Workshop Session #1

Title
Empowering Trainees: Navigating Gender-Affirming Care in Resident & Fellow Training Programs in Texas

Primary Category
Curriculum

Presenters
Eric Shute, MD, UT Southwestern Medical Center
Kari Whatley, MD, University of Texas Austin Dell Medical School
Lindsey Pershern, MD, Baylor College of Medicine
Sasha Jaquez, PhD, University of Texas Austin Dell Medical School
Kathlene Trello-Rishel, MD, UT Southwestern Medical Center

Educational Objectives
By the end of the session, participants will be able to:
1) Describe how state level legislation can impact education and training of gender-affirming care for children and adolescents
2) Recognize the impact of legal changes and policy on psychiatry training community members including trainees and faculty.
3) Develop a framework for meeting resident/trainee and faculty needs in response to laws that affect medical practice.

Abstract
Recent laws and judicial rulings in many states have restricted access to gender-affirming healthcare for youth. These changes in the legal landscape of medicine have impacted medical education in these states. Medical trainees in these states are no longer able to directly rotate in clinics providing specific types of gender affirming care, and the need for medical schools and residency/training programs to provide education on treating transgender patients is imperative. Medical education interventions around transgender health care are a recognized priority to alleviate health inequities faced by transgender individuals.1 Physicians who lack adequate training and awareness in gender-affirming care results in lower satisfaction with care and adverse healthcare experiences for transgender patients. (2,3) Trickle down effects of lack of provider knowledge and sensitivity result in transgender patients being less likely to seek medical care or complete recommended preventative screenings that can result in severe life threatening consequences for transgender patients. (3,4)

Due to the new legislation, programs may be unsure of how to create a curriculum that includes education about gender dysphoria and gender diverse patients. Other barriers to training implementation include lack of educational materials, lack of experienced staff or (simulation) staff with transgender lived experience, lack of ties to the local LGBTQ+ community, and time and costs constraints. (6) However, research advocates for equipping medical students and residents/trainees with knowledge and skills to provide culturally competent care. (5,7)

It is important for residents and trainees to be aware of the laws in their state and how they impact their patients and parents. Residents and trainees should be prepared to validate emotional reactions and support parental figures and patient coping strategies in relation to the impact of these laws. (8) Programs should also be aware of the need to provide support for residents as they learn and navigate the impact of new laws. Current trainees may grapple with the implications of pursuing training in a region in which these laws are in place and the need for advocacy and support for transgender youth in these areas.

In this workshop, we will explore the implications of state laws restricting access to gender-affirming healthcare for transgender youth on psychiatry training programs and work to develop a framework for meeting resident and faculty needs in response to these new laws. We will discuss the importance of providing a curriculum on transgender care. We propose that several interventions are available to training directors, including opportunities for residents to discuss concerns with faculty, resident led process groups, faculty led process groups, and individual psychotherapy supervision. In this workshop we will consider the risks and benefits of each intervention type in different scenarios.

Practice Gap

New legislation and judicial rulings at the state and local level can impact the legal landscape of practicing medicine and may limit exposure to important areas of practice for trainees. For example, several states have passed laws prohibiting some aspects of gender affirming care for youth. This has raised concerns in training programs in states with these laws about how to educate residents and provide care to youth who are struggling with gender dysphoria. These laws have also resulted in difficulty with recruitment to training programs in these states as potential applicants may feel they would miss out on equitable training in these areas. Curriculum development to provide equitable education for trainees in jurisdictions with these laws is untouched by the literature, and an opportunity for program leadership to create interventions that may be helpful to support residents during this time.

Agenda

Introduction. (10 minutes): Background on recent changes in law; brief discussion of how this is being handled from the viewpoint of individuals, as a community, as a team, and as physicians.

Small group discussion 1: (20 minutes): Small groups will discuss vignettes with discussion questions highlighting various situations with legislation changes during residency, including reflecting on how individuals may be responding to these and what interventions may be helpful in facilitating support and growth for residents.

