Workshop Session #1

Title
Addressing Oppressive Action to Foster Safer Learning Environments

Primary Category
Faculty Development

Presenters
Amanda Wallace, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry
Claudia Rugama, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry
Oliver Stroeh, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry
Wilfred Farquharson IV, PhD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry
Patrice Malone, MD, PhD, Columbia University/New York State Psychiatric Institute

Educational Objectives

1. Apply Dialectic Behavior Therapy-based interventions to address microaggressions and other oppressive actions in clinical and academic settings.

2. Utilize guided, case-based practice to strengthen real-time intervention skills in psychologically safe environments.

3. Demonstrate approaches that promote accountability, foster repair, and support inclusion during challenging interactions.

4. Identify opportunities and potential challenges in incorporating these strategies within their own institutions

Abstract
Microaggressions and discriminatory behaviors in clinical learning environments significantly affect the professional development and well-being of trainees, particularly those from underrepresented or marginalized backgrounds. Research shows that exposure to these experiences undermines identity formation, contributes to burnout and psychological distress, and negatively impacts engagement and performance.

Despite this evidence, many psychiatry departments lack practical, scalable interventions to address these challenges. While cultural competency and implicit bias trainings are widespread, they often remain limited to raising awareness or teaching boundary-setting and may fall short in fostering genuine inclusion, accountability, or systemic change (Bullock et al., 2021; Sawin et al., 2023).

This workshop moves beyond passive recognition of harm by equipping psychiatry educators and trainees with two practical, evidence-informed tools to both respond to and repair oppressive harm in real time. We define oppressive harm as “behavior or systems that uphold inequity and marginalize individuals based on social identities, often through unconscious or systemic means” (Okun, 2020; Chavez-Dueñas et al., 2021).

The first tool, the Levels of Validation Framework, provides a structured approach to navigating difficult conversations and acknowledging harm without defensiveness, a crucial step in preserving trust. The second, the Upstander Repair Process, expands the role of the bystander beyond calling out harm by offering a model for public repair and collaborative action planning. This focus on repair, including acknowledgement, accountability, and forward-looking solutions, distinguishes our approach from traditional upstander trainings. By making repair visible and shared, participants learn how to transform moments of harm into opportunities for collective growth, modeling how institutions can move toward thriving and togetherness rather than silence or rupture. The workshop includes an experiential, role-play component, in which participants embody the roles of source, recipient and upstander. This immersive practice deepens understanding of the emotional and relational dynamics at play, enhancing skill retention and empathy beyond what lecture-based training can provide.

The workshop format integrates brief didactic teaching, live facilitator modeling of psychiatry-specific scenarios, and small-group practice with structured facilitation to ensure psychological safety. Reflection and collaborative planning will conclude the session, giving participants the opportunity to share strategies from their institutions and identify ways to integrate these tools into their programs.

By the end of this session, participants will leave with increased confidence, practical skills, and concrete strategies to foster inclusive learning environments, support colleagues and trainees, and promote institutional accountability and repair. In doing so, they will be better equipped to build trust, catalyze transformation, and contribute to the togetherness and thriving of the psychiatric learning environment.

Practice Gap

Psychiatry trainees, particularly those from underrepresented and marginalized groups, are disproportionately affected by microaggressions and discriminatory behaviors in clinical learning environments. These experiences undermine professional identity, contribute to psychological distress, and reduce engagement, leading to burnout, depression, and impaired performance (Boyle et al., 2025; Gilliam & Russell, 2021; Trinh et al., 2021). Although cultural competency and implicit bias training are common, they have shown limited effectiveness in addressing racism, microaggressions, and systemic inequities, often failing to create lasting inclusion (Bullock et al., 2021; Sawin et al., 2023). Faculty also report feeling unprepared to respond in real time. We address this gap through a case-based, skills-focused workshop that equips faculty and trainees to intervene effectively, model validating communication and allyship, and foster an inclusive learning environment.

Agenda

- Welcome and Introduction (5 min)
  - Brief poll to assess participants' baseline comfort and experience with addressing microaggressions
- Didactic Session (20 min)
  - Overview of microaggressions, oppressive harm, and their impact in training
  - Introduction to the Levels of Validation Framework and the Upstander Repair Process
- Modeled Example Scenario (5 min)
  - Facilitators demonstrate use of both tools in a psychiatry-specific scenario
- Debrief of Model Scenario (10 min)
  - Group discussion of observed strategies and reflections
- Co-Creating Community Agreements & Group Formation (10 min)
  - Participants establish psychological safety and norms for practice
- Small-Group Practice (20 min)
  - Groups apply frameworks to a psychiatry-specific case with facilitator support
- Large-Group Reflection and Strategy Sharing (20 min)
  - Debrief of exercise
  - Collaborative planning on integrating these tools into psychiatry programs

Scientific Citations

Boyle, J., Chan, S. E., Joneja, M., Gauthier, S., & Leung, M. (2025). An identity on guard: The impact of microaggressions on the professional identity formation of

residents. BMC Medical Education, 25, Article 242. https://doi.org/10.1186/s12909-025-06818-3.

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Chavez-Dueñas, N. Y., Adames, H. Y., & Salas, S. P. (2021). Healing from internalized oppression: A theoretical framework for providers working with marginalized populations. The Counseling Psychologist, 49(4), 587–617. https://doi.org/10.1177/0011000020967263.

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Title
Better Together: Faculty and Residents working to see past bias in recruitment

Primary Category
Recruitment and Selection

Presenters
Morgan Faeder, MD, PhD, Western Psychiatric Hospital
Piper Carroll, MD, Western Psychiatric Hospital
Grace Wood, MD, Western Psychiatric Hospital

Educational Objectives

1. Define underrepresented in medicine (URiM) and understand the importance of increasing the number of URiM individuals in the physician workforce.
2. Recognize how structural inequities impact different aspects of residency applications.
3. Review ways in which bias may be introduced into residency applications and practice assessing for this bias.
4. Discuss ways to select applicants who are most likely to have success in residency programs.
5. Develop methods to implement systems to recognize bias in residency applications across all programs.

