WORKSHOPS SESSION 2

Title

A Call to Adventure: Reimagining Culture, Identity, and Belonging in Psychiatry Residency

Primary Category

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

Presenters

Andrew Hunt, MD, Case Western Reserve U/University Hospitals of Cleveland Program, Cathleen Cerny-Suelzer, BA, MD, Case Western Reserve University/University Hospitals of Cleveland Program, Tolu Odebunmi, MBBS, MPH, University of Minnesota, Jessica Khan, MD, University of North Carolina Hospitals

Education objectives

1. Identify key elements of residency culture that influence trainee belonging, professional identity formation, and well-being.

2. Apply cultural interventions to foster and support the developmental transitions and challenges of psychiatry residency training.

3. Describe how narrative, shared traditions, symbolism, and group identity can be used intentionally to create meaning, connection, and belonging within a psychiatry residency program.

4. Analyze the potential benefits and challenges of a residency “House” system as a structure for strengthening community, cross-cohort relationships, engagement, and shared identity.

5. Develop at least one practical culture-building strategy that participants can adapt and implement within their own residency or fellowship programs.

Abstract

Professional identity development (PID) happens at the intersection of personal values and beliefs, professional ethics, codes of practice, societal rules and personal experience. Our professional identities are continually evolving but residency and fellowship training are particularly intense and rapid periods of PID growth. Trainees are in the early stages of internalizing professional values and becoming socialized within the medical community. For that reason, training programs need to be intentional about their cultural milieu, as trainees navigate stressful clinical environments and burnout..

To date, professional identity development in graduate medical education has been taught in a variety of ways. Reflective and narrative curricula have addressed identity formation in a variety of training programs (1).



Joseph Campbell's Hero's Journey has been studied extensively as a conceptual framework for the development of meaning in world literature. Methods have been outlined applying this concept in the field of medical education, and in the context of making life more meaningful in general (3). Trainees reported acquisition of skills in self-reflection, empathy, transforming challenges into meaningful accomplishments.

Joseph Campbell's "Hero's Journey" describes the narrative structure of stories, but it can also be used as a developmental and culture-building framework for psychiatry training. Story based learning has also emerged as a tool in mentorship, known as narrative mentorship. Narrative mentorship has been shown to increase learner connection, promote vulnerability, and uncover the hidden curriculum. From the "Call to Adventure" through "Return with the Elixir," Campbell's seven phases metaphorically mirror psychiatry training across the four years of general residency and within each individual year of general training or subspecialty fellowship. Envisioning training as a Hero's Journey allows for creative inclusion of meaning-making and belonging building elements that support positive PID. These elements include:

- Reflective and narrative curricula
- Coaching, role modeling and mentorship
- Rituals and celebrations
- Artistic endeavors
- Structures of Belonging

In this workshop, we will review PID, summarize the Hero's Journey and how it maps on to residency training and then share our own examples of narrative reflection and culture-building activities. Participants will then have the opportunity to participate in a professional identity reflection activity, and create a tailored cultural intervention plan for their own programs.

Practice Gap

TDs and ATDs need to create training environments that foster a sense of belonging while helping trainees make connections between their daily work and their developing professional identities. In keeping with the 2027 meeting theme, this workshop seeks to inspire psychiatry training directors to use creative and human elements in the cultivation of trainee belonging and professional identity development within the context of our rapidly changing educational and healthcare landscape. By answering the "call to adventure" and applying Joseph Campbell's Hero's Journey frame to psychiatry training, directors will learn tangible ways to nurture belonging, support trainees with meaning-making and intentionally influence program culture.

Agenda

1. Presenters review professional identity development (PID) - 5 minutes
2. Presenters map the Hero's Journey onto residency training – 5 minutes



3. Presenters review narrative-based cultural and reflective interventions for medical trainees - 10 minutes

4. Participants separate into small groups: - 10 minutes

   a. Share your program's culture-building and PID challenges

   b. Discuss the stages of the Hero's Journey as they relate to your programs

   c. By vote, select a fictional world for your group to create a cultural-intervention within

5. Presenters share examples of interventions that have been used in their programs – 15 minutes

6. Groups will be provided with a menu of cultural interventions that they can choose from to complete a design challenge. The presenters will provide structured worksheets and guidance for the challenge – 25 minutes

7. Group Report Out – 15 minutes

8. Wrap-up – 5 minutes

Scientific Citations

1. Yaden, M. E., Sawaya, R. T., Reddy, J., Jong, K. A., White, J., Moniz, T., & Chisolm, M. S. (2023). A systematic review of the arts and humanities in psychiatry education. International Review of Psychiatry, 35(7–8), 540–550. https://doi.org/10.1080/09540261.2023.2278718

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6. Msheik A, Thani HA, Peralta R. Integrating narrative mentorship into simulation-based medical education to support professional identity formation. Qatar Med J. 2026 Aug 11;2026(3):49. doi:10.5339/qmj.2026.49

Title

Beyond Compliance: Reimagining the CCC as a Human-Centered Tool for Growth and Innovation

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, DeJuan White, MD, Emory University School of Medicine

Education objectives

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

1. Identify key regulatory requirements for clinical competency committees (CCCs).
2. Describe strategies for transforming the CCC from a compliance-focused process into a human-centered forum for learner development and continuous program improvement.
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

Clinical competency committees (CCCs) were designed to synthesize assessment data, support learner development, and advance competency-based medical education. Yet in practice, they can become compliance-focused exercises centered on milestone ratings and struggling residents rather than opportunities for meaningful reflection, growth, and program improvement. When intentionally designed, however, CCCs can serve as human-centered spaces that support both individual learners and the programs in which they train. Well-functioning CCCs serve as engines of transformative growth for both individual residents and entire programs. Their unique vantage point in synthesizing data from multiple stakeholders places them in an important position within training programs to support 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. By using thoughtful structure and technology to reduce the administrative burden of data synthesis, CCCs can devote more of their time to what requires human judgment: understanding learners, mitigating bias, supporting growth, and identifying opportunities for program improvement. Participants will then explore strategies for translating CCC findings into individualized educational approaches for learners across the performance spectrum. Finally, participants end by examining potential sources of bias in their own CCC's decision-making process through a complex case discussion that humanizes the work of the committee. 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 linking the learner-focused work of the CCC with the program-focused work of the PEC and program leadership, participants will learn to use individual assessment data to generate broader insights about the learning environment.. Ultimately, the workshop will equip program leaders to redesign CCCs as efficient, fair, and human-centered processes that foster learner growth while generating meaningful improvements in the educational program.

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 human-centered spaces for reflection, growth, innovation, and continuous program improvement.

Agenda

Introduction (25 minutes)

- 5 minutes: Introduce speakers, review objectives, and conduct a needs assessment using Poll Everywhere.
- 10 minutes: Mini-didactic on the ACGME CCC Guidebook.
- 10 minutes: Exercise 1 – "CCC Highs and Lows: Reflecting on What Works and What Doesn't" using think-pair-share, quiz questions, and discussion prompts.



