WORKSHOPS SESSION 1

Title

Bigger by Mandate, Better by Design: Practical Playbooks for Managing Growth in a Rapidly Expanding Field

Primary Category

Program Administration and Leadership

Presenters

Jonathan Heldt, MD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA, Jason Schillerstrom, BS, MD, University of Texas Health Sciences Center at San Antonio, Steven Server, MD, PhD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA, Asher Simon, MD, Icahn School of Medicine at Mount Sinai, Antonia New, MD, Icahn School of Medicine at Mount Sinai

Education objectives

1. Analyze and categorize the operational, cultural, and leadership challenges unique to larger programs including scheduling bottlenecks and inequities in resident experience.

2. Design collaborative, sustainable administrative structures that streamline program workload while preserving individualized clinical supervision and educational excellence.

3 Apply relationship-centered leadership frameworks to mitigate trainee isolation, preserve individualized psychotherapy supervision, and manage career advocacy at scale.

Abstract

Larger programs offer distinct opportunities, but also introduce unprecedented operational and cultural hurdles. While some aspects of program design can scale easily (e.g., lectures), the core pillars of psychiatric education resist economies of scale and increase linearly with trainee count, including recruiting psychotherapy supervisors, managing off-service capacity, and individualizing Clinical Competency Committee reviews. Culturally, trainees in a larger program risk feeling “lost in the crowd” and lacking a sense of community.

This highly interactive 90-minute workshop, led by program directors and chief residents from the three largest psychiatry programs in the United States, will begin with a brief didactic overview examining the forces behind expansion in psychiatry GME positions and the unique operational, financial, and cultural considerations of expanding programs.

The core of the session relies on active learning through large-group interactive simulation. We will engage the entire audience in responding to a live situation: “The Chair just texted you: We need to cover a new site. I want you to expand the residency.” Following this, participants will form small groups to tackle specific problem cards based on friction points as experienced by our three programs.



The workshop concludes with small groups reporting their strategies, followed by the facilitators sharing the methods they used to resolve these issues in their own programs. While not every program is in the process of expanding, the universal themes of trying to maintain educational excellence and a close-knit community in the face of rapid changes and scarce resources are broadly applicable for program directors and residents across the country.

00 – 15 mins | Didactic Input: Our Rapidly Expanding Landscape

Exploring the forces driving the rapid expansion of psychiatry spots, including federal funding, hospital mergers, and new programs. Framing the core friction points: logistics, finance, and culture.

15 – 30 mins | Large-Group Interactive Simulation: "The Text from the Chair"

A live interactive scenario where participants respond to a sudden expansion mandate. Audience-wide brainstorming to capture and categorize immediate concerns and systemic risks.

30 – 60 mins | Small-Group "Problem-Card" Sprints

Breakout groups focusing on three structured areas using provided worksheets:

Track 1: How to source additional individual psychotherapy supervisors, expand off-service neurology and medicine rotations, and redesign committee and chief resident structure.

Track 2: How to design a program structure that protects community building, ensures equitable access to program director time and attention, and supports class cohesion during unexpected events (e.g., extended medical leaves).

Track 3: How to write dozens of individualized fellowship recommendation letters, advocate for multiple internal applicants competing for the same subspecialty fellowship spots, and screen surging applicant volumes efficiently.

60 – 70 mins | Small-Group Reporting

Group representatives share key structural or cultural innovations developed during the breakout session.

70 – 75 mins | Facilitator Declassification: "How We Solved It"

Facilitators present concrete, real-world workflows and systems that successfully resolved these exact issues in their respective large programs.

75 – 90 mins | Large-Group Q&A and Session Evaluation

Facilitated discussion on implementing these strategies locally. Final 5 minutes dedicated to completing the official session evaluation form.

Practice Gap

Psychiatry GME is expanding rapidly. Psychiatry positions have increased by 29% since 2011, the largest increase of any specialty. This increase has been driven by both the emergence of new programs and the growth of existing ones. Despite these increases, a critical shortage of psychiatrists is still projected, suggesting the need for further growth. Given this landscape, training directors may find themselves managing program expansions. This workshop aims to equip participants with practical tools to keep harmony and humanity at the center of our expanding field by bringing together program directors and residents in active simulation. To our knowledge, this would be the first AADPRT workshop in recent years addressing the unique challenges of expanding an existing program.

Agenda

00–15 min | Didactic Overview: Trends driving psychiatric residency expansion and the core operational, financial, and cultural friction points.

15–30 min | Interactive Simulation ("The Text from the Chair"): A live, audience-wide exercise navigating an immediate mandate to expand.

30–60 min | Problem-Card Sprints: Small-group breakouts addressing three specific operational challenges: clinical capacity (off-service/psychotherapy), class culture and community, and scalable mentorship/fellowship advocacy.

60–70 min | Group Reporting: Cross-institutional sharing of innovations generated during the sprint.

70–75 min | Facilitator Declassification: Leaders and chief residents from the three largest psychiatry residencies share the playbooks and systems used to resolve these issues.

75–90 min | Large-Group Q&A & Evaluation: Implementation strategies for diverse program sizes and completion of session evaluations.

Scientific Citations

1. Pheister M, Cowley D, Sanders W, Keeble T, Lu F, Pershern L, Wolf K, Walaszek A, Aggarwal R. Growing the Psychiatry Workforce Through Expansion or Creation of Residencies and Fellowships: the Results of a Survey by the AADPRT Workforce Task Force. Acad Psychiatry. 2022 Aug;46(4):421-427. doi: 10.1007/s40596-021-01509-9. Epub 2021 Jul 22. PMID: 34292538; PMCID: PMC8296832.

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3. Ramesh T, Tsai TC, Yu H. Changes in Specialty and Geography of Medicare's New Residency Positions. JAMA. 2026 Jul 14;336(2):163-165. doi: 10.1001/jama.2026.7929. PMID: 42295775; PMCID: PMC13270301.

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5. Aggarwal R, Balon R, Beresin EV, Coverdale J, Morreale MK, Guerrero APS, Louie AK, Brenner AM. Addressing Psychiatry Workforce Needs: Where Are We Now? Acad Psychiatry. 2022 Aug;46(4):407-409. doi: 10.1007/s40596-022-01690-5. PMID: 35882768; PMCID: PMC9321299.

Title

Creative Approaches to Journal Club: Teaching PBLI-1 Through Games, Debate, and Patient Narratives

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Andrew Halls, MD, University of California, San Francisco, Rebecca Lundquist, MD, TriHealth GME (Non-accredited), Joshua Salvi, BBA, MD, PhD, Massachusetts General Hospital, DeJuan White, MD, Emory University School of Medicine

Education objectives

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

1. Design engaging journal club experiences that teach critical thinking and research literacy, rather than content from individual articles.

2. Incorporate active learning strategies into journal clubs, including gamification, debate, and patient narratives.

3. Utilize readily accessible artificial intelligence tools to efficiently generate instructional content for journal clubs, such as podcasts, data infographics, and case vignettes.