Abstract
The presentation will begin with an introduction to the breadth of structural inequities and its impact on healthcare. This includes defining underrepresented in medicine, reviewing the importance of diversity in residency programs, comparing national demographics to residency demographics, and discussing why discrepancies in demographics may be occurring due to the residency application selection process. Next, components of residency applications (board scores, MSPE, letters of recommendation, experiences, publications, and personal statement) will be reviewed as potential sources of bias are highlighted within each component. Participants will then break into small groups and 1) discuss personal experiences encountering bias while reviewing residency applications in the past, 2) propose other potential sources of bias in the residency application selection process, 3) identify biased language in a

provided excerpt from the (deidentified) application of a Black female applicant. The large group will then reconvene to discuss small group findings and different forms of language (agentic vs communal, trait- vs competency based) will be reviewed. The presentation will then move into an examination of various qualities our program has identified as indicators for success within our program; participants will be encouraged to again break into small groups to identify other qualities which may be success indicators for their programs, as well as ways these qualities may be identified within applications. Small groups will then read over the provided, deidentified excerpts of two real applications and discern 1) potential "red flags," 2) qualities of potential success, 3) level of willingness to offer an interview to either applicant. This will be discussed as a large group, then the presentation will end with space for further comments or questions.

Practice Gap

Many psychiatry training programs have methods in place for recruitment of trainees from populations underrepresented in medicine (URiM), as research has elucidated the importance of representation both within the workplace and upon the healthcare outcomes of patients. However, at the point of application review, these individuals are more likely to be "screened out" of consideration to interview due to structural societal inequities which impact key aspects of a residency application including board scores, clerkship grades, written evaluations and letters of recommendation, work experiences, service experiences, and research (posters/presentations/publications). These components of the application, which training programs rely on to determine whom to interview for residency, are shown to be biased against URiM applicants. We created a workshop for faculty and residents learning together to acknowledge and recognize these sources of bias with the overarching goal of improving recruitment to create programs that look more like the communities they serve.

Agenda

- Background and reviewing the scope of the problem (presenters, 5 min)
- Components of the application highlighting potentials for bias (presenters, 10 min)
- Discussion of personal experience with bias in applications, Identifying bias in a de-identified application (small group, 20 min)
- Discussion of small group findings and review of language (large group, 10 min)
- Identification of indicators of success in residency (presenters and large group, 10 min)

- Discussion of program-specific indicators of success and de-identified application excerpt review (small group, 20 min)
- Large group discussion of small group findings (10 min)
- Wrap-up and Q&A (10 min)

Scientific Citations

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Title
Bridging the Gap: Rethinking CBT Training for Psychiatry Residents

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Sarah Marks, MD, MS, Zucker School of Medicine at Hofstra/Northwell
James Hambrick, PhD, Zucker School of Medicine at Hofstra/Northwell
Anika Suddath, MD, Zucker School of Medicine at Hofstra/Northwell

Educational Objectives

1. Describe the unique challenges and contextual factors that influence how psychiatry residents engage with CBT training.

2. Apply evidence-based strategies to design or adapt CBT training approaches for psychiatry residents that integrate supervision, didactics, and clinical experiences while promoting cultural humility and interdisciplinary collaboration.

3. Reflect on and reassess personal and institutional assumptions about psychiatrists' roles in delivering psychotherapy, fostering openness to innovative and collaborative training models that bridge psychiatry and psychology.

Abstract
ACGME requirements specify that residents must demonstrate competence in supportive, psychodynamic, and cognitive-behavioral therapies as an essential part of psychiatry residency education. Yet, psychiatrists are asked to develop a set of complex competencies in CBT in a small fraction of the didactic training, supervision, and clinical contact allocated to the average psychology Ph. D. graduate student. At this same time, CBT training programs are rarely adapted to address the distinctions between psychiatry training models and populations. Psychiatrists first encounter with patients is often in emergency department or inpatient settings, contributing to a particular sense of what mental illness is that does not readily map onto typical outpatient work. CBT training cases are frequently drawn from acute community populations who either rarely present in research samples or are actively excluded by researchers as too complex or risky. Psychiatric residents confront suicidality and risk in their initial patient contacts at a level not commonly seen in other training disciplines. Frequently, training traditions emphasizing biological and psychodynamic training can impact the receptiveness of psychiatrists to CBT as a viable therapeutic option. Finally, psychiatrists practice CBT in

the context of combined treatment, requiring them to balance two different models simultaneously while they are taught each separately. Meeting the training needs of psychiatry residents requires a radical rethinking of how we handle CBT training. This workshop will focus on crystalizing the challenges confronted when training psychiatrists in CBT and discussing how we can address these challenges at the program development level. Additionally, it will provide specific training guidance for delivering the best, evidence-supported practices in didactic training and supervision. Special attention will be given to how to keep training models up to date in an ever-transforming learning environment while emphasizing culturally responsive care.

Practice Gap

Close allyship between psychiatrists and psychologists is critical to the delivery of gold standard cognitive behavioral therapy (CBT) training and clinical care. However, current psychiatric residency training models are not always sufficient to truly support these partnerships. In addition, psychiatry residency training often provides limited, fragmented exposure to CBT that is rarely tailored to the realities of psychiatric practice. Optimal CBT training models would equip psychiatry residents with developmentally sequenced, context-specific CBT training that integrates cultural humility, addresses common psychiatric care settings, and supports collaboration with psychologists, ultimately enhancing patient care quality and safety.

Agenda

- Introduction: Presentation & Group Discussion on the challenges facing psychiatry residents learning CBT (20 min)
- Small Group Activity 1 - Adapting curricula to meet the challenges (20 min) - Didactics, Supervision, and Clinical contact small groups
- Large Group Didactic: Evidence-supported practices for CBT training (15 min)
- Small Group Activity 2 – Addressing cultural humility in practice - Role Play (15 min)
- Small Group Activity 3 - Collaborating with other disciplines to enhance training and scaffold learning (10 min)
- Large Group Debrief – Wrap Up & Takeaways (10 min)

Scientific Citations

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Fefergrad M, Mulsant BH. (2021). Psychotherapy Training in a Competency-Based Medical Education Psychiatry Residency: A Proposal for a Practical and Socially Responsible Model. The Canadian Journal of Psychiatry. 67(6):423-427.