Efficiency Strategies (25 minutes)

- 5 minutes: Mini-didactic on flipped classroom/pre-work models, as well as the use of AI and dashboards to synthesize and display information.
- 20 minutes: Exercise 2 – “Design the Dashboard: Building Feedback Tools that Balance Thoroughness with Clarity” using breakout group stations (MedHub and New Innovations) and report back.

Bias Mitigation Strategies (25 minutes)

- 5 minutes: Mini-didactic on innovations to reduce bias and groupthink.
- 20 minutes: Exercise 3 – “The Problem Resident or the Problem System? Creating Safe and Brave Spaces for All Participants” using breakout groups and report back.

Conclusion (15 minutes)

- 15 minutes: Question and answer session, workshop evaluations.

Scientific Citations

1. Abbott KL, George BC, Sandhu G, Harbaugh CM, Gauger PG, Ötleş E, Matusko N, Vu JV. Natural language processing to estimate clinical competency committee ratings. J Surg Educ. 2021;78:2046–2051.

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8. Karpinski J, Fantaye AW, Hendry P, Wiesenfeld L, Whiting S, Lochnan H, Wood TJ, Kitto S. Implementation, operationalization, and optimization of clinical competency committees in postgraduate training programs: a scoping review. Acad Med. 2025;10–97.



9. Rowland K, Edberg D, Anderson L, Wright K. Features of effective clinical competency committees. J Grad Med Educ. 2023;15:463–468.

10. Vennemeyer S, Kinnear B, Gao A, Zhu S, Nattam A, Knopp MI, Warm E, Wu DT. User-centered evaluation and design recommendations for an internal medicine resident competency assessment dashboard. Appl Clin Inform. 2023;14:996–1007.

Title

Beyond the One-way Mirror: Cultivating Bidirectional Feedback with Humility and Humanity

Primary Category

Faculty Development

Presenters

Theadia Carey, BS, MD, MS, Authority Health/Michigan State, Aisha Omorodion, MD, University of California, San Diego, Ruby Lekwauwa, BS, MD, Yale University School of Medicine, Myo Thwin Myint, MD, Tulane University School of Medicine, Dionne Blake, MD, Authority Health/Michigan State

Education objectives

1. Examine common faculty concerns about giving negative or corrective feedback, including fear of damaging the trainee–faculty relationship, creating conflict, receiving a negative reaction, or being perceived as unfair or unsupportive.

2. Explore how avoidance, delayed feedback, overly softened feedback, or reliance on written evaluations can affect trainee development.

3. Identify the ways culture, identity, hierarchy, language, bias, and prior educational experiences may shape how feedback is delivered, interpreted, and used.

4. Apply structured approaches for delivering feedback that are psychologically safe, culturally responsive, and aligned with competency-based psychiatric education.

5. Practice strategies for faculty to invite, receive, reflect on, and respond constructively to feedback from trainees, including feedback that feels harsh, poorly timed, vague, or difficult to hear.

Abstract

Feedback is central to psychiatric training, yet it is often experienced as inconsistent, vague, overly evaluated, or emotionally difficult for both trainees and supervisors. Since psychiatric education depends heavily on longitudinal relationships and reflective practice, the quality of feedback can profoundly shape a trainee's confidence, clinical judgment, professional identity, and willingness to seek help. Faculty may fear giving negative feedback to trainees which can impede trainees' professional development. Literature on faculty evaluation and retaliation further suggests that fear of negative learner evaluation may influence how candidly supervisors address performance concerns. These pressures may discourage supervisors from giving warranted corrective feedback when they worry that necessary critiques could lead to negative assessments of their supervision. Participants will practice evidence-informed strategies for responding to difficult feedback, including pausing before reacting, identifying the actionable core of the message, seeking clarification,

separating feedback quality from emotional impact, repairing supervisory relationships when proper, and creating a concrete change plan. Feedback can also be affected by bias, microaggressions, inequitable assessment practices, and power dynamics related to race, ethnicity, gender, language, disability, sexual orientation, religion, immigration history, socioeconomic background, and professional status. When faculty do not acknowledge these dynamics, feedback may feel less useful, trustworthy, or burdensome for some learners.

This interactive workshop will help faculty develop a practical, culturally responsive approach to feedback in psychiatric training. The workshop will also highlight evidence that structured feedback processes can make feedback more consistent and actionable. Broader formative assessment literature emphasizes that feedback is most effective when learners understand the expected standard, recognize the gap between current and desired performance, and receive clear guidance for closing that gap. Through case-based discussion and skills practice, attendees will learn to describe observed behaviors, explore trainee perspectives, acknowledge cultural and contextual factors, and create actionable next steps.

The workshop will also emphasize that faculty are recipients of feedback. Faculty can help shape a learning culture by inviting trainee input, responding without defensiveness, clarifying concerns, and making changes in their teaching approach. Receiving feedback as a supervisor can still be difficult, especially when concerns first appear in a written evaluation, formal assessment, or after the supervisory relationship has ended. Participants will reflect on experiences of receiving feedback that felt harsh, poorly delivered, vague, delayed, or difficult to integrate, and will consider how those experiences influence their own approach to giving feedback. This reflective part will help faculty distinguish feedback that is uncomfortable but useful from feedback that is less helpful because it lacks timeliness, specificity, respect, or actionable next steps.

Medical education literature increasingly frames feedback as a social and relational process shaped by assessment systems, learner agency, educational alliance, psychological safety, and the credibility of the feedback source. The literature highlights the importance of learner and faculty perceptions of evaluation, including how trainees understand opportunities to evaluate supervisors and how faculty experience trainee evaluations as consequential. By the end of the session, attendees will leave with concrete language, structured feedback tools, and reflective practices they can apply immediately in training settings.

Practice Gap

Feedback is central to psychiatric training, yet it is often experienced as inconsistent, vague, over evaluated, or emotionally difficult for both trainees and supervisors. In psychiatry, feedback occurs in complex clinical contexts that involve direct patient care, supervision, psychotherapy, interdisciplinary collaboration, documentation, professionalism, and identity formation. Faculty may fear giving negative feedback to trainees due to risk of retaliation in the form of critical feedback of the program and faculty on their evaluations. These pressures may discourage faculty from giving warranted corrective feedback which could impede trainee development leading to graduation of psychiatrist without the necessary professional skills.

Agenda

- Introduction — 7 minutes: Establish feedback as a bidirectional clinical teaching skill.
- Interactive Poll and Pair Reflection — 8 minutes: Identify participants' experiences giving and receiving negative feedback.
- Brief Didactic — 15 minutes: Review principles of effective feedback in medical education, including growth-oriented language.
- Culturally Responsive Feedback Cases — 15 minutes: Small groups discuss cases involving hierarchy, identity, bias, indirect communication, stereotype threat, and differing expectations.
- Supervisor Reflection Exercise — 15 minutes: Participants privately reflect and then discuss in pairs a time when they received feedback that felt harsh, vague, or delayed; Identifying what helped, what harmed, and what they would want to model differently.
- Skills Practice — 15 minutes: Participants practice giving feedback using structured language in pairs.
- After Difficult Feedback — 7 minutes: Discussion of strategies for extracting actionable information, repairing ruptures, managing discouragement and developing a concrete change plan after negative feedback.
- Conclusion and Evaluation — 8 minutes

Scientific Citations

1. Yilmaz, Y., Carey, R., Chan, T. M., et al. (2022). Sharing perspectives on feedback: A combined resident-faculty workshop. BMC Medical Education.