Abstract

This workshop builds on and adapts work previously presented at the AAP Annual Meeting in September 2026 under the title “Anchoring to the Evidence: Incorporating Active Learning and Artificial Intelligence into Biopsychosocial Journal Clubs.” For AADPRT 2027, we reframe the session around creative teaching of PBLI-1 and the urgent need to help residents develop evidence-based reasoning amid rapid change. Multiple converging forces, including artificial intelligence (AI), market pressures, and political and regulatory uncertainty, are reshaping the skills future psychiatrists will need for long-term success. When taught well, Practice-Based Learning and Improvement (PBLI) can anchor trainees with the research literacy, critical thinking skills, and habits of lifelong learning needed to navigate a rapidly evolving evidence base. Unfortunately, the primary instructional tool for PBLI, the journal club, too often devolves into dry, abstract discussions of specific articles with limited clinical relevance. This workshop therefore aims to empower educators to design fun, creative, and innovative didactic formats that transform journal clubs into a more human, creative, and meaningful educational experience.

Following a brief needs assessment, participants receive a concise didactic introduction to published journal club formats and innovations in the education literature. The workshop then progresses through three

interactive exercises that illustrate novel ways to teach research articles, increase learner buy-in, and model practical approaches to evidence-based reasoning. Across the modules, biomedical, psychological, and socio-structural literature are examined to highlight the value of holistic PBLI education. This approach moves beyond a narrow definition of evidence-based medicine focused primarily on psychopharmacology RCTs.

The first module focuses on biomedicine by comparing and contrasting two classic depression studies (STAR*D and VAST-D) using a competitive word-search game. In small groups, participants debrief ways to use a two-study comparison, no-prep journal club model with competitive gamification that increases retention through affective activation. The second exercise turns to the psychology and psychotherapy literature, where participants engage in an AI-assisted debate examining a landmark trial comparing interventions for borderline personality disorder (Clarkin et al., Am J Psychiatry, 2007). Split into teams, educators reflect on the power of debates as a way to teach AI literacy, model psychoeducation, and improve professional communication skills while also making space for playful, respectful disagreement in the setting of conflicting evidence. The final exercise uses a case vignette to humanize complex socio-structural interventions targeting health inequities. Participants analyze how a fictional patient might qualify for trials on Housing First and Individual Placement and Support (employment first), with an emphasis on inclusion/exclusion criteria and external generalizability.

Throughout the workshop, participants engage in structured think–pair–share reflections, small-group discussions, and self-reflection to explore how to adapt the content for their programs. The workshop concludes with a guided group discussion, allowing participants to share experiences and practical strategies from diverse institutional contexts. By the end, participants leave with concrete ways to transform journal clubs from a passive review of articles into an active, clinically relevant space where trainees can practice evidence-based reasoning, reconnect data to human stories, and discover the joy of becoming lifelong learners.

Practice Gap

Practice-based learning and improvement (PBLI) is often seen as a more esoteric topic when compared to medical knowledge and patient care. Nonetheless, PBLI milestones capture a growth mindset and the identity of a lifelong learner, making them the engine of ongoing professional growth after residency. Strategies for teaching PBLI-1 in particular, the evidence-based medicine milestone, often fall to journal club (JC); however, many programs struggle to move JCs beyond a dry review of a specific article. At its best, JC should be fun, engaging, and active: a clinically relevant and creative learning experience where data are connected to patients, evidence is contextualized, and residents practice the critical thinking skills needed to navigate an uncertain field and rapidly evolving evidence base. Educators need practical, engaging strategies to reimagine JC as a space for creatively engaging with the literature, humanizing research, and making PBLI a core feature of resident identity formation.

Agenda

Introduction (20 Minutes)

- 5 Minutes: Introductions and overview
- 5 Minutes: Think-pair-share on prior journal club experiences with a needs assessment
- 10 Minutes: Mini-didactic on PBLI and education innovations for faculty development

Exercise 1: Biological + Gamification (20 Minutes)

- 3 Minutes: Instructions and word-search game rules
- 12 Minutes: Activity comparing STAR*D and VAST-D
- 5 Minutes: Debrief on gamification and the value of affective activation

Exercise 2: Psychological + Debate (20 Minutes)

- 3 Minutes: Instructions and debate rules
- 12 Minutes: AI-assisted debate on a landmark psychotherapy trial
- 5 Minutes: Debrief on the pros and cons of debate as a pedagogical tool

Exercise 3: Socio-Structural + Patient Narratives (20 Minutes)

- 5 Minutes: Instructions and case vignette
- 10 Minutes: Small group discussion of Housing First and Individual Placement and Support RCTs related to vignette
- 5 Minutes: Debrief on using patient cases to humanize research

Conclusion (10 Minutes)

- 10 Minutes: Q&A, evaluations

Scientific Citations

1. Fu KA, Elting S, Chan JM, Strowd RE. Exploring neurology resident experiences with a no-prep journal club to learn research study design and critical appraisal. BMC Medical Education. 2025 Dec 29;25(1):1732.

2. Johnson BR, Logan LD, Darley A, Stone RH, Smith SE, Osae SP, Thomas IS, Watts MT, Welch LH. A scoping review for debate-style journal clubs in health professional education. American journal of pharmaceutical education. 2023 Jun 1;87(6):100064.

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6. Zand V, Bazi R, Keshmiri F. Game-based blended learning versus traditional lecture for evidence-based medicine (EBM) competencies in undergraduate medical students: a quasi-experimental study. BMC Medical Education. 2026 Jun 8.

Title

From Pillars to Practice: Bringing Lifestyle Psychiatry into Residency and Fellowship Education

Primary Category

Curriculum

Presenters

Manassa Hany, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Nasreen Akbar, MD, SUNY Downstate Medical Center, Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program, Aashna Patel, DO, SUNY Downstate Medical Center, Ramaswamy Viswanathan, MD, SUNY Downstate Medical Center

Education objectives

1. Identify teachable applications of the six lifestyle medicine pillars in psychiatric assessment and treatment planning, recognizing differences in the strength of evidence across interventions and populations.

2. Design a longitudinal lifestyle psychiatry curriculum with learning objectives, teaching methods, and supervised clinical activities appropriate to residency and subspecialty fellowship training.

3. Apply a structured approach to teaching lifestyle assessment and collaborative behavior change using adult and child and adolescent psychiatry cases that incorporate developmental, cultural, and socioeconomic considerations.

4. Develop a feasible implementation and evaluation plan that assesses trainee knowledge, observed counseling skills, and integration into clinical practice.

Abstract

Lifestyle psychiatry integrates nutrition, physical activity, restorative sleep, stress management, social connectedness, and reduction of risky substance use into psychiatric care. These domains offer opportunities to teach the relationship between mental and physical health while strengthening patient-centered assessment and collaborative treatment planning (Lippman et al., 2024; Firth et al., 2020). Although psychiatry curricula address several of these topics, educators need practical approaches to organize them into progressive learning experiences with supervised application and meaningful assessment.

Drawing on a trainee-developed lifestyle psychiatry education initiative involving foundational didactics, self-directed resources, and pre- and post-intervention surveys, this workshop will guide participants in designing a longitudinal curriculum for residency and subspecialty fellowship programs. The proposed framework progresses from foundational concepts and relevant neurobiology to behavior-change counseling, supervised outpatient application, and advanced integration into psychiatric practice. Fellowship adaptations will

emphasize population-specific clinical needs; child and adolescent examples will address developmental stage, caregiver involvement, family routines, and school context.

Following a brief evidence overview, participants will identify opportunities within their existing curricula and work in small groups with adult and child and adolescent case vignettes. Groups will select a lifestyle assessment target, practice a brief motivational interviewing-informed conversation, and identify how a supervisor could observe and provide feedback on the trainee's skills. Cases will incorporate food insecurity, cultural preferences, access to safe physical activity, and competing family demands to support realistic, nonjudgmental recommendations alongside indicated psychiatric treatment.