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Sudak, D. M. (2009). Training in cognitive behavioral therapy in psychiatry residency: An overview for educators. Behavior Modification, 33(1), 124-137.

Title
Developing a Culture of Confidentiality – Addressing Professionalism Concerns in Residency Training

Primary Category
Program Evaluation

Presenters
Silvina Tonarelli, MD, Texas Tech University Health Sciences Center, El Paso
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center
Mariam Rahmani, MD, Eastern Virginia Medical School
Sonia Joutteaux Haro, MD, Texas Tech University Health Sciences Center, El Paso
Fernando Doval Perez, DO, MSc, Texas Tech University Health Sciences Center, El Paso

Educational Objectives

1. Participants will identify questions surveyed by the Accreditation Council for Graduate Medical Education (ACGME) regarding the professionalism competency.

2. Participants will discuss the most frequent difficulties in maintaining confidentiality when addressing problems and concerns related to professionalism.

3. Participants will develop program-specific strategies and goals to address confidentiality deficiencies related to professionalism and share best practices to improve survey outcomes.

Abstract
The Accreditation Council for Graduate Medical Education (ACGME) mandates an annual survey to assess various competencies in graduate medical education, with professionalism being a particularly challenging domain due to the breadth of its content, making it a difficult concept to fully understand and adequately address. Although the ACGME requires that trainees and faculty be able to raise concerns confidentially without fear of retaliation, many programs struggle to create a culture that supports this expectation. Confidentiality around professionalism concerns is difficult to maintain, and low scores in this domain suggest that existing mechanisms are perceived as inadequate. Program directors may lack structured approaches or best practices to identify barriers to confidentiality and implement interventions.

The aim of this workshop is to address the critical issue of maintaining confidentiality regarding professionalism concerns within residency training programs. Participants will engage in identifying key questions from the ACGME survey, discussing prevalent challenges in keeping professionalism-related issues confidential, and collaboratively developing program-specific strategies to enhance confidentiality practices. Through a combination of didactic presentations and interactive breakout sessions, attendees will analyze real program survey results and create actionable plans utilizing available resources. The workshop will culminate with the sharing of best practices and the distribution of materials to strengthen participants' understanding and skills.
The annual ACGME trainee and faculty survey evaluates multiple competencies, with professionalism being among the most challenging. Improving processes to maintain confidentiality around professionalism can enhance trainee and faculty satisfaction, strengthen program quality, and support accreditation readiness.

Practice Gap
The Accreditation Council for Graduate Medical Education requires accredited programs to participate in the annual survey to monitor feedback about clinical and educational hours, performance evaluation, educational content, professionalism, teamwork, and overall trainee and faculty experience, among other areas. The professionalism competency poses unique challenges due to the breadth of its content, making it a difficult concept to fully define, understand and address. Although the ACGME requires that trainees and faculty be able to raise concerns confidentially and without fear of retaliation, many programs struggle to create a culture that consistently supports this expectation. Confidentiality around professionalism concerns is difficult to maintain, and low scores in this domain suggest that existing mechanisms are perceived as inadequate. Program directors may lack structured approaches or best practices to identify barriers to confidentiality and implement effective interventions. This workshop will provide practical tools and strategies to foster a safe environment for raising concerns.

Agenda

- Welcome and Introductions (5 min)
- Brief Didactics to Introduce Concepts (10 min)
- Small Breakout Groups 1 (25 min): How to assess your survey results. The leader will walk participants through real program survey results, discussing content areas, comparing year-to-year data, and identifying challenges in maintaining confidentiality around professionalism concerns. A poll will be

conducted with the audience. ACGME requirements regarding professionalism will also be reviewed.
- Leg Stretch / Water Break (5 min)
- Small Breakout Groups 2 (25 min): How to act. The leader will guide participants through an exercise focused on building an action plan using trainee, faculty, and institutional resources.
- Presentation of Action Plan Examples (10 min)
- Questions, Feedback, and Survey Completion (10 min)

Scientific Citations

Morreale, M.K., Balon, R., Louie, A.K. et al. The Vital Importance of Professionalism in Medical Education. Acad Psychiatry 47, 340–343 (2023). https://doi.org/10.1007/s40596-023-01840-3

Shapiro, M. Raise Concerns Without Fear and Protect Confidentiality: Why the Two Orders?. Acad Psychiatry 43, 128–130 (2019). https://doi.org/10.1007/s40596-018-0891-9

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Title
Direct Observation/Structured Feedback in Competency-Based Education

Primary Category
Assessment – learner (summative, formative, programmatic)

Presenters
Anne Ruble, BA, MD, MPH, Johns Hopkins Medical Institutions
Kristina Jiner, MD, The Ohio State University College of Medicine
John Q Young, BA, MD, MPP, PhD, Zucker School of Medicine at Hofstra/Northwell
Suzanne Murray, MD, University of Washington Program

Educational Objectives

1. Participants will review and discuss the concept of, evidence regarding, and best practices for direct observation/structured feedback as a competency-based teaching and assessment tool.

2. Participants will evaluate the direct observation/structured feedback tools they currently use, including which tools, which clinical settings, frequency of use, perceived effectiveness, threats to equity, faculty skill, and faculty acceptance.

3. Participants will identify one goal for improvement in their own programs and outline a plan to address it.

Abstract
In this workshop, participants will examine the role of direct observation/structured feedback as a tool for competency-based assessment, identify threats and best practices regarding its implementation and validity, conduct a systematic assessment of their own programs, and outline 1 goal and implementation plan for their programs. Presenters will provide data, vignettes, and expert guidelines on the use of direct observation/structured feedback tools. Presenters will facilitate participants' evaluation of and goals for their own programs with specific prompts for reflection and group discussion.