2. Kumar, A., Kshamaa, H. G., & Gowda, V. S. (2026). Reflection and feedback in psychiatry teaching. In Teaching and Training in Psychiatry in South Asia (pp. 227–237). Springer Nature Singapore.

3. McCutcheon, S., & Duchemin, A. M. (2020). Formalizing feedback: Introducing a structured approach in an outpatient resident clinic. Academic Psychiatry, 44(4), 399–402.

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Title

Building from Within: Scaffolding Change in Psychiatry Residency Curricula and Rotations

Primary Category

Curriculum

Presenters

Kitty Leung, MD, University of Florida College of Medicine-Jacksonville, David Lindars, MD, University of Florida College of Medicine-Jacksonville, Austin Cook, MD, University of Florida College of Medicine-Jacksonville, Amal Bhullar, MD, University of Florida College of Medicine-Jacksonville, Steven Cuffe, MD, University of Florida College of Medicine-Jacksonville

Education objectives

1. Identify opportunities to leverage existing program resources to overcome obstacles in developing a robust didactic curriculum.

2. Develop approaches to revise and strengthen residency curricula in response to program needs, resident feedback, and changing clinical demands while maintaining trust and cohesion.

3. Anticipate and address the challenges of implementing a new rotation in the setting of emerging clinical demands.

Abstract

Psychiatry residency programs operate in near-constant change, revising didactic curricula and clinical rotations in response to evolving resident needs, shifting clinical demands, accreditation requirements, and increasingly constrained educational budgets. Competency-based accreditation has raised expectations for how programs structure and document training (1,2), extending into domains such as resident well-being (2). Meeting these demands while preserving educational quality, resident engagement, and trust in the learning environment is a challenge common to programs of every size and resource level (1).

Evolution of didactics and rotation changes are common challenges residency programs come across. Curriculum revision requires deliberate sequencing grounded in adult-learning principles, alignment with milestones, and active faculty ownership; priorities that persist even when funding is minimal and programs must leverage existing faculty expertise (3,4,5). Implementing a major rotation change such as a night-float system requires balancing institutional and staffing demands against resident and faculty perspectives, transparent communication, and collaborative scheduling. Poorly managed transitions can erode morale and continuity of care while well-designed transitions can improve well-being without compromising training (6). In both tasks, engaging faculty and residents as partners strengthens implementation and fosters ownership (6,7).



This workshop uses two case-based scenarios to explore these challenges. Participants will work in small groups to develop approaches to 1) building an updated didactic curriculum with no funding and 2) implementing a new night-float rotation. Facilitators will present their program's personal experience with restructuring their didactic curriculum and their implementation of a night-float system. Large group discussion will highlight strategies to optimize use of existing educational resources, incorporate resident and faculty input, communicate updates with transparency, and foster educational innovation. Participants will leave with practical approaches that can be adapted to their own residency programs.

Practice Gap

Residency programs routinely revise their educational and clinical structures, yet these changes are often enacted without a formal infrastructure for collaboration among administrators, faculty, and residents. Discussions tend to fixate on the desired outcome rather than the process, overlooking the deliberations, trade-offs, and stakeholder input that determine whether a change is feasible, sustainable, and accepted by those involved. Programs that instead cultivate ongoing dialogue are better positioned to generate solutions that fit their specific training environment while preserving trust and cohesion. This workshop gives participants the opportunity to practice program-level problem-solving through realistic residency scenarios, compare their approaches with the real-world experience of another program, and develop actionable, process-oriented strategies for their own programs.

Agenda

- Introduction and Workshop Framing (5 min)
- Small Group Case Discussion 1: Revising Didactics With Limited Resources (15 min)
- Micro-Didactic: Building From Within (10 min)
- Large Group Debrief: Curricular Problem-Solving (10 min)
- Small Group Case Discussion 2: Implementing a Major Rotation Change (15 min)
- Micro-Didactic: Navigating Change Together (10 min)
- Large Group Debrief: Implementing Change Collaboratively (10 min)
- Closing Reflection and Synthesis (15 min)

Scientific Citations

1. Aggarwal R, Balon R, Morreale MK, et al. Is It Time to Rethink Psychiatry Residency Training? Part I: Overview. Acad Psychiatry. 2023;47:117–119.

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Title

Creating Harmony and Keeping Humanity from Day 1: Best Practices in Orientation

Primary Category

Learning Environment

Presenters

Brendan Scherer, MD, San Mateo County Behavioral Health and Recovery Services., Julia Shekunov, MD, Mayo School of Graduate Medical Education, Mariam Rahmani, MD, Eastern Virginia Medical School, Sumru Bilge-Johnson, MD, Northeast Ohio Medical University, Emily Bray, DO, Jefferson Health Medical Education/Jefferson Einstein Philadelphia Hospital Program

Education objectives

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

1. identify evidence-based best practices in orientation for residency and fellowship programs.

2. Recognize common pitfalls in orientation design, including overload, redundancy, unclear relevance, and failure to anticipate trainee wellbeing and basic-needs risks.

3. Critically appraise their orientation, mapping its components against best practices to identify gaps and redundancies.

4. Create a written, prioritized plan of concrete orientation changes using evidence-based practices and engaging tools.

Abstract

Orientation plays a pivotal role in welcoming new learners, establishing expectations, and introducing professional identity, workplace culture, and role-specific responsibilities. Programs must meet ACGME common and specialty-specific requirements while addressing trainees' educational, logistical, social, and wellbeing needs. Yet orientation best practices remain incompletely defined. Programs must decide how long orientation should last; whether it should be in person, virtual, or hybrid; who should deliver particular content; whether trainees should be paid for orientation time; and how much attention to devote to wellbeing, experiential learning, health equity, community resources, and practical needs.

Orientations also face predictable pitfalls. They may overwhelm trainees with dense presentations, required documents, and introductions to individuals whose roles are unclear. Conversely, overly brief orientations can leave trainees feeling unwelcome or uncertain about expectations, professional identity, available supports, and reporting pathways. These challenges are especially timely: psychiatry residency positions increased 76% between 2015 and 2025, while the number of programs nearly doubled. Fellowship programs face parallel but

distinct needs: fellows enter as more experienced physicians but must adapt to a new subspecialty role, culture, and set of expectations, often with less institutional scaffolding than interns receive. Across training levels, orientation is best understood as an evolving curriculum that should be refined in response to trainee feedback and program needs.