Participants will then use a curriculum-planning worksheet to develop one teaching module, specifying the learner level, educational objective, teaching strategy, clinical application, and assessment method. Facilitated peer feedback will address limited didactic time, faculty expertise, resource availability, and opportunities for interprofessional collaboration. Evaluation planning will distinguish self-reported knowledge and confidence from objective knowledge, observed clinical performance, and practice change.

Each participant will leave with a draft module and an implementation plan identifying a faculty partner, an existing curricular entry point, and a feasible evaluation measure. Through collaborative curriculum creation and attention to patients' lived contexts, the workshop will support humanistic teaching and the development of future educators, consistent with the meeting's emphasis on creativity and generativity.

Practice Gap

Lifestyle interventions are underutilized in psychiatric care despite opportunities to improve mental and physical health through nutrition, physical activity, restorative sleep, stress management, social connectedness, and reduction of risky substance use. Residents and fellows need skills to critically appraise the literature and translate these pillars into personalized, culturally responsive recommendations. Without structured education, trainees may rely on internet resources and social media, where conflicting messages and misinformation about “healthy” behaviors can obscure evidence-based guidance. The educational gap is a longitudinal framework that distinguishes established findings from emerging evidence and unsupported claims while developing practical skills in assessment, counseling, and treatment planning. This workshop addresses this gap through curriculum development and case-based practice, equipping educators to teach feasible lifestyle interventions tailored to patients’ needs, preferences, and resources. Participants will engage in curriculum mapping, counseling practice, and module development while identifying clinical teaching opportunities and assessment methods for residency and fellowship programs.

Agenda

- Introduction (5 minutes)
- Review pillars of lifestyle psychiatry and curriculum overview (15 minutes)



- Small group case practice and group discussion with using adult and child or adolescent cases to practice assessment and collaborative goal setting (25 minutes)
- Small group curriculum design with goal of drafting one module with objective and assessment measure (25 minutes)
- Large group facilitated discussion and questions (15 minutes)
- Workshop evaluation (5 minutes)

Scientific Citations

1. Firth, J., Solmi, M., Wootton, R. E., & Vancampfort, D. (2020). Lifestyle psychiatry: Evidence-based lifestyle interventions for mental and physical health. Cambridge University Press. https://doi.org/10.1017/9781108610810

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Title

Generative Leadership in Action: Co-Constructing Professionalism Curricula for IMG Psychiatry Trainees

Primary Category

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

Presenters

Consuelo Cagande, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Abhishek Allam, MD, Abigail Konopasky, PhD

Education objectives

The aim of this session is for participants to collaborate to develop curricular strategies regarding IMG professionalism that they can implement in their own programs.

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

1. Know: Identify divergent team member viewpoints (faculty, nursing, program coordinators, and trainees) regarding hierarchy, bedside communication, and administrative etiquette that influence perceived professionalism.

2. Do: Design structured, multi-perspective curricular modules and coaching guides to make the "unwritten rules" of U.S. training visible and support milestone progression.

3. Value: Appreciate the role of multi-perspective alignment and culturally responsive mentorship in establishing equitable, supportive training environments.

Abstract

International medical graduates (IMGs) represent approximately 25% of the total U.S. graduate medical education (GME) pool and practicing physician workforce.4 Despite their essential contributions, IMGs often encounter challenges in adapting to the U.S. medical training environment, particularly regarding professionalism expectations, communication norms, hierarchy, and patient-provider dynamics alongside acculturation stress and limited institutional support.5–7 Difficulties in navigating these expectations can negatively affect evaluations, collegial relationships, and confidence in clinical practice.1,5,8

Faculty frequently observe professionalism challenges among IMGs that stem not from deficits in knowledge or skill but from cultural differences (e.g., communication style, self-advocacy, boundary setting, documentation).8,9 Meanwhile, the lack of IMG-specific professionalism curricula makes it difficult to know how to address these challenges. Recent systematic reviews offer a wide range of strategies to assist programs, but these are neither specific to psychiatry, nor is it clear which strategies a particular program ought to adopt,

given the local context.10,11 This becomes all the more complicated when considering perspectives of various team members. Cultural variances in non-hierarchical clinic environments, interprofessional communication with nursing, administrative etiquette, and bedside small talk are often mischaracterized as professionalism deficits. For instance, a communication style that might be totally acceptable to an administrative coordinator might feel unprofessional to a nurse; or an IMG's patient care decision might be fine with one faculty member, but not another. Programs need curricular guidelines to create IMG professionalism supports that work for their local context and team members.

Drawing from the literature and our interview study of individuals from different team perspectives (faculty, nurses, program coordinators, and IMG trainees themselves), we offer a four-pillar curricular model for creating IMG-specific professionalism supports that are concordant with a program's local culture and context. These four pillars--U.S. clinical norms, interprofessional communication, administrative etiquette, and faculty coaching—can be adapted to any psychiatry residency or fellowship. Presenters will share their knowledge of the literature and the foundation of the four pillars and participants will work together to co-construct educational models to respond to cases representing common challenges faced by IMGs.

Throughout, participants will explore two key questions:

- How can educators distinguish cultural communication variances from true professionalism lapses across interprofessional teams?
- What educational tools best decode the "unwritten rules" of U.S. clinical practice (e.g., lack of hierarchy with nursing, administrative responsiveness, proactive help-seeking)?

Targeting ACGME Professionalism and Interpersonal and Communication Skills, this session equips educators to design multi-tiered orientation curricula and faculty coaching frameworks.

Practice Gap

International medical graduates (IMGs) face a multitude of barriers that their U.S.-educated peers do not, from complex legal policies to linguistic and cultural differences.1 A recent scoping review found IMGs experienced marginalization and stigmatization, harsher responses to poor performance, and even verbal insults.2 Moreover, they may struggle in particular with professionalism, because they may not see clinical contexts as their peers do.3 Professionalism is one of the six ACGME Core Competencies and is explicitly assessed through the Milestones framework. Yet IMG trainees often begin residency with limited orientation to how professionalism is defined and evaluated in the U.S. context. Moreover, Currently, no structured professionalism curriculum exists in U.S. residency training that is tailored specifically for IMGs, leaving a critical gap in preparing this large segment of the physician workforce for success.



Agenda

Introduction: Framing the Problem (15 mins)

- Presenters review literature on acculturation stress and professionalism assessment gaps

Empathy Mapping (15 mins)

- In groups separated by role (trainee, A/PD, program administrator, chair), participants complete an 'empathy map': what their group sees, thinks, feels, and needs
- Participants share maps in the large group through a live poll

Presenting the Curricular Model: Four Pillars of Professionalism (10 mins)

- Presenters outline pillars: U.S. clinical norms, interprofessional communication, administrative etiquette, and faculty coaching

Small-Group Problem Solving: Case Application (30 mins)

- In mixed role groups, participants apply the 4 pillars to a different case
- Participants present cases to the large group, "popcorn" fashion so different roles can share perspectives

Application to Local Context (10 mins)

- Participants work in pairs, assisting each other in generating strategies for their programs

Conclusions and Q&A about IMG Professionalism Curricula and Survey (10 mins)

Scientific Citations

1. Al-Haddad M, Jamieson S, Germeni E. International medical graduates' experiences before and after migration: A meta-ethnography of qualitative studies. Med Educ. Published online 2021. 2022 May;56(5):504-515. doi:10.1111/medu.14708

2. Healey SJR, Fakes K, Nair BR. Inequitable treatment as perceived by international medical graduates (IMGs): a scoping review. BMJ Open. Published online 2023. doi:10.1136/bmjopen-2023-071992

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9. Saxena SG, Tisdell E, Farace E, et al. Achieving equity for International Medical Graduates: a systematic review. Front Med (Lausanne). 2025;12:1601492.