Large group discussion / polling. (20 minutes) Small groups will report back to a larger group discussion.

Didactic (10 min) Ideas on implementing training in Gender affirming care

Small group discussion 2: (15 min) participants utilize ideas presented to develop an education plan for their program

Large group (15 min) Small groups will report back to larger group to share ideas on education plans. Time for completion of workshop evaluation.

Scientific Citations

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7. Jecke, L., Zepf, F.D. Delivering transgender-specific knowledge and skills into health and allied health studies and training: a systematic review. Eur Child Adolesc Psychiatry 33, 1327–1354 (2024). https://doi.org/10.1007/s00787-023-02195-8

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Title
CANCELLED - Facilitate the Shift: Crafting Inclusive Spaces through Facilitation Excellence

Primary Category
Faculty Development

Presenters
Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa
JCorey Williams, MA, MD, Georgetown University Medical Center
Kaosoluchi Enendu, MBA, MD, Yale University School of Medicine

Educational Objectives
By the end of this session, participants will be able to:
1. Recognize the unique training needs of educators leading discussions focused on anti-racism and social justice topics.
2. Describe strategies to practice solidarity with marginalized and historically oppressed identities within group discussions.
3. Establish community agreements that guide group discussions, and respond to direct violations of the community agreements.

Abstract
Recent curriculum reform efforts in undergraduate and graduate medical education have led training programs to incorporate more anti-racism-related content into curricular programming. However, medical trainees (and faculty), even within the same cohort, exhibit significantly different levels of competency – ranging from beginner to advanced – when it comes to anti-racism and social justice-related learning. These learning gaps often lead to difficult conversations around these topics, resulting in learners and colleagues exhibiting a range of responses (e.g., defensiveness, anger, disengagement, etc.), especially among multi-racial teams. Psychiatric educators are not immune to these problems themselves and would benefit from additional, specific skills to successfully facilitate difficult conversations around emotionally laden topics – such as racism, sexism, homophobia, etc. These improved facilitation skills can lead to more inclusive learning sessions, stronger relationships with trainees, and higher-performing clinical teams. We have developed a facilitators' course for program directors and other faculty educators who are interested in enhancing their discussion facilitation skills around anti-racism topics. In this workshop, we will deliver a condensed version of the course, focusing on the most critical components, emphasizing strategies that involve practicing solidarity with learners from marginalized backgrounds. The workshop format will integrate direct instruction of best practices for navigating difficult conversations surrounding race and

other social identities. The format will include modeling or direct instruction, practice and discussion in small groups, and whole-group Socratic reflection.

Practice Gap

Since 2020, many training directors have strived to integrate more anti-racism and social justice-related content within their curriculum. These topics tend to reveal significant differences in trainees' lived experience, knowledge, skills, and attitudes, which in turn, can lead to emotionally-charged and potentially harmful discussions. Program directors and instructors need specific facilitation skills to navigate such learning gaps and discussions. With effective facilitation, anti-racism discussion can deepen connections, improve the learning environment, and serve as anti-bias interventions by enhancing trainees' ability to empathize with patients.

Agenda

10min - introduction
10min - didactic content
10min - large group demonstration of community agreements
10min - small group role play and reflection on vignette
10min - large group discussion
10min - small group role play and reflection on vignette
10min - large group discussion
10min - small group role play and reflection on vignette
10min - large group discussion and Q&A

Scientific Citations

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Aysola, J, and Thomas, R. (2020). Starting the Conversation about Race and Racism: Talking Points and Guidance. Penn Medicine Center for Health Equity Advancement.

McGowan, B. L., Jones, C. T., Boyce, A. S., & Watkins, S. E. (2021). Black faculty facilitating difficult dialogues in the college classroom: A cross-disciplinary response to racism and racial violence. The Urban Review, 53(5), 881-903.