Practice Gap
Over the past two decades, professional associations, regulatory bodies, and credentialing organizations such as the AAMC, ACGME, and ABPN have emphasized the importance of competency-based medical education to ensure graduates possess the knowledge, skills, and attitudes needed for modern care delivery. Despite broad

agreement on these goals, programs use relatively few competency-based teaching and assessment tools. Most faculty lack formal training in their use, standardization is limited, and both implicit and explicit biases can distort formative feedback and summative assessments. Workplace-based assessments, particularly direct observation and structured feedback, are designed to capture not only what trainees know but also how they perform in real clinical encounters. However, these methods are often criticized for their infrequency and inconsistency in purpose and application. Residency programs therefore face the dual challenge of developing valid observation and feedback tools while also training and motivating faculty to employ them effectively.

Agenda

- Overview of the role of direct observation/structured feedback as a tool for competency-based assessment, and threats and best practices regarding its implementation and validity (30 min).
- Small groups (3-5 participants) will evaluate and discuss their own programs with specific prompts for reflection and discussion (30 min).
- Large group debriefing, Q&A (15 min).

Scientific Citations

Young JQ, Sugarman R, Schwartz J, O'Sullivan PS. Overcoming the Challenges of Direct Observation and Feedback Programs: A Qualitative Exploration of Resident and Faculty Experiences. Teaching and Learning in Medicine 2020: 32:541–51

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Aug;9(4):210-219. doi: 10.1007/s40037-020-00587-z. PMID: 32504446; PMCID: PMC7459074.

Title
Flipping the CCC: From Regulatory Task to Transformative Tool

Primary Category
Assessment – learner (summative, formative, programmatic)

Presenters
Samuel Dotson, BS, MD, Northeast Georgia Medical Center Program
Adrienne Gerken, MD, Thomas Jefferson University Hospital
Joshua Salvi, BBA, MD, PhD, Massachusetts General Hospital
Ann Schwartz, MD, Emory University School of Medicine
DeJuan White, MD, Emory University School of Medicine

Educational Objectives

1. Identify key regulatory requirements for clinical competency committees (CCCs).
2. Advocate for a broader vision of the CCC as a space for intentional, continuous quality improvement in a training program.
3. Apply efficiency strategies in their own CCCs to maximize impact, including AI tools, standardized dashboards, and flipped classroom methods.
4. Implement structural reforms in their CCC process to mitigate bias and amplify perspectives that may otherwise be missed in the discussion.

Abstract
In healthcare systems, as with any bureaucracy, an intervention initially designed to add meaningful value can gradually become a rote exercise in compliance. The clinical competency committee (CCC) is one such case for residency programs. Originally envisioned as a method for structuring feedback and supporting the gradual shift toward competency-based medical education, CCCs are now often perceived as stale regulatory burdens with limited added value. Yet well-functioning CCCs can serve as engines of transformative growth for both individual residents and entire programs. Their unique vantage point in synthesizing data from multiple stakeholders gives them a privileged position within training programs as spaces for critical reflection and quality improvement.

This workshop aims to elevate the CCC from a regulatory task to a transformative tool by emphasizing best practices for efficiency, bias reduction, and programmatic impact.

The session begins with an overview of ACGME minimum regulations and requirements, followed by a review of published innovations and best practices. Participants then engage in reflective exercises to identify strengths and growth areas in their own committees. The workshop progresses to strategies for optimizing data review, including established methods such as pre-work assignments and dashboards, as well as emerging approaches like AI-assisted rating tools. Additionally, various strategies for acting on the CCC's findings are presented for both struggling and excelling residents.

Finally, participants end by examining potential sources of bias in their own CCC's decision-making process through a complex case discussion. In groups, they consider a struggling resident's performance and whether it represents an individual remediation issue or a systemic curricular concern requiring broader structural interventions and attention from the Program Evaluation Committee (PEC).

Active learning techniques (e.g., needs assessments, polling, think–pair–share, breakout discussions) are integrated throughout. By learning to link the individual-level work of faculty and CCCs with the broader programmatic improvements of the PEC and program director team, attendees will gain an appreciation for the oversimplified dichotomies between individual-focused assessments and program-focused evaluations. The ultimate aim of the workshop is to empower program leaders to elevate their CCC as an opportunity to advance innovation within their programs and improve the overall learning environment with a focus on efficiency and fairness.

Practice Gap

Clinical competency committees (CCCs) are a core requirement of any residency program, but they are often experienced as regulatory burdens rather than as tools for meaningful educational improvement. Programs frequently rush through milestone ratings, focusing on a few "problem residents," with little attention to the broader vision of competency-based medical education which these committees were designed to support. Although CCCs assess individual learners, ACGME best practice guidelines emphasize that a well-functioning committee is in a unique position to identify systematic errors (biases) and gaps in a training program's curriculum for the Program Evaluation Committee. Without a thorough understanding of the regulatory requirements, best practices, and vision and mission of the CCC, programs risk complacency and fail to capture the full potential of these meetings. Practical strategies are therefore needed that engage faculty and program leaders to position CCCs as engines of transformation and quality improvement at their institutions.