Title

Learning Together: A Guided Approach to Teaching Youth Substance Use Treatment

Primary Category

Curriculum

Presenters

Gerald Busch, MD, MPH, Tripler Army Medical Center, Ray Hsiao, BA, MD, University of Washington Program, Ravi Shankar, MD, University of Kentucky, Cathryn Galanter, MD, SUNY at Stony Brook, Justine Welsh, MD, Emory University School of Medicine

Education objectives

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

1. Explain selected psychosocial and medication treatment approaches for youth cannabis, nicotine, and opioid use disorders using case examples and relevant clinical resources.

2. Practice teaching a selected treatment approach to fellows and residents through a case-based exercise with presenter guidance.

3. Develop a plan to incorporate and evaluate at least one case-based teaching activity in their home training program.

Abstract

Limited faculty expertise and insufficient clinical training opportunities present barriers to adolescent addictions education in child and adolescent psychiatry (CAP) fellowships. Program directors and faculty need resources that support their own learning while helping them prepare fellows and residents to treat youth substance use disorders. Building on previous subcommittee workshops introducing portable curricula and the Cannabis Youth Treatment (CYT) manual, this workshop will provide guided practice in delivering defined teaching activities across cannabis, nicotine, and opioid use disorders.

Participants will receive three teaching packages, each containing learning objectives, a clinical vignette, step-by-step facilitator instructions, suggested language, anticipated learner questions, key clinical explanations, and supporting references. The cannabis scenario will address engaging an adolescent who is ambivalent about change using a selected CYT intervention. The nicotine scenario will address an adolescent who vapes daily and wants to quit, introducing behavioral treatment and medication considerations. The opioid scenario will address an adolescent seeking help for opioid use, emphasizing medications for opioid use disorder, overdose prevention, and ongoing care. Medication discussions will distinguish adolescent-specific evidence, age-related prescribing considerations, and areas of uncertainty.



Presenters will demonstrate a lesson component using the facilitator guide, making the clinical reasoning and instructional steps explicit. Participants will join one scenario group, supported by a presenter with relevant clinical expertise, and rehearse in pairs or triads so everyone practices teaching. Presenter guidance and structured feedback will support faculty learning the clinical material themselves. Discussion will address common questions, misunderstandings, and situations requiring additional consultation.

Groups will share lessons from their rehearsals, including how the materials could fit into existing didactics, supervision, or clinical case conferences. All participants will receive the three teaching packages and develop a plan to deliver at least one activity in their home program.

The workshop reflects Harmony and Humanity through shared learning supported by presenter expertise and facilitator guides. Creative rehearsal and adaptation to local settings will help educators prepare trainees to engage adolescents and families. Generativity will emerge as participants bring these teaching activities to their programs and share them with colleagues.

Evaluation will include linked baseline and three-month surveys and structured observation during supported rehearsal. Baseline questions will assess teaching experience, attendance at prior subcommittee workshops, and subsequent use of their resources. The primary outcome will be the proportion of follow-up respondents who report delivering at least one activity whose content they were not teaching at baseline. Follow-up response rates and confirmed implementers among eligible baseline participants will also be reported. Findings will be examined by prior adolescent addictions experience and will include trainees reached and remaining support needs. Presenters will administer follow-up, and the evaluation plan will be submitted for institutional review board determination before the meeting. Findings will inform further faculty development and potential dissemination.

Practice Gap

Welsh and colleagues identified limited faculty expertise and insufficient clinical training sites as barriers to adolescent addictions education in child and adolescent psychiatry (CAP) fellowships. Clinical need remains substantial: the 2025 National Survey on Drug Use and Health estimated that 1.9 million adolescents had a past-year substance use disorder and 1.6 million had vaped nicotine in the past month.

Previous AADPRT subcommittee workshops introduced portable curricula and treatment resources. However, faculty with limited addictions experience may need additional support to translate these resources into teaching. Welsh and colleagues' subsequent train-the-trainer publication provides a relevant faculty development model.

This workshop addresses that need through presenter demonstrations and guided practice teaching selected cannabis, nicotine, and opioid treatment concepts. Follow-up evaluation will assess whether participants implement these activities, particularly faculty with limited prior expertise who were not previously teaching the content.



Agenda

0:00–0:10 | Introduction and Training Gap

Review training needs and complete a brief survey of teaching experience, prior workshop participation, and resource use.

0:10–0:25 | Teaching Demonstration

Presenters demonstrate case-based teaching, explaining clinical reasoning and responses to common questions.

0:25–0:30 | Scenario Selection

Introduce cannabis, nicotine, and opioid cases and organize breakout groups.

0:30–1:00 | Guided Teaching Practice

Participants rehearse selected teaching activities in pairs or triads, supported by a presenter with relevant clinical expertise who provides guidance and feedback.

1:00–1:15 | Shared Learning and Implementation Planning

Groups share insights. Participants identify an activity, setting, timeframe, and evaluation approach for teaching at home.

1:15–1:25 | Questions and Discussion

Address remaining questions and additional support needs.

1:25–1:30 | Evaluation

Complete the workshop evaluation form.

Scientific Citations

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4. Welsh JW, Krishnan SD, Terranella A. Prevention and management of opioid use disorder and overdose in adolescents and young adults. Current Psychiatry Reports. 2025;27(11):660–670. PubMed.

The following older sources are included for their foundational relevance:

5. Welsh JW, Schwartz AC, DeJong SM. Addictions training in child and adolescent psychiatry fellowships. Academic Psychiatry. 2019;43(1):13–17, the original CAP fellowship needs assessment establishing the educational gap;

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7. Sampl S, Kadden R. Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions. Cannabis Youth Treatment Series, Volume 1. SAMHSA; 2001

Title

One Service, Many Learners: The Yale Interventional Psychiatry Service Training Model

Primary Category

Curriculum

Presenters

John Cahill, MBBS, PhD, Yale University School of Medicine, Simran Ailani, MD, Yale University School of Medicine, Marcus Hughes, MD, Yale University School of Medicine, Katie Cioe, MD, Yale University School of Medicine, Robert Ostroff, MD, Yale University School of Medicine

Education objectives

1. Describe how a multimodal clinical service can support progressive interventional psychiatry education from foundational exposure through advanced training.

2. Use a longitudinal case to identify meaningful clinical decision points and translate them into learning objectives, teaching methods, and assessments.

3. Compare curricular pathways, including brief rotations, longitudinal half-day experiences, credit-based distinction tracks, and advanced fellowship training.

4. Develop one feasible addition to interventional psychiatry training at their home program, including programs without onsite services.