This interactive workshop is designed for program directors and others who plan or implement orientation. It begins by linking orientation to the meeting theme: this transition is when relationships within the learning community begin to take root and trainees form early impressions of whether they belong. Audience polling will identify participants' contexts, goals, challenges, and priorities, including residency versus fellowship and new versus established programs. Presenters will review orientation requirements and evidence-based practices, emphasizing wellness, belonging, structured social connection, and early identification of basic-needs insecurity.

Participants will then work in residency- and fellowship-focused groups to map their programs' first-year transition journeys, identifying stress points, existing supports, and gaps. A second brief didactic will highlight successful engagement activities, common pitfalls, and practical strategies for addressing them. Case studies involving food insecurity before the first paycheck and inadequate or unsafe housing will prompt participants to consider how orientation can better anticipate and respond to trainee needs. Groups will report proposed solutions during a facilitated discussion. Using a structured worksheet, each participant will identify at least one concrete change to implement.

Together, these activities emphasize the human dimension of orientation: welcoming trainees as whole people while thoughtfully addressing the realities they bring to training. Participants refining an existing orientation will identify strengths, gaps, and high-priority improvements; those developing a new program will leave with an initial framework and a broader toolkit of engaging approaches.

Practice Gap

Orientation plays a vital role in onboarding residents and fellows to new clinical, occupational, and learning environments. Programs must satisfy ACGME common and specialty-specific requirements alongside program-specific content while avoiding information overload, tedium, and repetition. Well-designed orientation can strengthen belonging, psychological safety, patient safety, and professional identity formation; poorly designed orientation may be quickly forgotten, feel irrelevant, and leave trainees feeling more disoriented than welcomed. Yet psychiatry program directors have limited shared guidance on what orientation should include, who should deliver specific content, and how best to incorporate wellbeing and basic-needs support. This workshop translates current evidence and best practices into practical tools for designing more effective orientations. Through interactive pedagogy and small-group work, attendees will identify concrete changes to their own residency or fellowship orientations and leave with a prioritized set of actionable next steps for implementation.



Agenda

Introduction (5 min): Goals and connection to meeting theme.

Audience polling (7 min): Identify participants' program type, program maturity, orientation goals, and key challenges.

Didactic (15 min): Review orientation requirements for residents and fellows, evidence-based practices, and strategies that promote wellness, belonging, and early identification of basic-needs risk.

Small groups (15 min): Residency and fellowship groups map first-year transition journey, noting stress points, supports, and gaps (Worksheet Part 1).

Didactic (10 min): Share high-yield engagement activities used by the speakers/ AADPRT Wellbeing/Burnout Committee members, plus strategies for common pitfalls.

Case studies (15 min): Small groups address real-life scenarios (e.g., trainees with food insecurity or unsafe housing) and identify orientation changes needed to anticipate them (Worksheet Part 2).

Large-group discussion (13 min): Report solutions and planned changes.

Individual action planning (5 min): Document one concrete change to implement (Worksheet 3).

Wrap-up/evaluation (5 min): Summarize takeaways and assess learning.

Scientific Citations

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Title

Developing Faculty Facilitators for Psychiatry Didactics

Primary Category

Curriculum

Presenters

Omair Abbasi, MD, Memorial Regional Hospital, Shirley Alleyne, MBBS, Lakeland Regional Health Program, Rebecca Lundquist, MD, TriHealth GME (Non-accredited), Julia Triggs, BS, MD, Novant Health New Hanover Regional Medical Center Program

Education objectives

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

1. Explain how faculty facilitation can address curricular gaps when preparation time or topic-specific expertise is limited.

2. Demonstrate questioning, discussion management, and intellectual humility that support active participation and collaborative evidence seeking.

3. Design a didactic session using existing educational content, a clinical application exercise, and an assessment of learning.

4. Develop a feasible faculty development plan that includes observed facilitation practice, feedback, and follow-up.

Abstract

Comprehensive psychiatry didactics can be difficult to sustain when faculty face competing clinical responsibilities or limited expertise in particular topics. Existing educational videos, modules, and shared curricula provide content that faculty can use to guide resident learning. Flipped-classroom approaches create opportunities for application and discussion, although the format alone does not ensure better learning.[3,4] Effective implementation requires faculty development in facilitation, including the ability to acknowledge uncertainty while maintaining educational rigor.

This 90-minute interactive workshop will prepare psychiatry educators to facilitate learning with existing content. Participants will identify curricular gaps and examine assumptions about the faculty role, including the expectation that educators must have an immediate answer to every question. Presenters will demonstrate intellectual humility through statements such as “I do not know; let us identify what evidence would help us answer that question,” followed by a structured search and appraisal of relevant evidence.[5]



Participants will practice establishing psychologically safe discussion norms, using open-ended questions and wait time, inviting quieter learners, redirecting dominant voices, eliciting clinical reasoning, and correcting misconceptions without humiliation.[6,7] Faculty will retain responsibility for reviewing materials, clarifying learning objectives, checking conclusions, and seeking additional expertise when needed.

In small groups, participants will complete a “tomorrow’s didactics” exercise using a supplied resource and clinical case. Each group will develop a brief session that includes preparation or a short shared viewing segment, guided discussion, real-time investigation of an unanswered question, and application to patient care. Participants will rotate through facilitator, learner, and observer roles, receiving feedback using a behavioral checklist. Groups will also consider how a discrepancy between reviewed evidence and local practice could generate a quality improvement question, a proposed intervention, and a measurable outcome.

A practical resource discussion will address selection of credible, current materials; adaptation to resident level; preparation expectations; and options when learners have not completed assigned content. Participants will outline a local faculty development plan incorporating rehearsal, peer observation, feedback, and follow-up.

Participants will leave with a draft facilitated teaching session, a checklist for observing facilitation, and a plan for developing faculty at their institutions. Proposed evaluation will include observed facilitation behaviors, participant confidence before and after the workshop, and subsequent use of the model. These are intended outcomes; no workshop effectiveness data are reported.

Practice Gap

Psychiatry residency programs in rural, underserved, and resource-limited settings may struggle to provide comprehensive didactics when faculty time or topic-specific expertise is limited. Existing videos, modules, and shared curricula offer opportunities to expand access to educational content.[1,2] Flipped-classroom approaches pair independent preparation with guided application, but their implementation requires deliberate instructional design and a change in faculty roles.[3,4] Faculty accustomed to delivering lectures may need preparation to facilitate inquiry, manage group dynamics, and connect unfamiliar material to clinical practice. Intellectual humility and psychological safety provide foundations for acknowledging uncertainty, inviting questions, and learning collaboratively [5,6]. This workshop addresses the faculty development needed to turn existing content into structured, participatory learning. Participants will practice facilitating discussion, role modeling evidence seeking, and guiding residents from knowledge acquisition toward clinical application and identification of local opportunities for quality improvement.

Agenda

10 minutes: Introduce the educational rationale for shifting from content delivery to facilitated learning.

10 minutes: Small groups identify curricular gaps and barriers to faculty participation in didactics.



15 minutes: Demonstrate core facilitation skills—including intellectual humility, collaborative evidence seeking, and eliciting learner discussion—and introduce resources for facilitated-learning session including a brief skit/video to illustrate implementation of these approaches.