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Title
From Policy to Practice: Educating & Leading Through ACGME Leave Policy Changes

Primary Category
Program Administration and Leadership

Presenters
Lauren Kaczka-Weiss, DO, Hackensack Meridian Health- Jersey Shore University Medical Center
Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Senada Bajmakovic-Kacila, MD, Rush University Medical Center Program
Bushra Shah, MBBS, Virginia Commonwealth University Health System Program
Erica Coffman, MD, Hackensack Meridian Health- Jersey Shore University Medical Center

Educational Objectives
1. Familiarize psychiatry program leadership with the ACGME parental, family, and medical leave policy.
2. Recognize the implications of ACGME leave policy on the training requirements for general psychiatry and subspecialty fellowship programs.
3. Based on the scenarios discussed in the workshop, create or modify your program's execution of the ACGME leave policy.

Abstract
Stakeholders at the American Board of Medical Specialties (ABMS) and other accrediting agencies have advocated for trainees' well-being, recognizing the importance of taking time off from training to fulfill parental responsibilities or for medical reasons. ABMS announced that as of June 2021, member boards must allow a minimum of 6 weeks away from training for parental, caregiving, or medical purposes without exhausting the trainee's vacation or sick leave and without extending training. In 2022, ACGME went a step further and required programs to offer trainees paid six weeks of parental or medical leave from when they start their training. The ABMS policy did not require the time off to be paid, but ACGME requires paid leave for trainees. Training programs across the country have implemented this policy in different ways.

For many trainees considering the use of paid time off, a critical concern is whether their training will be extended. While ABMS recommends that the 6-week time off should not

result in an extension, and ABPN places the responsibility on programs to discuss the impact of the leave with trainees, the final decision rests with the training director and each program's CCC. They are tasked with determining if the trainee who took the leave has met the training requirements to graduate on time.

Whereas general psychiatry residency is four years long, and there is some flexibility to make up lost time in training during electives in PGY4 year, fellowships that are one or two years in length would have a more significant impact from a trainee's absence for six weeks. Navigating the balance between supporting the trainee during a crucial time in their lives of parenthood versus ensuring that all the training requirements are met within 12-24 months of fellowship is a challenge for many training directors. In this workshop, we will review the ACGME and ABPN leave policy requirements for the programs, foster discussion among participants related to the policies and their implementation, learn from scenarios faced by facilitators in implementing this leave policy at their institutions, and allow participants to get clarification on various aspects of this leave policy as it relates to ensuring that trainees meet the graduation requirements for their programs.

Practice Gap

There has been substantial variability in medical and parental leave policies in post-graduate medical education. The 2022 ACGME institutional requirements mandated a minimum paid parental/medical leave for residents to address this. The differences in interpretation of these requirements in psychiatry residency training programs can significantly impact the well-being, professional development, and career satisfaction of trainees, faculty members, and program leadership. There is a need for continued discussion across different institutions about how leave policies are implemented to aid training programs in developing transparent, supportive, and equitable policies within their programs.

Agenda

Agenda:
Minutes 0-5: Welcome, introduction and overview
Minutes 5-10: Review current leave policies from ACGME & ABPN
Minutes 10-20: Small breakout groups for general discussion of how policies impact individual programs
Minutes 20-25: Small group report out
Minutes 25-40: Discussion of scenarios from authors' programs and how they were handled
Minutes 40-50: Individual program analysis (create a handout)

Minutes 50-60: Provide support and resources in small groups
Minutes 60-65: Report out
Minutes 65-80: Large group discussion
Minutes 80-90: Workshop evaluation

Scientific Citations

Accreditation Council for Graduate Medical Education. ACGME Institutional Requirements. Effective July 1, 2022. https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements2022.pdf Accessed on August 30, 2024

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Dillinger R. L. (2022). From Requisite to Right: Assessing and Addressing Paid Maternity Leave in US Psychiatry Residency Programs. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 46(2), 167–171. https://doi.org/10.1007/s40596-021-01523-x