Abstract

Training in interventional psychiatry is often organized around individual procedures or brief rotations. At Yale, a high-volume, multimodal service instead brings learners at multiple stages into the same clinical environment. Medical students, psychiatry residents, geriatric psychiatry fellows, child and adolescent psychiatry fellows, and interventional psychiatry fellows participate at different levels across inpatient and outpatient consultation, ECT, TMS, intravenous ketamine, intranasal esketamine, and brief follow-up care.

Depending on their experience, learners observe or participate in treatment selection, patient counseling, treatment delivery, assessment of response and tolerability, and decisions about acute, continuation, and maintenance care. This structure allows responsibilities to progress while learners see the full patient journey rather than one procedure in isolation. Regular clinical meetings and collaboration with the Yale Depression Research Program also expose trainees to ongoing studies and show how emerging evidence can inform clinical discussions within established standards of care. Building on this model, the service is developing a credit-based Interventional Psychiatry Distinction Track for PGY-2 through PGY-4 residents, that would provide a longitudinal half-day experience for those seeking greater depth during residency.

Brief perspectives from program leadership, clinical faculty, and a trainee will describe how the model is organized, how supervision changes across levels, and the challenges of incorporating education into a high-volume service. One longitudinal composite case will anchor the interactive portion. As the patient moves from referral through treatment selection, incomplete response, transition to another modality, and continuation planning, participants will identify what should be learned at foundational, enhanced, and advanced levels. Groups will use these clinical decision points to develop appropriate learning objectives, teaching settings, supervision, and assessment at each level. They will also consider how the model could be adapted by programs without one or more onsite modalities.

The large-group discussion will compare curricular pathways and allow participants to identify one feasible component for their own programs. Participants will leave with a case-based planning tool for developing longitudinal, progressive interventional psychiatry training. This workshop was developed by a trainee with faculty mentorship.

Practice Gap

Interventional psychiatry education remains highly variable across residency programs (Menon et al., 2024; Giacobbe et al., 2025). Even when ECT, TMS, and ketamine/esketamine are available, exposure may consist of isolated didactics or procedural observation rather than longitudinal experience in consultation, counseling, treatment planning, follow-up, and continuation care. Programs also lack clear pathways distinguishing foundational knowledge for every resident from enhanced clinical exposure and advanced training (Egan et al., 2024; Siddiqi et al., 2025). Consequently, a high-volume service does not automatically produce a coherent curriculum. Programs without onsite services may struggle to provide meaningful exposure (Green et al., 2026). Educators need adaptable models connecting clinical cases to progressive objectives, supervised experience, assessment, and scholarship. They also need pathways for residents seeking greater depth without requiring fellowship training. This workshop addresses that gap through a multilevel service-based model and development of a credit-based distinction track for residents in PGY-2 through PGY-4.

Agenda

1. Model overview and case setup - 20 minutes

Briefly describe the multimodal service, multilevel learner pathway, distinction-track development, and research collaboration. Introduce the longitudinal case and curriculum-planning worksheet.

2. Small-group case-based curriculum design - 30 minutes

Groups use decision points in the case to define foundational, enhanced, and advanced learning objectives; select teaching and assessment methods; and adapt the pathway for different resources.

3. Large-group debrief and program application - 25 minutes

Groups share their proposed curricula. Facilitators compare approaches, connect themes to lessons from the service, and discuss what could be adapted in programs with different faculty, clinical volume, and available modalities.

4. Questions and discussion - 10 minutes

Address remaining questions about implementation, supervision, faculty time, access, and sustainability.

5. Evaluation and closing - 5 minutes

Complete the evaluation and summarize the principal takeaways.

Scientific Citations

1. Nikayin S, Taylor JJ, Ostroff RB. Advanced training in interventional psychiatry. J Neurol Sci. 2022;434:120093. doi:10.1016/j.jns.2021.120093.

2. Menon SN, Torrico T, Luber B, et al. Educating the next generation of psychiatrists in the use of clinical neuromodulation therapies: What should all psychiatry residents know? Front Psychiatry. 2024;15:1397102. doi:10.3389/fpsyt.2024.1397102.

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6. Green YS, Ailani S, Ehrie J, Zabinski J. Building inter-institutional education in psychiatric subspecialties: Experiences from the Interventional Psychiatry Consortium. Acad Psychiatry. Published online April 9, 2026. doi:10.1007/s40596-026-02338-4.

Title

TikTok Trends Under a Clinician's Lens: Teaching Trainees to Navigate Social Media Suggestibility and Self-Diagnosis

Primary Category

Curriculum

Presenters

Shreya Maniar Nagula, MD, Jacobi Medical Center, Yanal Matari, MD, Westchester Medical Center, Sara Friedman, MD, Westchester Medical Center, Amanda Timek, MD, Louisiana State University School of Medicine/Ochsner Clinic Foundation Program, Wilson Tan, MD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA

Education objectives

After attending this workshop, participants will be able to:

1. Analyze rapidly changing media trends, social media suggestibility, and self-diagnosis behaviors impacting adolescent and young adult mental health.

2. Integrate a structured "media/tech history" into standard biopsychosocial assessments and risk evaluations for transition-age youth and university students.

3. Formulate collaborative, non-judgmental communication strategies with young patients and parents regarding concerning and prosocial online engagement.

4. Design a feasible, sustainable social media-literacy curriculum framework with clear ACGME-aligned competencies for psychiatric trainees at their home institutions.

Abstract

Background & Rationale

Media immersion both positively and negatively shapes identity, coping, and risk across youth development. Roughly 95% of teens use social media, and 18% of college students demonstrate problematic use. Beyond exposure to cyberbullying, self-harm, or pro-suicide content, emerging trends like TikTok-driven psychiatric self-diagnosis and peer-led digital "therapy" alter how young patients present clinically. Despite this, clinicians rarely evaluate media usage thoroughly, lack training in taking a "media/tech history," and struggle to assess its functional role in psychopathology. Addressing this requires shifting from only assessing total screen time to evaluating drivers for social media consumption as well as specific content. Nearly 40% of social media use serves as intentional emotion regulation, functioning as self-directed "therapy", with readily accessible peer support. However, much of the content can drive functional deterioration and symptom contagion. Establishing

reproducible, humanistic approaches to digital literacy and how best to understand the pros and cons of social media usage for any given individual represents a critical, unaddressed gap across residency and fellowship training.

Workshop Description

Aligned with the meeting's theme of humanistic connection, creativity, and generative mentorship, this 90-minute interactive workshop equips educators to bring social media literacy into clinical care and training curricula. Developed through extensive faculty-trainee mentorship and collaboration, this session provides modular teaching tools refined through multiple years of didactics and clinical care, utilizing motivational interviewing techniques to better understand the functions and impact of social media usage for teens and young adults.

Presenters will briefly discuss the positive and negative impacts of current social media trends, while demonstrating screeners (e.g., HEADS4 social media screen) to fold digital history-taking into biopsychosocial assessments. Role-plays then will illustrate navigating complex presentations, including TikTok-driven symptom-manifestation (ie 'TikTok tics') and self-imposed diagnoses. Participants will then engage in facilitated small-group exercises: executing a live "trend audit," analyzing de-identified digital feeds, drafting non-judgmental exploration prompts for patients/parents, and constructing an actionable media-literacy curriculum draft for their home institutions. Groups present their curriculum frameworks during a large-group synthesis, followed by Q&A and evaluation.