Agenda

- Introduction:
  - Introduce speakers, review objectives, and conduct a KW(L) needs assessment (Poll Everywhere) (5 min)
  - Mini-didactic on the ACGME CCC Guidebook (10 min)
  - Exercise 1 – “CCC Highs and Lows: Reflecting on What Works and What Doesn't" (think-pair-share with quiz and discussion questions) (10 min)
- Efficiency Strategies:
  - Mini-didactic on flipped classroom/pre-work models, as well as the use of AI and dashboards to synthesize and display information (5 min)
  - Exercise 2 – “Design the Dashboard: Building Feedback Tools that Balance Thoroughness with Clarity" (breakout groups, report back) (20 min)
- Bias Mitigation Strategies:
  - Mini-didactic on innovations to reduce bias and groupthink (5 min)
  - Exercise 3 – “The Problem Resident or the Problem System? Creating Safe and Brave Spaces for All Participants” (breakout groups, report back) (20 min)
- Conclusion:
  - Question and answer session, finish (KW)L (Poll Everywhere), and complete evaluations (15 min)

Scientific Citations

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Title
From Beepers to AI: Modernizing the Emergency Psychiatry Training Curriculum

Primary Category
Curriculum

Presenters
Gerald Busch, MD, MPH, Tripler Army Medical Center
Michael Allen, MD, University of Colorado Denver

Educational Objectives

1. Facilitate discussion among residency directors on practices and challenges in structuring emergency psychiatry rotations, with attention to curriculum updates that reflect both enduring foundations and emerging clinical demands.

2. Identify the core components of the original 2004 AAEP curriculum—such as crisis intervention, risk management, and professional communication—that continue to provide stability in resident training.

3. Introduce new priority areas, including telepsychiatry competencies, substance use and emerging cannabis-induced emergencies, updated psychopharmacology, and technology integration in emergency psychiatry.

4. Explore strategies to incorporate the 2025 ACGME Program Requirements on interprofessional, team-based care, fostering collaborative practice and strengthening the learning environment for residents.

Abstract
Emergency psychiatry has evolved dramatically since the American Association for Emergency Psychiatry (AAEP) released its model curriculum in 2004. While core competencies such as rapid assessment, crisis intervention, and risk management remain essential, the practice environment has been reshaped by the opioid epidemic, the emergence of cannabis-induced emergencies, new service delivery models, expansion of telepsychiatry, and rapid advances in digital health technology. At the same time, the Accreditation Council for Graduate Medical Education (ACGME) has revised its requirements, with the 2025 Psychiatry Program Requirements emphasizing safe, interprofessional, team-based care as an essential feature of the learning environment.

This workshop will convene residency directors and faculty to review which elements of the 2004 AAEP model curriculum remain durable and to build consensus around new training needs. The session will provide participants with a structured opportunity to reflect on their own emergency psychiatry training environments, examine updated educational priorities, and identify strategies to strengthen resident preparation in these high-stakes settings.

Discussion will emphasize eight domains for modernization:

1. Telepsychiatry Competencies – Preparing residents to conduct effective emergency assessments and interventions remotely, reflecting the widespread adoption of telepsychiatry in emergency departments.

2. Substance Use and Emerging Cannabis-Induced Emergencies – Enhancing training in the management of acute intoxication, withdrawal, and substance-associated psychosis, including the growing prevalence of cannabis-induced agitation and psychotic presentations.

3. Interprofessional, Team-Based Care – Training residents to collaborate effectively with psychiatric nurses, social workers, psychologists, and other professionals in high-pressure environments, consistent with the 2025 ACGME requirements.

4. Community-Based Crisis Care – Providing exposure to mobile crisis teams and alternatives that reduce crowding and boarding in emergency departments.

5. Updated Psychopharmacology – Incorporating newer and rapid-acting medications for the treatment of agitation, suicidality, and withdrawal syndromes.

6. Legal and Ethical Considerations – Strengthening resident competence in capacity assessment, involuntary treatment, patient rights, duty to protect, and the legal implications of prolonged boarding.

7. Suicide and Violence Risk Assessment – Training in evidence-based tools, integration of electronic health record (EHR) alerts, and collaborative safety planning approaches.

8. Technology and Digital Tools – Expanding resident familiarity with EHR-integrated screening, decision-support systems, and emerging AI-assisted triage methods.

The workshop will begin with a review of the 2004 model curriculum, followed by small-group breakout sessions to assess its enduring components and to explore proposed updates. An interactive consensus-building exercise will invite participants to identify the most pressing curricular priorities for their home institutions.

By the conclusion of the workshop, participants will have developed a clearer understanding of how to preserve the strengths of the original AAEP curriculum while incorporating updates that reflect the realities of modern practice. The session will model a collaborative approach to education that values continuity, embraces innovation, and strengthens the learning environment for the next generation of psychiatrists.

Practice Gap

The emergency department is one of the most critical learning environments in psychiatry, where residents must develop skills in rapid assessment, crisis intervention, and risk management. The 2004 AAEP curriculum, created through consensus with AADPRT, established a trusted foundation for these competencies. Over the past two decades, however, emergency psychiatry has been reshaped by the opioid epidemic, stimulant-related crises, and emerging cannabis-induced emergencies, which increasingly dominate acute presentations. Telepsychiatry has become a central mode of care delivery, altering how residents interact with patients and supervisors. Boarding of psychiatric patients in general emergency departments now poses significant ethical and systems-level challenges. At the same time, advances in digital tools—from EHR-integrated screening protocols to AI-assisted triage—are redefining the pace and scope of decision-making. These changes demand new competencies and collaborative, interprofessional training approaches. From Beepers to AI will revisit and modernize the 2004 curriculum to reflect current practice realities.

Agenda

- Introduction; audience feedback on changes in their emergency psychiatry training environments (10 min)
  Review of the 2004 AAEP Model Curriculum (10 min)
  Breakout Group #1 – Enduring elements of the 2004 curriculum (10 min)
- Presentation of new competency areas (telepsychiatry, substance use and emerging cannabis-induced emergencies, technology, updated psychopharmacology, legal/ethical issues) (20 min)
- Breakout Group #2 – Consensus-building on needed updates (20 min)
- Wrap-up and evaluation (5 min)

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Title
Gaining Patient Trust: Teaching Residents to Address Health Misinformation

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Rebecca Klisz-Hulbert, MD, Detroit Medical Center/Wayne State University
Sarah Mohiuddin, MD, University of Michigan
Heide Rollings, MD, Pine Rest Christian Mental Health Services
Nikita Roy, MD, Central Michigan University College of Medicine
Abishek Bala, MD, Central Michigan University College of Medicine

Educational Objectives

1. Define health misinformation in popular media formats;
2. Identify strategies that can be used during patient encounters to productively discuss health misinformation; and
3. Provide practical guidance to trainees on addressing health misinformation with patients and families.