Leandre, F. M., Sudak, D. M., & Ginory, A. (2022). Are Psychiatry Programs Providing Adequate Parental Leave to Their Residents?. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 46(2), 162–166. https://doi.org/10.1007/s40596-021-01558-0

Shankar R. (2022). Paternity Leave: Traversing the Landscape as Trainee and Faculty. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 46(2), 180–181. https://doi.org/10.1007/s40596-021-01448-5

Title
From Pre-Brief to Debrief: Using Simulation in a Changing Educational Environment

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Molly Camp, MD, UT Southwestern Medical Center
Adriane dela Cruz, MD, PhD, UT Southwestern Medical Center
Kathy Niu, MD, UT Southwestern Medical Center
Rachel Beck, MD, UT Southwestern Medical Center

Educational Objectives
1. Describe at least 3 components of an effective simulation exercise in medical education
2. Explain the importance of a pre-briefing session prior to a simulation exercise, and identify elements required for an effective pre-brief.
3. Demonstrate elements of an effective debrief following a simulation exercise
4. Identify resource limitations and potential solutions for the implementation of simulation at your home institution
5. List at least one area where simulation could be implemented in educational systems at your institution

Abstract
An ever changing medical education environment often means that educators have increasing educational mandates with limited resources. This necessitates novelty and resourcefulness in developing educational interventions. Simulation is a powerful tool for medical education that may be underutilized if educators lack resources or skills to implement simulation-based educational activities. In this workshop, we will present the core principles of simulation in medical education, and we will practice these skills using three activities that teach geriatric psychiatry to general psychiatry residents. The presenters will share resources to allow participants to use these specific geriatric and neurocognitive focused activities in their home institutions. However, the main focus of the workshop will be the transferability of skills in simulation, and we will consider how these skills can be used in a broad array of medical settings and specialties.

To lay the foundation for the use of simulation in medical education, we will teach the key components of the pre-brief and debrief. Participants will participate in an interactive improv-based activity that the presenters use to teach about the lived experience of patients with dementia. Participants will be invited through pre-brief and debrief to reflect on their experiences with the activity and consider additional applications. In the second activity, participants will watch a filmed standardized patient interview in which a

trainee has a difficult conversation with a patient with dementia. In small groups, participants will consider how they would approach the debrief with the resident in a constructive way. Lastly, participants will participate in an exercise in which they administer a cognitive screening, and also have the opportunity to practice skills in the pre-brief and debrief. We will then have the opportunity for large group discussion related to how the material in the workshop could be applied to other areas of medicine, what barriers may exist, and what strategies could be used to overcome these barriers.

Practice Gap

Educators must continuously adopt new teaching modalities in an ever-changing teaching environment. Simulation in psychiatry education is considered an underused modality with demonstrated effectiveness in changing learners' knowledge, attitudes, and behaviors. Simulation ensures that learners can practice specific skills in areas where they may have limited spontaneous clinical exposure, including psychiatric subspecialties. While some simulation activities require significant resource and time investment, others can be implemented easily and with little to no funding. Further, the core principles of the pre-brief and debrief, which are critical to the success of any simulation activity, can be readily adapted to other clinical teaching.

In this workshop, we use examples from the presenters' geriatric psychiatry curriculum to teach the core principles of simulation, allow participants time to practice, and provide information about how to incorporate simulation in a variety of training settings.

Agenda

-Introduction (10): We will introduce key concepts related to a pre-brief, in order to invite participants into our first activity.
-Large Group Activity (15): "What Matters Most" – Participants will take part in an interactive improv exercise involving balancing multiple tasks simultaneously, followed by small group debriefing.
-Brief Presentation of Components of Debrief (10): We will introduce the core components of the debrief.
-Small Group Activity (20): The participants will watch a video of a resident completing a standardized patient interview in the simulation center. Participants will discuss an optimal debriefing strategy for the encounter.
-Small Group Activity (20): In groups of 3, participants will participate in a role play and debriefing related to a cognitive screening.
-Large Group Discussion and Q&A (15): Participants will be invited to reflect on their experiences and ask questions.