Conclusions & ACGME Alignment

Participants gain adaptable curricular frameworks, evaluation tools, and sample competencies to teach digital media literacy. This session directly addresses ACGME Milestones, including Development Through the Life Cycle (MK1), Community-Based Care (SBP3), Self-Education through Practice-Based Learning and Improvement (PBL2), Patient Care and History Taking (PC1), and Treatment Planning and Management (PC3).

Intended Audience

Training directors, associate training directors, faculty, fellows, residents, and medical students.

Practice Gap

Adolescents and young adults consume 7–11 hours of media daily. Unlike traditional media, modern digital platforms eliminate physical boundaries, following youth into private spaces and amplifying exposure to cyberbullying, self-harm, and evolving TikTok trends, including psychiatric self-diagnosis. Furthermore, social media suggestibility increasingly drives symptom contagion and self-directed "therapy". Optimal psychiatric care necessitates continuously evaluating media's overarching role in psychopathology. However, clinical practice rarely assesses media usage or takes a structured "media/tech history," leaving biopsychosocial

formulations and risk assessments largely incomplete. While awareness of cyberbullying's impact has grown, clinicians still lack familiarity with rapidly shifting online trends. A significant educational gap also remains: training programs seldom teach trainees to systematically explore digital media usage or navigate social media suggestibility with patients and families, leaving future psychiatrists poorly equipped to address a central determinant of mental health in our current population.

Agenda

0–10 min: Brief discussion of positive and negative impacts of current social media trends.

10-20 min: Clinical role-plays by workshop leaders illustrating navigating challenging past experiences related to social media suggestibility and self-diagnosis.

20–60 min: Facilitated small-group interactive breakout exercises:

- Conducting a live "trend audit".
- Reviewing de-identified digital feeds.
- Drafting non-judgmental communication prompts for patients and parents.
- Building an actionable media-literacy curriculum draft with learning objectives for home institutions.

60–75 min: Large-group synthesis and inter-institutional collaboration, with small-group representatives sharing curriculum models and implementation strategies.

75–90 min: Interactive Q&A, participant reflection, and session evaluation.

Scientific Citations

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7. Weigle PE, Shafi RMA. Social Media and Youth Mental Health. Current Psychiatry Reports. 2024.

Title

Traversing the Terrain of Educational Leadership in Academic Psychiatry

Primary Category

Program Administration and Leadership

Presenters

Ann Schwartz, MD, Emory University School of Medicine, Daniel Gih, BS, MD, University of Nebraska Medical Center College of Medicine, Kim Lan Czelusta, MD, Baylor College of Medicine, Kristi Kleinschmit, MD, University of Utah School of Medicine

Education objectives

1. Examine the scope and evolution of the educational leadership roles in academic psychiatry, including formal titles and informal leadership responsibilities.

2. Develop strategic opportunities for leadership by aligning personal strengths and interests with departmental and institutional priorities across different career stages.

3. Apply core leadership skills such as relationship building, perspective taking, compromise, prioritization, negotiation, and escalation to problem-solve effectively in common educational leadership scenarios.

Abstract

Many academic psychiatrists serve as educational leaders within departments (e.g., clerkship, preclinical, residency, and fellowship directors), and an increasing number of junior and mid-career faculty assume informal or formal leadership roles early in their careers. The work is essential to the academic department's operational and strategic success. Educational leaders have varying experience with evaluations and surveys, expectation management, budgets, faculty development, and quality improvement. While these are essential leadership responsibilities, these skills are rarely taught explicitly or longitudinally.

Often, academic psychiatrists are asked to assume educational leadership positions for which they have had limited formal preparation and mentorship. Educational leaders are expected to address interpersonal conflicts, manage competing interests, and provide support for learners and faculty. While some organizations (e.g., AADPRT) offer programs to orient first-time program directors to their new roles, there are few programmatic opportunities for faculty at all career stages to develop, refine, and adapt their leadership skills as their roles expand or evolve.

In this AAP-sponsored interactive workshop, four vice chairs of education will share brief reflections on their personal educational leadership journeys, including transitions into leadership, common missteps, and lessons learned. The session will emphasize mentorship, peer learning, and practical skill-building, offering participants

opportunities to engage in structured case discussions, reflect on their own leadership contexts, and build shared strategies and resources. Cases will be intentionally designed to apply to a broad range of roles, from emerging leaders to senior education administrators, highlighting both the challenges and joys of educational leadership.

Practice Gap

Academic psychiatrists frequently assume formal and informal educational leadership roles with limited preparation for the leadership skills these positions require. Although faculty may develop expertise as educators, they may have less experience navigating competing priorities, managing conflict, negotiating for resources, building relationships, and adapting their leadership approach as responsibilities evolve. Existing faculty development often focuses on orientation to specific roles rather than longitudinal leadership development across career stages. As a result, educational leaders may learn these skills largely through experience, informal mentorship, and trial and error. There is a need for practical, career-spanning approaches that help faculty identify leadership opportunities aligned with their strengths and institutional priorities, anticipate common challenges, and develop strategies for navigating the interpersonal and organizational complexities of educational leadership.

Agenda

15 min – Introduction: faculty describe their leadership journeys, roles, and transitions.

10 min – Think-pair-share: participants identify personal strengths, career interests, current or anticipated leadership roles, and challenges.

10 min – Background didactics: faculty present common educational leadership challenges and strategies.

25 min – Small-group case discussions: participants serve as consultants to an education leader facing a challenging situation. Faculty circulate among groups to facilitate discussion.

25 min – Large-group discussion and action planning: participants identify shared themes, practical strategies, mentorship opportunities, and next steps for their leadership development.

5 min – Evaluations

Scientific Citations

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6. Kruse SD. Department chair leadership: Exploring the role's demands and tensions. EMAL. 2022 Sep;50(5):739-57.

Title

When Life Happens: Approaches to Supporting Psychiatry Trainees through Personal Adversity

Primary Category

Faculty Development

Presenters

Nisha Shah, MD, Medical College of Wisconsin (Milwaukee), Elina Drits, DO, Zucker School of Medicine at Hofstra/Northwell - Staten Island University Hospital, Gary Swanson, BS, MD, Allegheny Health Network Medical Education Consortium Program, Colleen Manak, MD, Medical College of Wisconsin (Milwaukee), Martina Peralta-Leon, DO, Medical College of Wisconsin (Milwaukee)

Education objectives

1. Identify common personal life stressors experienced by psychiatry trainees

2. Recognize systemic, interpersonal, and regulatory barriers that limit faculty support of trainees during personal life challenges

3. Apply evidence-informed strategies to support individual trainees and/or cohorts experiencing shared stressors

4. Develop an actionable, program-specific framework for responding to trainee life challenges while maintaining professionalism and regulatory compliance

Abstract

Psychiatry trainees frequently encounter significant personal life stressors during residency and fellowship, with experiences that are far more common than many faculty to recognize and carry serious consequences for trainee well-being and patient care. These stressors span a wide range of domains- pregnancy and parenting challenges, bereavement, immigration and visa concerns to name a few. Psychiatry trainees face additional specialty-specific burdens as well- exposure to patient suicide, workplace aggression and stigma.

The prevalence of these stressors is striking. Between 38.9% and 56% of US trainee pregnancies are affected by complications. Approximately one in seven trainees experiences food insecurity. Nearly 12% of first-year residents report at least one disability, yet more than half of those who need accommodations do not request them. Roughly one in four US physicians is an international medical graduate, many of whom navigate J-1 visa constraints, microaggressions, and inadequate mentorship support alongside their clinical training. Trainees who experience discrimination and mistreatment report poor educational experiences, loss of confidence, and thoughts of discontinuing training entirely.