Abstract
Health misinformation refers to misleading or erroneous public health information that spreads without the intent to cause harm. During the COVID-19 Pandemic, many people sought guidance online in the context of often changing guidelines for a disease which we knew little about initially. Coupled with the increased time spent online due to quarantine precautions, medical misinformation, myths, and conspiracy theories spread through social media rampantly. In response, professional groups, government agencies, and academic medical centers have developed guidance for responding to health misinformation. This guidance often focuses on addressing misinformation that appears through social media, and advocates relying on government professionals for validity. With the further politicization of many healthcare issues over the past year, these strategies may be less beneficial in the current climate and do not necessarily correlate to addressing misinformation when face-to-face with patients.

Research suggests that social determinants of health may impact patients' tendency to believe health misinformation and consequently may impact their health-care decision making. From the clinician perspective, trainees' attitudes may impact discussions with

patients when families question evidence-based recommendations, resulting in spending less time responding to questions, perceiving families as “difficult,” and having less respect for the families’ views. Physicians have reported that they are less likely to address misinformation during a patient visit, due to concerns about managing conflict, not having enough time, and not knowing how to manage misinformation.

Several strategies exist that focus on correcting health misinformation. These include the 3E’s (educate, enlist, and end), the “teach-back” technique, the SIFT Method, “debunking” and “prebunking,” and use of toolkits such as MisinfoRx. This workshop focuses on guiding trainees to address misinformation during a clinical encounter.

Presenters will define different types of medical misinformation. Recognized strategies to address health misinformation in patient encounters will be discussed. A journal club curriculum involving multiple programs will be presented and participants will engage in a sample session. Pairing mainstream news articles with patient vignettes, participants will break into small groups to “fact check” statements that appear to oppose evidence-based psychiatric practice and then role play having relevant discussions with patients and families.

Practice Gap

Health misinformation can create a significant barrier to care for our patients, often discouraging them from seeking evidence-based care or even popularizing treatments that may cause more harm than good. Physicians are more likely to address misinformation online, as they perceive a lack of training, time constraints, and fear of conflict as barriers to addressing misinformation during a clinical encounter. Further, patients and families who present as questioning evidence-based care may be seen by trainees as “difficult,” leading to less time spent answering clinical questions which could impact patient care. Fighting misinformation can contribute to burnout. Residents and fellows must learn to address health misinformation with patients and families.

Agenda

- Introduction and quiz (10 min)
- Definitions and recognized strategies for addressing health misinformation (20 min)
- Small groups: participants review sample article and role play strategies to address misinformation in a mock patient encounter (30 min)
- Small groups report back (15 min)
- Q&A (10 min)

- Feedback Form (5 min)

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Title
Maintaining Trust (and Surviving) through Residency Leadership Transitions

Primary Category
Program Administration and Leadership

Presenters
Benjamin Li, MD, Baylor College of Medicine
Jeffrey Khan, MD, Baylor College of Medicine
Kari Wolf, MD, Southern Illinois University School of Medicine
Jai Gandhi, MD, Baylor College of Medicine
Danielle Egbe, MD, Baylor College of Medicine

Educational Objectives

1. Identify key challenges and opportunities during rapid leadership transitions in residency programs.
2. Apply organizational change theories to medical education settings.
3. Explore strategies to preserve program identity, morale, and trust among residents and faculty.
4. Reflect on personal and institutional experiences to foster resilience and transformation.
5. Develop a framework for supporting future transitions with transparency and collaboration.

Abstract
Leadership transitions in residency programs—especially when occurring in rapid succession—can destabilize the learning environment, challenge institutional memory, and disrupt trust among trainees and program leadership (2). This workshop explores the lived experience of residency programs that have undergone multiple leadership changes (e.g. Program Director and Associate Program Directors) within one academic year. Through a multidisciplinary lens, we will examine how these programs navigated uncertainty and fostered togetherness amidst transformation, especially given the impact of leadership team behaviors on resident burnout and satisfaction (3).

Drawing parallels from business leadership literature, we will discuss how executive turnover impacts organizational morale, instability, and strategic direction (4). These insights will be juxtaposed with personal narratives from department leadership, program leadership, and a chief resident, highlighting the emotional and operational realities of transition in medical education.

Participants will engage in interactive exercises including case-based discussions, small group reflections, and role-play scenarios to identify strategies for maintaining trust and cohesion. We will explore philosophical approaches to leadership, including servant leadership and adaptive leadership, and how these models can guide programs through change.

The workshop will culminate in the development of a transition toolkit—co-created by attendees—that includes communication strategies, stakeholder engagement plans, including succession planning, and resilience-building practices (5). This session is designed for program directors, associate program directors, chief residents, and institutional leaders seeking to proactively manage leadership transitions and cultivate thriving learning environments.

Practice Gap

Residency programs often face abrupt leadership transitions, yet little guidance or open discussion exists on how to maintain program stability, resident morale, and mission continuity during these periods (1). While corporate literature explores the impact of executive turnover on organizational culture and performance, medical education lacks parallel frameworks to support residency programs through similar disruptions. This gap is particularly pronounced when multiple leadership changes occur within a short timeframe, affecting both faculty and trainees. Understanding the organizational and relational dynamics of such transitions is essential to maintaining trust and cohesion in the learning environment and amongst the residents at large.

Agenda

- Introduction (3 min)
- Word Cloud: Leadership Changes (2 min)
- Case Presentation – A Whirlwind of Program Leadership Changes (10 min)
- Small Group Breakout: Case Discussion (7 min)
- Large Group Discussion: Perspectives (8 min)
- Case Presentation: Resident Perspective (10 min)
- Department Leadership Perspective: Business Parallels and Evidence (10 min)

- Small group breakout – Toolkit Creation (15 min)
- Large group: Synthesizing Ideas (10 min)
- Q&A, reflections, and evaluation (15 min)

Scientific Citations

Kathlyn E. Fletcher, Alec B. O'Connor, Michael Kisielewski, Lisa L. Willett, Why Do Residency Program Directors Consider Resigning? A Mixed-Methods Analysis of a National Program Director Survey, The American Journal of Medicine, Volume 133, Issue 6, 2020, Pages 761-767, ISSN 0002-9343, https://doi.org/10.1016/j.amjmed.2020.02.016.