30 minutes: “Tomorrow’s Didactics” interactive exercise: participants use supplied educational content and a clinical case to practice facilitated learning. Participants rotate through facilitator, learner, and observer roles, then provide structured feedback using the demonstrated techniques and resources.

10 minutes: Review a faculty-development and implementation plan, including selection of resources. Participants will be provided with a resource repository for ready-made, nationally available material that can easily be utilized with facilitation.

10 minutes: Participant groups will discuss the model and its application to a local clinical or educational gap and feasibility.

5 minutes: Share reflections, identify key takeaways, and complete the session evaluation.

Scientific Citations

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Title

Graduate Medical Education Funding

Primary Category

Program Administration and Leadership

Presenters

Jed Magen, DO, MS, Michigan State University, Bryan Bolen, DO, Michigan State University, Sarah Mohiuddin, MD, University of Michigan, Emily Schnurr, DO, Michigan State University, Krystle Graham, DO, Gateway Behavioral Health CSB

Education objectives

1) Program leadership will be able to determine the direct and indirect Medicare GME funding for their institution 2) Program leadership will know how to access information on alternative state and Federal funding mechanisms 3) Program leadership will be able to construct a residency education budget 4) Program leadership will be able to discuss with department or hospital leadership impacts of Medicaid funding cuts on program and department revenues

Abstract

Graduate Medical Education programs rely heavily on Medicare GME funding flowing through hospitals. However, Medicaid cuts will impact some programs directly because Medicaid programs in many states provide some funding for GME and other programs directly or through decreases in clinical revenues and hospital revenue decreases. Departments of Psychiatry are also facing funding cuts for research and from medical school funding. For program leadership to be most effective, they will need to understand these funding mechanisms as they interact with Chairs, DIO's and hospital administrators. Program leadership from an academic medical center, a community based program and an academic program using community institutions will lead this workshop. The following topics will be discussed: 1. the basics of Graduate Medical Education Funding a. direct GME costs/reimbursement b. indirect GME costs/reimbursement c. caps on house staff numbers and years of training d. how decreases in Medicaid payments will affect hospital and department revenues. e. Medicaid as a funder of large state programs that affect GME f. alternative funding mechanisms: Graduate Medical Education Teaching Health Centers, VAMC's and other state funding

Practice Gap

Program directors and other program leadership know very little about how programs are financed. Directors of community-based programs have a particularly difficult time finding resources around program financing. Medicare and in some states, Medicaid contributes to residency program funding but there are other federal funding sources that are generally unknown to program directors. PD's also generally do not understand how

state funding for programs is generated. Changes in health care funding by the federal government, much of which will come on-line after the midterms will impact hospital revenues and will indirectly affect training programs. Other changes mandated by the federal government may result in decreases in clinical revenues. Program Directors do not have a knowledge base nor training in dealing with many of these issues.

Agenda

- Thirty- minute presentation on GME funding basics and Medicaid funding cuts
- Small group discussions based on program type-academic medical center, community based programs. Discussion topics:
    - funding issues
    - how programs are responding to current and projected funding cuts
    - what other information program leadership thinks is needed to manage programs in light of cuts
    - effect of clinical funding decreases
- Group report out.
- Web based questions to assess understanding of concepts from workshop

Scientific Citations

1. Changes to Medicaid, the ACA and other key provisions of the One Big Beautiful Bill Act Updated Sep 18, 2026

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Title

Lights, Camera, Reflect, Humanity! Film as an Educator of Psychiatry and Cultural Understanding

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Consuelo Cagande, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Jamie Hom, MD, Children's Hospital of Philadelphia, Francis Lu, MD, University of California, Davis, Brittany Milo, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education objectives

1. Recognize the unique pedagogical value of film in humanizing psychopathology, fostering cultural understanding, and cultivating empathic clinical reasoning.

2. Critically analyze cinematic portrayals of mental illness and cultural experiences, distinguishing accurate representations from those that are stigmatizing or under-represented, and apply this analysis as a structured learning activity.

3. Design a film-based educational session incorporating selected film clips, and discussion prompts addressing psychopathology, cultural formulation, and reflective narrative.

Abstract

What does it truly mean to lead generatively in psychiatric education? How do we cultivate learning environments that honor the full humanity of both trainees and patients, where creativity is central and a harmonious balance between scientific rigor and thoughtful reflection defines educational excellence? This workshop proposes that utilizing film as a pedagogically innovated tool taps into a deeper educational experience.

Erikson defined generativity as the fundamental human drive to establish and guide the next generation, investing in one's wisdom and care. For seasoned psychiatric educators, this is a lived professional calling, expressed through mentorship and shaping training cultures that produce not only competent but also whole, reflective, and humane clinicians. This workshop will demonstrate that a film-based curriculum is a powerful tool for transmitting knowledge and cultivating new understanding, generating clinical insight that is simultaneously intellectual, emotional, moral, and cultural.

A systematic review by Yaden et al. (2023) highlights the value of arts and humanities in psychiatry education. Studies on "cinemeducation" further demonstrate its effectiveness: Rueb et al. (2022, 2024) found that learning through reflective thinking, perspective-taking, and emotional narratives is enhanced by film. Arkan and

Bostanlı (2024) showed that film-based instruction generated deeper empathic engagement, richer critical thinking, and more meaningful connections to complex clinical material than traditional methods. Additionally, Trinh et al. (2021) on cultural humility and Bala et al. (2026) on trauma-informed care, collectively suggest that creative, humanities-centered pedagogy produces clinical understanding that science alone cannot provide.

The workshop will focus on three domains: 1) Psychopathology Through a Human Lens: Film serves as a vehicle for teaching psychiatric diagnosis and psychopathology in ways that preserve the humanity of those who suffer. Cinematic portrayals offer an experiential encounter with illness and viewers will critically analyze misrepresentation or stigmatizing cinematic portrayals. 2) Cultural Psychiatry and the Harmony of Many Stories: Using specific film clips of Asian culture themes, participants will engage in discussing cultural aspects of harmonizing diverse human stories. International and non-Western cinema opens windows into varied illness experiences, explanatory models, and healing traditions, which is clinically essential for cultural formulations and cross-cultural care. 3) Reflective Practice: Drawing on film as a mirror for professional self-examination, this domain explores how cinematic depictions of therapeutic relationships, countertransference, burnout, and ethical complexities catalyze trainee reflection. Film-based reflection groups foster deeper professional formation, embodying the educator's gift of developmental maturity passed forward.

Film creates the conditions—the meeting of story and science, the encounter with human suffering, the generative space between what we see on screen and what we carry into the clinic—enabling us to empower the next generation of psychiatrists with not only what they need to know, but what they need to be.

Attendees will view selected film clips of Asian culture as anchors for facilitated small-group discussion, reflection, and skills in formulating film-based questions. Participants will gain practical resources, including an annotated film list, session design frameworks and discussion guides.