This interactive 90-minute workshop is designed to address this gap directly. Using a combination of evidence-based didactic content, facilitated small-group discussion, and case-based exercises, participants will examine the full landscape of trainee personal adversity-including stressors that are often overlooked in faculty development programming, such as financial strain, immigration challenges, and discrimination. Presenters bring diverse and complementary perspectives grounding the discussion in both scholarship and lived experience.

Participants will engage in structured small-group discussions to identify barriers within their own programs and apply evidence-informed strategies to realistic clinical scenarios. Participants will leave with a program level self-assessment checklist and practical, adaptable framework to guide their ongoing efforts.

Practice Gap

Current faculty development efforts in graduate medical education rarely address the practical, day-to-day skills needed to support trainees through personal adversity while maintaining professionalism and regulatory compliance. Program directors and faculty are frequently left to navigate these situations reactively and without a structured framework. This workshop addresses a clear gap: psychiatry faculty need evidence-informed, practical tools to proactively and equitably support trainees when life happens.

Agenda

Welcome/Introductions (10 minutes): Presenter introductions, session overview, and audience discussion of what brought participants to this session and what they hope to take away.

Mini-Lecture: What Trainees Go Through (10 minutes): Evidence-based review of trainee life stressors and their impact on well-being and training outcomes.

Discussion: Barriers to Supporting Trainees (10 minutes): Small-group discussion of systemic and interpersonal barriers, followed by integration of relevant literature.

Mini-Lecture: Best Practices (5 minutes): Evidence-informed strategies for supporting trainees at the individual and program level.

Small-Group Case Discussions (10 minutes): Structured case vignettes applying strategies to realistic scenarios.

Large-Group Debrief (15 minutes): Theme synthesis and integration of literature and presenter experience.

Self-Assessment and Toolkit Building (5 minutes): Participants complete a self-assessment checklist and begin drafting their program-specific toolkit.

Table Discussion (10 minutes): Applying and refining toolkits with peers.



Large-Group Discussion (10 minutes): Sharing commitments and action steps.

Wrap-Up and Questions (5 minutes)

Scientific Citations

1. Dason, E. S., Kapsack, A., Baxter, N. N., Gesink, D., Shapiro, H., & Simpson, A. N. (2024). Resident and fellow perspectives on family planning and building during training. JAMA Network Open, 7(8), e2429345. https://doi.org/10.1001/jamanetworkopen.2024.29345

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8. Kay, C., Bernstein, J., Yass, N., Woodard, J., Tesfatsion, S., & Scholcoff, C. (2022). Faculty physician and trainee experiences with micro- and macroaggressions: A qualitative study. Journal of General Internal Medicine, 37(13), 3419–3425. https://doi.org/10.1007/s11606-022-07423-6

Title

Wide Open Spaces, Narrow Training: Preparing Psychiatrists to Treat Eating Disorders

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Ronke Babalola, MD, MPH, Rutgers Robert Wood Johnson Medical School, Jo Everett, BS, MD, Kaiser Permanente Southern California Program, Wendy Oliver-Pyatt, MD, Pauline Dimaano, MD, Hackensack Meridian Health - University Medical Center Program, Olasupo Samuel Olabanji, BS

Education objectives

1 Identify common gaps and challenges in eating disorder recognition, diagnosis, and management, including diagnostic bias, weight stigma, and underrecognized presentations that may limit trainee preparedness.

2. Apply case-based teaching strategies within existing training structures including consultation-liaison rotations, outpatient supervision, didactic sessions, and standardized patient encounters without requiring a dedicated eating disorder rotation.

3. Use clinical vignettes to apply APA guidelines for determining appropriate levels of care for patients with eating disorders.

4. Develop practical, evidence-informed educational interventions that can be integrated into participants' own psychiatry training programs to improve trainee recognition, assessment, and management of eating disorders

Abstract

Eating disorders are common, medically complex, and among the deadliest psychiatric illnesses, yet residency training in their recognition and management remains inconsistent (1). Most programs lack a dedicated eating disorder rotation, and residents and faculty alike often report low confidence diagnosing eating disorders, assessing medical instability, determining level of care, and initiating evidence-based treatment (3,4). This gap is not simply a matter of curricular time: eating disorders sit at the intersection of psychiatry, internal medicine, nutrition, psychotherapy, and family systems, and diagnostic training tends to emphasize a narrow presentation, underweight young women with anorexia nervosa, while underrepresenting binge-eating disorder, bulimia nervosa ARFID, atypical anorexia nervosa, OSFED, and presentations in males, older adults, individuals in larger bodies, and culturally diverse populations (5, 6, 7). Faculty who received limited formal training themselves often feel similarly underprepared to teach residents, compounding educational avoidance.



This interactive 90-minute faculty-development workshop equips program directors and teaching faculty with practical, evidence-based strategies for integrating eating disorder education into existing curricula without requiring a dedicated rotation. Using facilitated discussion and case-based learning, participants first examine common pitfalls in recognition, missed presentations, diagnostic bias, weight stigma, and incomplete risk assessment, grounded in realistic clinical vignettes spanning the diagnostic spectrum.

Participants will examine measurement-based care using screening and symptom-monitoring tools, including the SCOFF, EDE-Q, CIA, BEDS-7, and NIAS, with discussion of when comprehensive assessment is indicated. The presentation will also review a Delphi-informed, competency-based educational framework developed through the Eating Disorder Education Institute, illustrating how consensus-defined content and supervised practice can support the translation of evidence into teachable residency competencies across diverse residency programs and clinical settings.

The workshop closes by synthesizing these exercises into a practical framework of core eating disorder knowledge and skills expected of every graduating psychiatrist, along with adaptable teaching materials, case vignettes, and simulation guidance that faculty can implement at their home programs immediately. By combining case-based teaching with an experiential simulation grounded in gold-standard care recommendations by APA guidelines closing a persistent gap in psychiatric education and helping to ensure eating disorders are no longer treated as a niche topic dependent on electives or institutional resources.

Practice Gap

Eating disorders carry substantial psychiatric and medical morbidity and one of the highest mortality rates in psychiatry (1). Despite their prevalence they remain inadequately recognized and assessed across healthcare settings and inconsistently taught in residency (2). National surveys show most programs lack dedicated eating disorder rotations (3), and psychiatrists often report limited confidence diagnosing, assessing medical risk, determining appropriate level of care, and initiating treatment (2). Training tends to emphasize anorexia nervosa while neglecting binge-eating disorder, avoidant/restrictive food intake disorder (ARFID), atypical anorexia nervosa, other specified feeding and eating disorders (OSFED), and presentations in males, older adults, individuals in larger bodies, and culturally diverse populations (2).

Consequently, residents may miss early warning signs, delay diagnosis, or defer care unnecessarily. Trainees and faculty need practical, evidence-based strategies to prepare trainees to recognize eating disorders early, conduct initial assessment, initiate both psychiatric and medical management, and collaborate with multidisciplinary teams.

Agenda

0–10 min | Introduction

- Challenges teaching about eating disorders.

10–20 min | What Are We Missing?

- Overview of eating disorders, diagnosis and barriers important timely recognition.