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Dyrbye, Liselotte N. MD, MHPE; Leep Hunderfund, Andrea N. MD, MHPE; Winters, Richard C. MD; Moeschler, Susan M. MD; Vaa Stelling, Brianna E. MD; Dozois, Eric J. MD; Satele, Daniel V.; West, Colin P. MD, PhD. The Relationship Between Residents' Perceptions of Residency Program Leadership Team Behaviors and Resident Burnout and Satisfaction. Academic Medicine 95(9):p 1428-1434, September 2020. | DOI: 10.1097/ACM.0000000000003538

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Title
Mentorship that Matters: Innovative Models to Support Diverse Trainees in Psychiatry

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

Presenters
Vrashali Jain, MD, Cleveland Clinic Foundation
Timothy Kreider, MD, PhD, Zucker School of Medicine at Hofstra/Northwell
Dimitri Fiani, MD, Cleveland Clinic Foundation
Angela Liu, DO, MD, Zucker School of Medicine at Hofstra/Northwell
Avni Shah, DO, Christiana Care Health System

Educational Objectives

1. Describe traditional and emerging mentorship models in psychiatry and medicine
2. Identify challenges faced by underrepresented and minority trainees in accessing effective mentorship.
3. Recognize the importance of mentorship models that take into account minority resident experiences
4. Discuss strategies to implement structured, culturally responsive mentorship programs within psychiatry residency training.
5. Develop an action plan for mentorship initiatives that promote equity, inclusion, and professional thriving at their own institutions.

Abstract
Mentorship is a cornerstone of professional development in psychiatry training, yet traditional models often fail to address the evolving needs of today's diverse trainee population. Physicians from minority and marginalized groups, in particular, face structural barriers such as underrepresentation among faculty, lack of identity-concordant mentors, and unequal access to sponsorship. Psychiatry training programs have an opportunity to implement more inclusive mentorship structures to foster professional growth, equity, and belonging.

Effective mentorship for URiM and diverse trainees thrives when programs combine multiple models to build robust ecosystems of support. Affinity group mentorship, such as BIPOC, LGBTQ+, women's, or IMG mentorship circles, provides safe spaces where shared identity and lived experience foster belonging and mutual support. Peer and near-peer mentorship pods connect trainees across residency years, normalizing shared struggles, reducing hierarchy, and developing leadership skills among more senior residents. Cascade mentorship models, in which faculty mentor residents who in turn mentor medical students, extend this impact across multiple training levels. Structured faculty mentorship programs embedded into residency curricula can be valuable when paired with mentor training, evaluation, protected time, and efforts to hire and retain diverse faculty. Finally, programs can leverage cross-institutional mentorship networks through national organizations to expand access to mentors beyond local institutions, break down geographic barriers, and help URiM trainees build broader professional communities.

This interactive workshop will begin with a brief didactic overview of traditional and emerging mentorship models in psychiatry and medicine. Special emphasis will be placed on mentorship models that support minority trainees and mitigate the "minority tax" often borne by URiM faculty. Next, presenters from three institutions will share narratives and case examples, highlighting their personal experiences accessing mentorship and the interventions available at their programs. Presenters will draw upon their varied positionalities—including differences in race, gender, ethnicity, country of origin, immigration status, and sexual orientation—to illustrate diverse trainee experiences. Participants will then engage in small-group case discussions to explore mentorship challenges within their own institutions and brainstorm strategies to adapt or implement innovative models. Groups will reconvene for facilitated large-group sharing and synthesis of practical solutions. In alignment with the AADPRT theme — Trust, Transformation, Togetherness — these approaches strengthen trust between trainees and faculty, transform the learning environment to be more inclusive, and promote togetherness across diverse groups.

Practice Gap

Although mentorship is a critical factor in the professional development and career satisfaction of psychiatry residents, traditional mentorship structures often fail to meet the unique needs of minority trainees, including BIPOC, LGBTQ+, international medical graduates (IMGs), DOs, immigrants, first generation physicians, and women. Research highlights that these groups face barriers such as bias, microaggressions, reduced access to academic networks, and fewer role models who share their lived experiences. Without structured, intentional mentorship models, programs risk perpetuating inequities in recruitment, retention, and advancement.

Agenda

- Introduction and framing (15 min):
  - Ice breaker activity
  - Brief didactic overview of traditional and emerging mentorship models in medicine. Special emphasis will be placed on mentorship models that support minority trainees.
- Presenter narratives and case examples (25 min):
  - Three residents from diverse backgrounds and institutions will share their personal challenges in accessing effective mentorship and highlight the mentorship models available at their respective programs.
- Small breakout groups (30 min):
  - Participants will then engage in small-group case discussions to explore mentorship challenges within their own institutions and brainstorm strategies to adapt or implement innovative models.
- Large group debrief (20 min):
  - Groups will reconvene for facilitated large group sharing and synthesis of practical solutions.

Scientific Citations

Bonifacino E, Ufomata EO, Farkas AH, Turner R, Corbelli JA. Mentorship of Underrepresented Physicians and Trainees in Academic Medicine: a Systematic Review. J Gen Intern Med. 2021 Apr;36(4):1023-1034. doi: 10.1007/s11606-020-06478-7. Epub 2021 Feb 2. PMID: 33532959; PMCID: PMC7852467.

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Title
Ready or Not: Preparing for an ACGME Site Visit

Primary Category
Program Administration and Leadership

Presenters
Justin Meyer, BA, MD, SUNY Upstate Medical University
Brian Kurtz, MD, Cincinnati Children's Hospital Medical Center
Kevin Winders, MD, Gateway Behavioral Health CSB

Educational Objectives

1. Review the process of accreditation and site visits.
2. Highlight high-yield areas the ACGME focuses on when performing site visits for psychiatry residencies
3. Prepare and set your program up for success for any site visit (e.g. initial, re-accreditation, on-site or virtual).