Practice Gap

Psychiatric training programs rely heavily on didactic and case-based instruction, leaving significant gaps in trainees' empathic understanding of psychopathology and cultural psychiatry. Despite growing evidence supporting humanities-based pedagogy, film remains largely absent from formal psychiatric curricula. Most educators lack experience, pedagogical framework and curated resources to implement film-based teaching effectively. This gap is particularly consequential in cultural psychiatry, where trainees frequently report feeling underprepared to engage patients whose illness experiences and explanatory models differ from those represented in standard training materials. Bridging this gap requires innovative and creative educational approaches that harmonize scientific rigor with deep human understanding.



Agenda

90-minute interactive workshop with film clip viewing, small then large-group discussion, wrap up and QA.

- 0 – 10 mins: Welcome, Introduction, Pre-survey
- 11 – 25 mins: First Film Clip – KPOP Demon Hunters (Identity vs Role Confusion - Adolescent stage theme), Small[HJ1.1][CC1.2] Group Discussion
- 26 – 45 mins: Second Film Clip – Joy Luck Club (Intimacy vs Isolation - Adult[CC2.1] stage theme), Small Group Discussion
- 46 – 70 mins: Third Film Clip[CC3.1] - Ikiru (Integrity vs Despair - Later-life stage theme), Individual Skill on Formulating/Designing own Film Discussion Questions based on the clip, Pair and Share
- 71 - 75 mins: Discussion
- 76 - 88 mins: QA
- 88 - 90 mins: Session Survey

Scientific Citations

1. Trinh NH, Jahan AB, Chen JA. Moving from Cultural Competence to Cultural Humility in Psychiatric Education. Psychiatr Clin North Am. 2021 Jun;44(2):149-157. doi: 10.1016/j.psc.2020.12.002. Epub 2021 Apr 29. PMID: 34049639.

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Title

Promoting Disability Inclusion and Implementing Effective Accommodations Through an Expanded Conceptual Framework of the Learning Environment

Primary Category

Program Administration and Leadership

Presenters

Andrew Halls, MD, University of California, San Francisco, Erick Hung, MD, University of California, San Francisco, William Smith, MD, University of California, San Francisco, Edwin Joseph Klein, BS, MD, MPH, University of California, San Francisco, Kewchang Lee, MD, University of California, San Francisco

Education objectives

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

1. Identify barriers to equal access experienced by residents and fellows with disabilities.

2. Implement effective disability inclusion interventions and accommodations across graduate medical education settings including: during the transition to residency, across clinical placements, and in anticipation of certification exams.

3. Apply an expanded conceptual framework of the learning environment to foster an institutional culture of disability inclusion, advance equitable communication strategies, shape community norms, and promote social acceptance of disability.

Abstract

Navigating the needs of a growing number of residents and fellows with disabilities must be a priority to ensure a diverse and culturally adept physician workforce. Studies show that while 27% of Americans report a disability, only 3.1% of physicians identify as having a disability. While data suggests trainee self-reporting of disability status has increased over time, barriers to disclosure and accessing accommodations still persist, with 50.6% of first-year residents who reported a need for accommodation electing not to request them. In

fulfilling their obligations to the Americans with Disabilities Act, medical schools and residency training programs are required to implement policies and procedures to help support their trainees. Even so, trainees with disabilities continue to experience barriers to equal access to opportunities, perceive the learning environment less favorably than their non-disabled peers, and commonly face

mistreatment, bias, and discrimination.



Medical schools and residency training programs have many opportunities to exceed their legal responsibilities to improve disability inclusion and access, such as expanding and prioritizing resources, clearly communicating accommodation procedures, mediating privacy concerns, supporting intersectional identities, maximizing psychologically safe learning environments, orienting institutional values, implementing reporting systems, and addressing structural concerns to dismantle a culture of ableism. Through several real-world case vignettes, participants in this workshop will identify and address gaps in supporting trainees with disabilities through changes to both the material components (physical and virtual) and the psychosocial components (personal, social, organization, and societal) of learning environments.

Practice Gap

Residency and fellowship training programs have many opportunities to exceed their legal responsibilities to improve disability inclusion and access, such as expanding and prioritizing resources, clearly communicating accommodation procedures, mediating privacy concerns, supporting intersectional identities, maximizing psychologically safe learning environments, orienting institutional values, implementing reporting systems, and addressing structural concerns to dismantle a culture of ableism. Applying an expanded conceptual framework of the learning environment will help training directors see beyond the material dimensions of the learning environment (i.e., physical and virtual elements) to include psychosocial dimensions (i.e., personal, social, societal, and organizational elements.)

Agenda

Welcome and Presenter Introductions (5min)

Introductory Didactic (15min)

Participants will be introduced to current trends and future threats to disability inclusion. A brief overview of legal obligations of programs to accommodate trainees with disability will be provided. A expanded conceptual framework of disability inclusion in the learning environment will be outlined.

Introductory Case (10min)

A simple case vignette involving a resident requesting extended leave will be discussed in pairs, with brief report back.

Complex Case (20min)

A case vignette involving a resident requesting assistive devices and changes to clinical workflows on an inpatient service will be discussed, followed by report back to the large group.

Complex Case (20min)

A case vignette involving a resident who is requesting exceptions from taking 24-hour shifts or night float will be discussed, followed by report back to the large group.



Conclusion and Q&A - 15 minutes

Evaluation Forms - 5 minutes

Scientific Citations

1. Meeks LM, Plegue M, Swenor BK, Moreland CJ, Jain S, Grabowski CJ, Westervelt M, Case B, Eidtson WH, Patwari R, Angoff NR, LeConche J, Temple BM, Poullos P, Sanchez-Guzman M, Coates C, Low C, Henderson MC, Purkiss J, Kim MH. The Performance and Trajectory of Medical Students With Disabilities: Results From the Pathways Project. Acad Med. 2021 Nov 1;96(11S):S209-S210.

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Title

Rethinking Recommendations: The Psychiatry SLOR

Primary Category

Recruitment and Selection

Presenters

Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa, Lia Thomas, MD, UT Southwestern Medical Center, Daniel Gih, BS, MD, University of Nebraska Medical Center College of Medicine, James Haliburton, EdD, MD, Southern Illinois University School of Medicine

Education objectives

At the end of this workshop participants will be able to:

1) Assess how traditional LORs may contain significant bias and how the Psychiatry SLOR attempts to address this;

2) Evaluate how to effectively utilize SLORs in the residency selection process;

3) Contribute to plans for next steps with the SLOR to meet our specialty's needs and consider when and how to transition to a Standardized Letter of Evaluation (SLOE).

Abstract

Each year, medical students request that psychiatry faculty attest to their clinical skills, work ethic, and character in the form of a residency application letter of recommendation. Traditional letters of recommendation have been shown to include both gender and racial bias; such language discrepancies between applicants, including those from underrepresented in medicine (URM) groups, perpetuate disparities in medicine. Additionally, with the transition of Step 1 to pass/fail and many medical schools using similar binary structures for preclinical and clerkship grading, program directors may now have fewer variables with which to assess candidate qualifications. Many specialties have transitioned to the use of Standardized Letters of Recommendation (SLOR) or Evaluation (SLOE) to improve recruitment processes.