20–35 min | Interactive Case 1: "But the BMI is Normal"

- Small groups evaluate a patient with restrictive eating behaviors and normal BMI, followed by discussion of atypical anorexia nervosa and weight stigma.

35-40 min | Questions / Discussion of first case

40–55 min | Interactive Case 2: The Eating Disorder You Didn't Expect

- Groups explore why less stereotypical presentations including ARFID may be overlooked and how to broaden diagnostic thinking.

55-60 min | Questions / Discussion of second case

60-70 min | Recognition to Intervention

- Apply the framework: Recognize → Assess → Determine Risk → Intervene → Refer.

70-80 min | Share-Back and Take Home Tools

- Groups share strategies and facilitators consolidate practical teaching tools.

80–90 min | Closing

- Questions and filling out survey

Scientific Citations

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2. Bryant, E., Spielman, K., Le, A., Marks, P., Touyz, S., & Maguire, S. (2022). Screening, assessment and diagnosis in the eating disorders: findings from a rapid review. Journal of eating disorders, 10(1), 78.

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Title

"You've Got a Friend": Writing and Belonging

Primary Category

Research and Scholarship

Presenters

Adam Brenner, MD, UT Southwestern Medical Center, Lia Thomas, MD, UT Southwestern Medical Center, Andrea Seritan, MD, University of California, San Francisco, James Lee, BS, MD, University of Washington Program, John Coverdale, MD, Baylor College of Medicine

Education objectives

1. Describe collaborative writing activities beginning with framing the question.
2. Identify barriers and strategies to form a writing team.
3. Develop strategies to effectively ask for help.

Abstract

Academic writing positions each of us as part of an ongoing 'dialogue' in a professional community, strengthens our identity as a member of that community, and addresses any impostor syndrome we may feel. Each of our experiences of belonging, positive and negative, can foster or hinder our confidence in writing. In this workshop, we will explore writing and belonging with practical applications, such as strategies to form a writing team, access resources for writing support, collaborate beyond an individual or department, and engage in society connections.

Practice Gap

The culture of academia stresses singular competence, but without a sense of community, we risk feeling isolated or demoralized. Academic writing in particular may feel grueling to clinician-educators in academic environments with limited resources and time to engage in scholarly projects. The integrative and collaborative work of clinician-educators builds a professional community and strengthens one’s sense of belonging. This workshop will bridge the gap between individual efforts and group ’membership’.

Agenda

- 5 minutes – Introductions, participants’ goals for the workshop
- 10 minutes – Didactic on the intersection of scholarly writing and professional identity
- 5 minutes – Reflection by each participant on their experience of professional belonging



- 10 minutes – Pair Share: participants share examples of writing projects they are planning or currently working on and how they relate to professional belonging
- 10 minutes – Large group discussion (small group report-out, common themes)
- 10 minutes – Didactic on strategies for forming collaborations
- 10 minutes – Small group practice on reaching out to others for partnerships.
- 10 minutes – Didactic on overcoming barriers to collaborative writing
- 10 minutes – Small group practice identifying barriers and overcoming them.
- 10 minutes – Large group discussion and Q&A

Scientific Citations

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Title

You've implemented EPA evaluations… now what? Sharing solutions and considerations for the post-implementation phase.

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Jessica Obeysekare, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program, Michael Greenspan, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, William Smith, MD, University of California, San Francisco, Kari Whatley, MD, University of Texas Austin Dell Medical School, Timothy Kreider, MD, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education objectives

1. To review challenges in post-implementation "back-end" utilization of EPA data

2. To discuss high-level solutions for collection of results and dissemination to residents and the Clinical Competency Committee (CCC)

3. To briefly show samples of post-implementation strategies using different tech solutions (e.g., MedHub, Microsoft Office) and for programs with different levels of technical proficiency

4. To discuss implications of EPA results, including resident feedback, promotion, moonlighting, etc.

Abstract

EPA evaluations offer real-time opportunity for feedback on the resident's performance in a specific patient encounter (i.e., not a summative evaluation) that intuitively allows the attending to rate the resident performance by considering the amount of autonomy that would be appropriate. While many programs may be in the planning stage and asking how to set up EPA evaluations, programs who have already implemented EPA evaluations are now faced with wrangling the EPA data in a user-friendly, useful format.

With 13 EPAs identified that pertain to psychiatry [3], a large volume of EPA evaluation data can quickly accumulate for each resident. We identify a tension between EPA forms that are intuitive for faculty on the front-end, while also providing data output that is easy to manipulate, sort, and display. EPA evaluation results may be shared with the individual residents, their faculty supervisors, training directors, and/or the CCC. CCCs must efficiently and effectively synthesize multiple sources of data and are responsible for reviewing resident evaluations [4].



In this workshop, we will demonstrate examples of how “front end” collection strategies impact “back end” data output. We will review practical solution options for sharing EPA evaluation results with individual residents, without giving them access to all resident evaluation data. Sample strategies will be reviewed for aggregating and displaying EPA evaluation data for individual residents, which could be useful in CCC settings or semi-annual reviews.

Finally, once EPA evaluations have been collected, the program faces the decision of how to use this data. In surgery residency, CCCs felt high confidence in entrustment decisions when they had data from at least 4 EPA evaluations informing each decision [5]. The CCC reviews multiple data points (e.g., milestones, subjective feedback comments on evaluations, in-service training examination results, multi-source assessments, EPA evaluations, quality metrics); EPA evaluations represent one of many sources of data. In psychiatry, there are not standardized EPA thresholds for advancement/promotion to the next post-graduate year of training, graduation, moonlighting, etc. However, we also acknowledge that the language of readiness for autonomous practice lends itself nicely to this decision-making, which is being seen in other specialties. For example, the American Board of Pediatrics has announced that beginning in 2028, training directors will be required to attest that all of their graduates meet a Level 5 in all pediatrics EPAs [6]. The workshop will conclude with an open discussion about the “now what” once EPA evaluation data has been synthesized and displayed for the trainee and CCC to review.

Practice Gap

Entrustable Professional Activities (EPAs) are discrete units of professional practice that a resident should be able to perform independently by the end of training in order to practice in their specialty [1]. There is increasing interest in movement toward use of EPA evaluations in residency training [2]. In psychiatry, there are 13 EPAs identified in the American Association of Directors of Psychiatry Residency Training’s (AADPRT) EPA toolkit [3].

The Assessment Committee receives questions about EPA implementation and has identified two categories of challenge: 1) How does a program begin implementing EPAs and 2) Once a program has implemented EPAs, how does that program organize, review, and use the results? The Assessment Committee proposes two separate workshops focused on these practical applications during EPA implementation; the following abstract pertains to the second “post implementation” category.

Agenda

0-10 minutes: Discussion and demonstration of the “back end” data output during EPA evaluations and how the set-up of the evaluation influences the output

10-20 minutes: Small group exercise on defining most problematic challenges on the back-end of EPA evaluations



20-45 minutes: Review of barriers and solutions regarding possible ways to synthesize, display, and share data with stakeholders. Specific examples will be given using various software (MedHub, Microsoft Forms/Excel) and with various levels of technical proficiency (Ex: Microsoft Excel versus Power Automate versus PowerBI).

45-75 minutes: Small group activity in which participants use practice assessment data to role play a CCC deliberation on promoting vs remediating trainees

75-90 minutes: Questions & discussion, including 5 min for evaluation form

Scientific Citations

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