences in ways that humanize training, strengthen professional identity formation, and create lasting cultures of connection.

Agenda

- Introduction (20 Minutes)
    - 10 Minutes: Introduce speakers, review objectives, and conduct a needs assessment (Poll Everywhere)
    - 10 Minutes: Mini-didactic on liminality, organizational culture, and a pedagogy of connection
- Rituals of Transition: Who Are We Becoming Here? (20 Minutes)
    - 10 Minutes: Exercise 1, Small-group discussion of current practices for key events
    - 10 Minutes: Discussion of orientation, graduation, Match Day, and chief pass-off
- Rituals of Recognition: What Do We Value Here?" (20 Minutes)



    - 10 Minutes: Exercise 2, Think-Pair-Share exercise reviewing list of graduation awards and determining their encoded values
    - 10 Minutes: Large-group discussion of recognition practices across institutions
- Rituals of Routine: How Do We Behave Here? (20 Minutes)
    - 5 Minutes: Exercise 3, Self-reflection in which participants identify existing recurring practices that could be redesigned
    - 15 Minutes: Large-group discussion of strategies for embedding meaning into routine events
- Conclusion (10 Minutes)
    - 5 Minutes: Complete culture-building action plan
    - 5 Minutes: Complete evaluations

Scientific Citations

1. de Carvalho Filho MA, Hafferty FW. Adopting a pedagogy of connection for medical education. Medical Education. 2025 Jan;59(1):37-45.

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Title

No publications? No problem!: a case-based guide to publishing (for you and your trainees)

Primary Category

Research and Scholarship

Presenters

James Lee, BS, MD, University of Washington Program, Ashley Andreou, MD, MPH, Columbia University/New York State Psychiatric Institute, Richard Balon, MD, Detroit Medical Center/Wayne State University, Adam Brenner, MD, UT Southwestern Medical Center

Education objectives

Upon completion of this session, participants will be able to:

1. Describe peer-reviewed journal publication processes;
2. Identify various manuscript types in education journals; and
3. Explain the roles of editors, authors, and reviewers in publications.

Abstract

This workshop is a down-to-earth, hands-on introduction to the essential skills of developing manuscripts for publication in peer-reviewed academic medical journals. The workshop will be led by Academic Psychiatry journal editors and trainee editorial fellows, providing a variety of perspectives into the writing/editing process. Using interactive cases to review the steps in publishing, participants will walk through the entire publication process, including journal selection, manuscript type selection, manuscript preparation, submission, peer review, revision, editorial decision-making, and production. Specific strategies will be offered for assessing one's strengths and motivations as a writer and collaborator, recommendations for best practices in selecting target journals and manuscript types, responding to reviewer concerns, and working with editors. This workshop will enhance skills of trainees and early to middle career academic physicians and provide a framework for senior faculty to serve as mentors, senior authors, and guest editors.

Practice Gap

Academic writing and publishing are vital in career advancement and help in the development of crucial skills of articulating ideas and reviewing the literature. Despite this, trainees often find publishing to be intimidating and challenging. Barriers include lack of time, lack of experience, impostor syndrome, and limited training in the publishing process. Faculty themselves may also have never received formal training in publishing and may find this process difficult to teach. Academic Psychiatry is a journal that features scholarly work on innovative education, academic leadership, and advocacy in psychiatry. The journal aims to promote original

research and to support and mentor new authors, and often receives queries from prospective authors about how to get started.