The Association of Directors of Medical Student Education in Psychiatry (ADMSEP), with input from members of AADPRT, created a Psychiatry-specific SLOR template to provide a more informative, uniform, equitable, and less biased tool program directors can use to assess applicants. It was piloted in the 2024 Match and an updated template was utilized in the 2025 and 2026 Match cycles after feedback from stakeholders (applicants, letter writers, and letter readers).

The Physician's Coalition for Accountability recommended that Structured Evaluative Letters should replace all traditional LORs as a universal tool in the residency program application process, and the vast majority of

specialties now utilize either a SLOR or a SLOE. It is no longer a question of “if” but now a question of “how” do we make this process work for our diverse Psychiatric residencies across the country. Psychiatry SLORs are optimally poised to provide necessary information to program directors and will be more effective with more applicants and programs utilizing them.

In this workshop, participants will become familiar with the latest psychiatry residency SLOR template, as contrasted to both a traditional LOR and a potential future SLOE. Through small and large group discussions, participants will reflect on the utility of each of these formats, as well as contribute to recommendations for future iterations of these tools.

Practice Gap

In the ever-changing healthcare landscape, the goal of the Standardized Letter of Recommendation (SLOR) is to highlight characteristics and qualities of applicants in order to best shape the future of our field. While still allowing for individualization, compared to a traditional, narrative letter of recommendation, the SLOR can reduce bias and enhance the ability to directly compare applicants. AADPRT members contributed to the creation of the Psychiatry SLOR through survey completion in 2023; however, many are not up to date on the latest format or how to direct applicants to use it, resulting in slow uptake of the SLOR in our specialty. The SLOR is assessed annually and updated based on feedback from the Psychiatric community, particularly AADPRT members. This workshop is designed to provide necessary education about the SLOR, to both letter writers and letter readers, and recommendations for use in future recruitment cycles.

Agenda

- 5min: introduction, poll
- 5min: small group review of traditional LORs and identifying bias/impact
- 5min: large group discussion
- 15min: overview of SLOR
- 15min: small group review of example SLORs
- 5min: large group discussion
- 5min: moving toward SLOE
- 15min: small group discuss/debate SLOR/SLOE and next strategies
- 5min: large group discussion
- 15min: Q&A, wrap-up, evaluation

Scientific Citations

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Title

Teaching AI in Psychiatry Residency: A Workshop for Creating Effective AI Curriculum

Primary Category

Curriculum

Presenters

Mary Burris, MD, University of Utah School of Medicine, Denise Baughn, MD, University of Texas Medical Branch, Galveston, Bini Moorthy, MD, University of Missouri-Kansas City School of Medicine, Hiren Umrania, MD, Cone Health Program, Zehra Aftab, MD, University of Chicago

Education objectives

1. Identify key resources for faculty to learn basic AI foundation
2. Identify core concepts in AI education
3. Apply evidence-based teaching strategies to AI instruction
4. Design a resident level AI teaching session

Abstract

Artificial intelligence (AI) is rapidly transforming clinical practice and medical education, making AI literacy an essential component of residency training.The AAMC reports that the proportion of U.S. and Canadian medical schools incorporating AI into their curricula increased from 53% in 2023 to 77% in 2024, while simultaneously noting the need for competencies spanning foundational AI knowledge, evaluation, ethics, and practical use [1]. A recent scoping review similarly identified substantial variation in existing AI education and highlighted gaps in clinical relevance, practical application, defined competencies, and availability of qualified instructors.[2] The WHO emphasizes that responsible implementation of AI in health care requires attention to safety, ethics, equity, governance, and human oversight [3].

Psychiatry residents, and teaching faculty, have diverse backgrounds and prior experience with technologies, including AI. AI platforms for searching medical literature, generative technologies for clinical care, patient use of AI avatars or therapists, and AI scribes remain vital topics of education. AI education should be competency-based, relevant, and integrated into the curriculum.

Resident competencies should include the ability to: (1) explain fundamental AI concepts; (2) identify appropriate and inappropriate applications of AI in psychiatric practice; (3) Evaluate AI output for accuracy, reliability, and clinical relevance; (4) use AI responsibly for literature synthesis, patient education, documentation support, and educational activities; (5) recognize ethical, legal and professional implications; and (6) communicate effectively with patients and teams regarding AI-assisted care. These competencies are

consistent with established clinical AI competency frameworks emphasizing foundational knowledge, ethics, AI tool evaluation, AI-enhanced clinical encounters, workflow adaptation, and lifelong learning [4].

Assessment should be multimodal and performance-based, not limited to knowledge tests. Program directors can use pre/post-test questions to assess foundational knowledge; case-based exercises to evaluate critical appraisal of AI outputs; and simulation encounters to assess safe clinical application. A longitudinal portfolio could include an AI-assisted literature appraisal, reflective exercise, or resident-designed AI teaching product. AAMC recommends combining knowledge and performance-based assessments using standardized rubrics and realistic clinical scenarios [5].

Program Directors should focus on establishing clear policies for appropriate AI use, protecting patient and learner data, mapping AI competencies to the existing curriculum and ACGME competencies, faculty development on AI in education, and periodically evaluating the effectiveness and safety of AI tools. Faculty development can include AAMC educator resources, WHO guidance, interdisciplinary workshops with AI experts, hands-on practice, and ongoing updates[1, 6].

This interactive workshop aims to address the gap of structured didactic learning in AI for psychiatry GME. Participants will be introduced to the landscape of residency AI competencies. They will be refreshed on some core components of adult learning techniques to help guide the development of AI didactics. The presenters will provide a sample mini-lecture on an AI topic before allowing small groups to workshop ways to design high-yield, interactive and engaging AI mini-lectures on assigned AI competencies. Through this workshop, we aim to provide faculty with the knowledge and skills to curate an AI curriculum for their residency program.

Practice Gap

Artificial intelligence (AI) is rapidly becoming part of clinical care, medical education, and physicians' everyday workflows, yet many psychiatry residency programs lack a structured approach for preparing residents to use these technologies safely, effectively, and responsibly. Although national medical education efforts increasingly identify AI literacy as an emerging competency, implementation within graduate medical education remains inconsistent. Both the AAMC and the WHO have emphasized the need for responsible training and implementation of AI in health care. Thus, program directors need practical strategies for translating broad AI principles into a developmentally appropriate residency curriculum that combines foundational concepts with hands-on skills, specialty-specific applications, critical appraisal, and responsible-use practices. This workshop addresses that practice gap by providing program directors with a framework to identify essential AI concepts, define observable learning objectives, apply evidence-based teaching strategies to AI instruction, and design a resident level AI didactic.