Abstract
The Accreditation Council for Graduate Medical Education (ACGME) plays a critical role in safeguarding the educational integrity of residency programs by establishing standards that ensure consistent training across specialties. These standards enable applicants and residents to have confidence that their training experience will prepare them for board eligibility and independence practice. For this reason, residencies must uphold their accreditation status, both to demonstrate their commitment to resident education and to remain competitive within the graduate medical education landscape(1).

Over the past decade, the ACGME accreditation process has evolved significantly. New programs continue to require an initial site visit to attain accreditation. Established programs, once subject to routine visits approximately every ten years, are now randomly selected (1, 2). This change has led to a decrease in institutional knowledge about what to expect and how to prepare for site visits. Additionally, since COVID the ACGME has introduced the process of “Remote Site” visits conducted virtually, which have become increasingly common (3). While the process of accreditation and site visits remain the same regardless of specialty, there are many specialty-specific requirements within psychiatry (2).

There are many unique challenges that psychiatry residencies face in preparing for an ACGME site visit (2). These are compounded by the decreased frequency of these visits, which can heighten perceived stakes. In this workshop, we aim to help programs become more familiar with the process, including the requirements, process of uploading documents, timeframe, and other logistical challenges. Ultimately, our goal is to support program directors and administrators in effectively preparing for all types of ACGME visits, including those for new program accreditation, continuing accreditation, and prompted reviews. This workshop will provide psychiatry programs with high-yield areas that the ACGME is likely to focus on based both on available resources from the ACGME as well as our own experience based on recent site visits. These experiences span onsite and virtual site visits, and both randomly selected reviews and visits prompted by program citations(4, 5).

We plan to use active learning and roleplay to engage the audience and help them become more familiar with the process of an ACGME site visit. We also hope that this workshop will inspire programs to take a critical look at their own program and how the strengths and areas of improvement of the program map onto the ACGME program requirements so that they can feel better prepared for a future site visit(4, 5).

Practice Gap

While the ACGME has been performing site visits for many years, the process was paused for COVID and has since changed dramatically. We aim to educate programs (directors and coordinators) about what has changed and what to expect with a site visit, reviewing the process and high-yield topics. We will also share our recent experience with on-site and virtual visits to help others feel more prepared using mock visits and active learning.

Agenda

- Introduction of presenters (5 min) [Large Group]
- Introduction to ACGME site visit process (5 min) [Large Group]
- Identify your program's strengths/areas of improvement (15 min) [Break Out]
- Share items you discussed in groups and learn high yield areas [Large Group] (10-15 min)
- Break out into groups ID top 3 things you intend to work on, how you will solve them (15 min) [Break Out]
- Come together to discuss how you addressed them, novel ideas to solve (10 min) [Large Group]
- Wrap up, discuss how we addressed concerns (10 min) [Large Group]
- Evaluation (5 min)

Scientific Citations

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https://www.acgme.org/specialties/psychiatry/program-requirements-and-faqs-and-applications/

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Title
You, me, and the apocalypse – a neuroscience-informed approach to understanding and responding to current social challenges

Primary Category
Curriculum

Presenters
David Ross, MD, PhD, Yale University School of Medicine
Mayada Akil, MD, Georgetown University Medical Center
Joseph Cooper, MD, University of Illinois College of Medicine at Chicago
Katherine Klingensmith, MD, Yale University School of Medicine

Educational Objectives

1. Describe the impact of current social factors on trainees, PDs, and our healthcare system;
2. Describe core neurobiological processes relevant to physician burnout and distress;
3. Describe an organizational behavior framework that can be used to formulate and respond to social challenges;
4. Create a plan with specific actions that can be taken to navigate the current situation;

Abstract
As psychiatrists, we are trained that the first step to navigating complex clinical cases is a thoughtful formulation of the problem; this formulation can then be leveraged to create a nuanced and multi-faceted treatment plan. Complex social and organizational challenges require the same approach.

In this workshop, we will introduce a novel tool for formulating and responding to complex organizational situations. Participants will engage in a small-group, experiential learning exercise through which they will reflect on: a case vignette that highlights how social factors may influence our work performance; a brief video reviewing core neuroscience concepts relating to physician wellness and burnout; a brief video introducing an organizational behavior framework and how it can inform our response to our current situation.

As a full group, we'll then discuss the potential utility of this resource for faculty and trainees. We'll also discuss how this formulation tool can be incorporated into a longitudinal course to help both faculty and trainees navigate ongoing challenges in the workplace.

Practice Gap

The past year has seen unprecedented social upheaval in the US, with direct consequences to academic centers and training programs, including through: budget cuts (both to health care systems and to training grants); the apprehension, detention, and deportation of individuals who have expressed opinions contrary to the government's policy; removing basic rights of transgender individuals; the decimation of federal infrastructure for science and medicine. The government has embraced a deliberate "flood-the-zone" approach, designed to prevent opposition. This tactic has been highly effective, leaving many individuals feeling helpless and overwhelmed. The situation may be especially challenging for program directors who need to deal not only with their own reactions but must also help navigate their impact on patients and trainees.

Agenda

- Introduction (5 min)
- Experience learning exercise (70 min) (conducted in breakout groups of 3-4 individuals except where noted):
    - Case review and discussion (15 min);
    - Review video on relevant neuroscience (10 min);
    - Discuss and reflect (10 min);
    - Review video on organizational behavioral framework (10 minutes); discuss and reflect (10 min);
    - Full group discussion on core content, formulation, and constructive action-oriented steps we can take (15 min);
    - Full group discussion of strengths and limitations of this approach and how it might be incorporated into a longitudinal curriculum (10 min); and
- Evaluation and feedback (5 minutes)

Scientific Citations

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