Agenda

- Introductions and large group discussion identifying common challenges faced in publishing. (10 min)
- Small groups (60 min) – Participants will work through a three-step case, where they roleplay a faculty member advising a resident on publishing a scholarly project. For illustrative purposes, this exercise will use Academic Psychiatry author guidelines. There will be 12 min of small group discussion followed by 8 min large group debrief for each case.
    - Case 1 – Establishing goals and identifying manuscript type
    - Case 2 – Preparing the manuscript (including formatting guidelines, organization, authorship)
    - Case 3 – Responding to reviews (including revision etiquette, and growth mindset in the face of rejection revision decisions)
- Large group debrief and Q&A (20 min)
    - Summarize takeaways
    - Provide information about programs that enhance trainee scholarship skills (e.g. AJP Resident's Journal, Academic Psychiatry Trainee Editorial Fellowship)
    - Q&A with Academic Psychiatry journal editors and editorial fellows

Scientific Citations

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5. Yung MG, Brenner A. Publishing (2023). The Psychiatry Resident Handbook: How to Thrive in Training. Edited by De Golia SG, Wang RS. American Psychiatric Association Publishing.

Title

The Program Director’s AI Tool Kit

Primary Category

Program Administration and Leadership

Presenters

Jamison Bradshaw, DO, UMass Chan -- Baystate Medical Center, Deepika Sundararaj, MD, UMass Chan -- Baystate Medical Center, John Luo, MD, University of California, Irvine Medical Center, Michael J Peterson, MD, PhD, University of Wisconsin Hospital & Clinics, Alexis Dame, DO, UMass Chan -- Baystate Medical Center

Education objectives

By the end of this workshop, participants will be able to:

1. Apply generative AI tools to common residency program administrative workflows, including scheduling, data synthesis, and professional writing.

2. Evaluate the usefulness and limitations of AI-generated outputs for graduate medical education administration.

3. Discuss an approach to responsible AI use that considers privacy, bias, appropriate oversight, and preservation of human judgment in decisions affecting applicants, residents, and programs.

Abstract

Psychiatry residency program leaders manage numerous recurring administrative tasks that compete with time available for education, mentorship, and clinical work. Generative artificial intelligence (AI) offers opportunities to assist with some of these tasks, but program leaders need practical experience with these tools as well as frameworks for determining where AI assistance is appropriate.

This interactive workshop will explore generative AI use across common residency program workflows. Through demonstrations, audience polling, group exercises, and discussion, participants will explore how AI tools can support scheduling, applicant review, program data analysis, and professional writing. Rather than focusing on any single AI platform, the workshop will emphasize approaches that can be adapted across tools and programs.

Participants will have opportunities to interact directly with generative AI and critically appraise its output. A hands-on exercise will challenge participants to use AI to interpret a sample program survey finding and formulate potential programmatic responses, followed by discussion of whether the process improved efficiency or generated useful insights. An interactive writing exercise will explore whether providing AI with

samples of an individual's prior writing can produce more authentic professional communication, with participants comparing AI-generated and human-written letters through blinded audience polling.

These real-world applications will provide a foundation for examining broader questions surrounding responsible AI use in residency administration. Discussion will address privacy, bias, limitations of AI-generated outputs, environmental impact, appropriate human oversight, and emerging possibilities for analyzing program data. Particular attention will be given to decisions affecting applicants and residents, where efficiency must be balanced against fairness and transparency.

By combining practical experimentation with critical appraisal, this workshop will provide program leaders with both immediately applicable strategies, as well as important considerations for future AI applications. Participants will leave better equipped to identify administrative workflows that may benefit from AI assistance, evaluate whether AI meaningfully improves those workflows, and determine when human judgment and oversight should remain central.

Practice Gap

Psychiatry training programs require substantial recurring administrative work, including schedule construction, analysis of resident and program evaluation data, tracking of application deadlines, applicant review and written communication. Although generative AI tools may improve the efficiency of resident program operations, their integration into graduate medical education remains early, with emerging literature highlighting gaps in AI training, familiarity, and institutional guidance[DAD1.1]. Program leaders therefore need practical approaches for applying AI to specific administrative workflows while distinguishing tasks appropriate for AI assistance from decisions requiring human judgment and oversight. Without hands-on experience and a framework for responsible use, program leaders may underutilize potentially valuable tools or use them without adequately considering limitations, privacy, bias, and human accountability. This workshop addresses these gaps through demonstrations, interactive exercises, and discussion focused on practical, responsible applications of AI in graduate medical education administration.