Agenda

- Introduction/Objectives (5 min)



- Survey (5 min): Audience poll on presence and/or absence of AI curriculum, with interpretation and discussion.
- Background of AI (10 min): Review the practice gap and show AI resources by QR code
- Overview of AI Concepts (10 min): Presenters share information on AI concepts.
- Overview of adult learning techniques (5min): Presenters will provide examples of adult learning.
- Example of mini lecture (10min): Presenters will provide outline for the creation of an AI mini lecture. The presenters will review a handout that gives an outline for an AI didactic.
- Small Group Activity (20 min): Presenters will assign AI topics to small groups. Small groups will use the handout to create mini lectures.
- Small Group Reports (15 min): Small groups share with moderation from presenters.
- Summary of Best Practices (5 min): Presenters will summarize key points and review best practices.
- Close and Evaluation (5 min): Attendees will complete the program evaluation.

Scientific Citations

1. Association of American Medical Colleges. (n.d.). Artificial intelligence competencies across the learning continuum. AAMC.

2. Ma, Y., Song, Y., Balch, J. A., et al. (2024). Promoting AI competencies for medical students: A scoping review on frameworks, programs, and tools.

3. World Health Organization. (2024). Artificial intelligence for health.

4. Competencies for the use of artificial intelligence-based tools by health care professionals. (n.d.). PubMed.

5. Association of American Medical Colleges. (n.d.). Principles for the responsible use of artificial intelligence in and for medical education.

6. World Health Organization. (2024). Ethics and governance of artificial intelligence for health: Large multi-modal models.

7. American Medical Association. (2025). AI in medical education.

8. Bhalodi, R. G., et al. (2025). The need for artificial intelligence literacy in psychiatry residency training. Academic Psychiatry, 49(1), 48–49.

Title

“What Actually Helps?”: Psychotherapy Supervision Best Practices from the Trainee Perspective

Primary Category

Teaching, Supervision, Pedagogy

Presenters

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Education objectives

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

1. Identify supervisory behaviors that help psychiatry trainees develop psychotherapy competences.

2. Apply trainee-derived principles to common psychotherapy supervision situations, including case formulation, review of clinical material, feedback, assisting supervisees in distress, and discussion of the therapeutic relationship.

3. Describe supervisory and program-level strategies that reduce trainee anxiety about psychotherapy and support graduated autonomy.

4. Identify systems-level approaches that can help programs consistently offer high-quality psychotherapy supervision across trainees, supervisors, and training settings.

Abstract

Psychotherapy supervision is a central component of psychiatry residency training, yet quality and structure can vary substantially. Trainees may receive supervision that is thoughtful and supportive but difficult to translate into clinical action; alternatively, they may receive highly specific feedback that does not create sufficient space for reflection and development. These challenges can be particularly salient for residents who are anxious about “doing therapy wrong,” harming a patient, losing control of a session, or being uncertain about the direction of the session. For residency program directors, the challenge extends beyond individual supervision: How can programs create conditions in which consistently effective psychotherapy supervision is more likely to occur?

This interactive workshop takes a deliberately trainee-centered approach to these questions by treating trainees as key informants about psychotherapy supervision. The panel will include two supervisor-supervisee pairs and a senior/expert psychotherapy supervisor. A current trainee and a recent graduate will share concrete



experiences of supervision that facilitated or hindered their development, highlighting specific supervisory behaviors and relational processes that shaped their learning. Their former supervisors will then respond to these reflections, offering perspectives on supervisory intentions, challenges, and opportunities for growth. The senior/expert psychotherapy supervisor will synthesize these perspectives and facilitate discussion of practical applications. The workshop will also utilize video footage of effective supervisor-supervisee interactions and guided small group discussion to help participants identify supervisory practices that promote trainee learning, reflection, confidence, and clinical growth.

The workshop will then shift from individual supervision to program design. Participants will work in small groups to translate trainee-derived principles into practical strategies for their own settings. Groups will consider how to support supervisors in implementing effective practices, how to orient trainees to making effective use of supervision, and how residency programs can create structures that promote consistency across supervisors and training sites. Program directors will identify opportunities for supervisor development, curriculum design, and quality improvement, with particular attention to their role in shaping the supervisory environment and developing specific action steps to implement after the workshop.

Practice Gap

Psychotherapy supervision is one of the primary ways psychiatry residents develop psychotherapy competencies, yet there is considerable variability in how it is structured and delivered. Supervisors may have extensive expertise as psychotherapists without having received formal preparation in how to teach and supervise psychotherapy. At the same time, program directors may have limited direct access to the supervisory encounter and the trainee's experience of it. Furthermore, feedback sessions may have limited utility due to structural incentives for incomplete or dishonest reporting which can impair efforts to improve psychotherapy supervision.

Research on psychotherapy training suggests that trainees' perceptions of their educational experiences are an important source of information about the strengths and limitations of training. Yet trainee feedback about supervision is often reduced to broad measures of satisfaction instead of identifying specific supervisory behaviors that facilitate learning.

Agenda

- Opening: "The Most Important Supervision You've Had" (10 min)
    - Participants reflect on a meaningful supervisory encounter and discuss behaviors that made it effective.
- The Trainee Voice: "What Actually Helped" (30 min)
    - Early-career panelists each spend ten minutes sharing formative supervisory experiences, highlighting specific supervisory behaviors and relational processes that supported learning. Former supervisors reflect on these interactions, discussing supervisory intentions, challenges, and opportunities for growth.



- Story to Supervisory Practice (15 min)
    - Small groups identify specific supervisory best practices illustrated by the panel, followed by brief large-group discussion.
- Supervisory Practice to Training Program (20 min)
    - Small groups develop practical strategies to strengthen supervision in their home programs through supervisor development and psychological safety initiatives. This is followed by a facilitated large-group discussion for participants to share their program-specific action plans, identify potential barriers to implementation, and collaboratively generate possible solutions.
- Q&A and Workshop Evaluation (15 min)

Scientific Citations

1. Falender, C., & Shafranske, E. P. (2023). Revisiting Competence in Clinical Supervision. The International Journal of Supervision in Psychotherapy, 5, 7-20. https://doi.org/10.47409/ijsp.2023.5.4

2. Paunov, T., Weck, F., & Kühne, F. (2026). “Now we can think about it together” – A thematic analysis of what characterizes (in)effective supervision sessions for novice CBT supervisees. Psychotherapy Research, 36(7), 1264–1276. https://doi.org/10.1080/10503307.2025.2569042

3. Axelsson, S., Kihlberg, S., Davis, P., & Nyström, M. B. T. (2024). Psychotherapy students' experiences of supervisee-centered supervision based on deliberate practice, feedback-informed treatment and self-compassion. Counselling and Psychotherapy Research, 24, 719–733. https://doi.org/10.1002/capr.12708

4. Vaštakė, M., Kaluževičiūtė, G., Skruibis, P., & Grigutytė, N. (2026). Issues in identifying effectiveness factors in psychotherapy supervision: the current state of affairs. British Journal of Guidance & Counselling, 1–12. https://doi.org/10.1080/03069885.2026.2656770

5. Markowitz, J. C., Welton, R., Franklin, C., Ozdoba, A., & Ruble, A. (2026). “Unsafe” Psychotherapy Supervision. American Journal of Psychotherapy, 79(2), 78-83. https://doi.org/10.1176/appi.psychotherapy.20250002