Agenda

Introduction and live polling (5 min): Polling of administrative workload, current AI use, and tools used by participants.

Block A – Scheduling and organization (15 min): Demonstration of AI-assisted call scheduling and creation of a program director calendar incorporating application deadlines and meetings.

Block B – Data synthesis and program response (25 min): Structured applicant review; analysis of survey/evaluation trends; small-group activity using AI to develop a response to a sample program survey finding; discussion.

Block C – AI-assisted writing (25 min): Large-group blind comparison of human and AI-generated letters with and without writing-style personalization; audience polling; discussion of incorporating personal voice into AI-assisted writing.

Block D – Responsible AI and future directions (20 min): Responsible AI use, human oversight, potential for data mining and prediction, limitations, and future applications. Followed by question and answer session.

Scientific Citations

1. Wolthusen RPF, El-Tohami M, Hendler RA, Riordan PA, Stoklosa JB. A framework for artificial intelligence in medical education: Could I, Would I, Should I? J Grad Med Educ. 2025;17(4):430-433. doi:10.4300/JGME-D-25-00009.1. [DAD2.1]

2. Mercado AE, Ferguson L, Chastain J, Williams J, Nahhas RW, Tripathi S, Grant L. Are psychiatry faculty prepared to guide AI use? A national survey. Acad Psychiatry. Published online May 9, 2026. doi:10.1007/s40596-026-02352-6. [DAD3.1]

3. Benton J, Kewalramani D, Nieman DR, Bongu A, Loftus TJ, Barie PS, Lee LY, Patel NM, Narayan M. Familiar but unprepared: Artificial intelligence training needs in graduate medical education. Surgery. Published online June 16, 2026. doi:10.1016/j.surg.2026.110389. [DAD4.1]

4. Frederiksen O, Duman H. Transforming annual program evaluation reviews: AI-driven efficiency and consistency at a large institution. J Grad Med Educ. 2025;17(3):373-374. doi:10.4300/JGME-D-24-00881.1. [DAD5.1]

5. Antao EM, Rasheed A, Näher AF, Wieler LH. Reason and responsibility as a path toward ethical AI for (global) public health. NPJ Digit Med. 2025;8:329. doi:10.1038/s41746-025-01707-x[

Title

What Every Psychiatry Resident Should Know About Psychedelic Medicine: Building a Foundational Curriculum

Primary Category

Curriculum

Presenters

Jeffrey Zabinski, BS, MA, MD, Columbia University/New York State Psychiatric Institute, Simran Ailani, MD, Yale University School of Medicine, Mary Yaden, MD, Johns Hopkins Medical Institutions

Education objectives

By the end of the session, participants will be able to:

1. Identify foundational knowledge and clinical communication skills in psychedelic medicine appropriate for all psychiatry residents, distinguishing these from advanced training to deliver psychedelic-assisted therapy.

2. Use clinical teaching cases to help residents critically appraise evidence and address patient questions about safety, ethics, and access to care in psychedelic medicine.

3. Develop a feasible introductory curriculum in psychedelic medicine with teaching methods, an assessment approach, and options for faculty support and shared educational resources.

Abstract

Patients are already asking about psychedelics, and residents need to be prepared to have thoughtful, evidence-based conversations with them. This raises a practical question for residency educators: what should every graduating psychiatrist know about psychedelic medicine, whether or not they intend to provide psychedelic-assisted therapy?

A survey of 61 US psychiatry training directors conducted in 2022 found that 64% of respondents favored more time devoted to psychedelic education and 94% expressed interest in a standardized curriculum. Limited teaching materials and faculty expertise were leading barriers. These findings provide a starting point for considering what programs need now, including education beyond ketamine-focused experiences. (1)

This workshop will bring together residency educators to define a realistic foundation in psychedelic medicine and consider how to teach it within an already full curriculum. We will revisit the original survey and discuss priorities for a proposed five-year follow-up, including who teaches this content, how it is delivered, and whether programs address patient counseling, safety, ethics, and equity. We will then introduce the multi-institutional residency curriculum developed by a team from Johns Hopkins, NYU, and Yale as a model that

programs can adapt. Content will include critical appraisal of the evidence, pharmacology, treatment models, adverse effects, regulatory context, and culturally responsive patient care. (1, 2)

We will also examine how programs can find the teaching resources and faculty support needed to sustain this work. The Psychedelic Education Partnership's University Psychedelic Education Program (U-PEP) provides a model for faculty development and curriculum support, while its developing Clinician Psychedelic Education Program (C-PEP) extends this educational mission to practicing clinicians. The Interventional Psychiatry Consortium (IPC) offers psychedelic content within a broader program of shared teaching, discussion, and collaboration across institutions. We will discuss how educators can draw on these and other complementary efforts to support resident learning and keep teaching materials current. (3, 4)

Most of the session will involve participants working together. Small groups will use brief clinical teaching cases to identify what residents need to know when counseling a patient interested in psychedelics or evaluating concerns after use. Participants will then sort topics into essential, supplemental, or advanced content and build a three-hour foundational curriculum, selecting teaching methods and a practical way to assess learning. A final discussion will address implementation barriers, opportunities for shared teaching, and priorities for future curriculum development. Participants will leave with a draft curriculum outline and concrete next steps for their home programs. By collaboratively generating an adaptable curriculum and identifying opportunities for shared teaching across institutions, the workshop models a generative approach to educational leadership.

Practice Gap

Residency educators need practical ways to prepare trainees for patient questions about psychedelics while working within limited curricular time and faculty capacity. A 2022 program director survey identified strong interest in additional education, alongside gaps in teaching resources and expertise. Published course development work demonstrates one approach to organizing introductory content. The educational task is to translate available materials into a feasible foundation for general psychiatry residents, with clear learning objectives, opportunities to practice clinical reasoning and communication, and an approach to assessing learning in this rapidly developing content area.

Agenda

0-5 min:

Introductions and audience polling. Identify current teaching and areas where educators feel least prepared.

5-20 min:

The evolving psychedelic landscape: What should every resident know? Briefly review clinical and regulatory developments, the original survey and proposed follow-up, and the implications for foundational residency education.

20-45 min:



Interactive clinical teaching cases. Use audience polling, discussion in nearby pairs or trios, and facilitated discussion to identify what and how to teach a resident.

45-65 min:

Adapt a foundational curriculum. Use a supplied outline to prioritize content, choose a feasible teaching approach, and identify one practical assessment of learning.

65-75 min:

Report-out and examples from existing programs: Groups shared selected ideas. Presenters synthesize common themes and introduce relevant examples, alongside shared teaching and psychedelic content

75-85 min:

Questions and discussion. Discuss implementation challenges, unresolved issues, and opportunities for collaboration.

85-90 min:

Workshop evaluation. Complete the evaluation form.

Scientific Citations

1. Yaden ME, Ching THW, Goldway N, et al. Psychedelic medicine in psychiatry residency training: a survey of psychiatric residency program directors. International Review of Psychiatry. 2024;36(8):902-907.

2. Geller J, Glynos N, Lemmen A, Pacilio R, Kruger DJ, Hosanagar A. Trainees unprepared for advances in psychedelic medicine: a survey study. Journal of Psychoactive Drugs. 2025;57(3):235–242. doi:10.1080/02791072.2024.2341795

3. Barnett BS, Arakelian M, Weleff J, Squier-Roper T, King F 4th, Cumming D, Falcone T. Psychiatric Residents' Perspectives on Psychedelics and Psychedelic Assisted Therapy. J Psychoactive Drugs. 2025 Jul 2:1-11. doi: 10.1080/02791072.2025.2527296. Epub ahead of print. PMID: 40600242.

4. Prueitt WL, Sloshower J. Psychedelic medicine: creating an introductory course for mental health professionals and trainees. Academic Psychiatry. 2023;47(1):74-77