Scientific Citations

Abulebda K, Auerbach M, Limaiem F. Debriefing Techniques Utilized in Medical Simulation. In: StatPearls. StatPearls Publishing, Treasure Island (FL); 2023. PMID: 31536266.

Durling, P., Henni, J., Mrozowich, D. et al. A Mixed-Methods Realist Analysis of an Interdisciplinary Simulation Intervention for Psychiatry Residents. Acad Psychiatry 46, 95–105 (2022). https://doi.org/10.1007/s40596-021-01524-w

Neale J. What is the evidence for the use of simulation training to teach communication skills in psychiatry? BMJ Ment Health 2019;22:23-25.

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Title
Like, Post, Recruit: Harnessing Social Media for Psychiatry Residency Recruitment

Primary Category
Recruitment and Selection

Presenters
Zhanna Elberg, MD, University at Buffalo
Zheala Qayyum, MD, Children's Hospital Program/Boston, MA
Lauren Lucente, MD, University at Buffalo
Odeyuwa Izekor, MD, University at Buffalo
Vinh-Son Nguyen, MD, Children's Hospital Program/Boston, MA

Educational Objectives
1)List the various residency recruitment tools used in practice while highlighting pre & post COVID 19 pandemic shifts.
2) Evaluate Instagram insights data from two consecutive recruitment cycles to identify trends, engagement patterns, and effectiveness of social media strategies.
3) Discuss the various aspects programs should consider when utilizing social media as a method for recruitment, including best practices and pitfalls.
4) Compare and contrast two case studies of successful social media recruitment models (University at Buffalo & Boston Children's Hospital) while analyzing their strategies, outcomes, and lessons learned.
5) Attendees will develop an action plan for implementing or amending the use of social media for a recruitment cycle in their respective programs.

Abstract
INTRODUCTION:

Social Media has become embedded in most aspects of life, including academia. With the shift of residency interviews from in-person to virtual interviews, many programs started, or strengthened, their social media presence in order for it to be an avenue for candidates to learn about their program. Despite a majority of psychiatry residency programs now having social media accounts, there are no clear guidelines or established best practices.

METHODS:

We reviewed the literature surrounding social media usage as a recruitment tool, as well as the increase in social media usage by both programs and candidates in the post-COVID-19 era. We analyzed two successful models for program representation on instagram, resident-run accounts at University at Buffalo and Boston Children’s, using both Instagram Insights and surveys to current residents at these programs. Several

patterns emerged that lead to our development of a roadmap for programs when using social media for recruitment. This workshop will be delivered using visual aids and engaging activities. Two models of resident-run social media accounts will be presented. Participants will be engaged through real-time polls, small group activities, and small group discussions. Participants will be challenged to construct sample posts and posting timelines for their home programs.

Results

Through this workshop, participants will learn the basics of running a social media account and the different options that exist for social media platforms. Participants will learn tips for increasing the efficacy of their social media accounts. Through practice crafting sample posts and planning content timelines, participants will gain confidence and comfort in using social media to recruit candidates. This workshop will guide participants in taking a more serious look at their program's social media's impact on trainee recruitment efforts and learn to use social media as an effective recruitment tool.

Conclusions

Candidates are increasingly expecting a residency program to have a robust social media presence. This is possibly more important for psychiatry residency candidates, as opposed to other specialties, who are more attuned to the underlying social experience of their education and workplace. It is undeniable the role social media has, and will continue, to play in recruitment. This workshop will help participants develop skills and strategy for social media, helping them recruit more successfully through social media.

Practice Gap

The COVID-19 pandemic significantly altered residency recruitment, shifting from in-person to virtual interviews and challenging programs and candidates to assess mutual "fit" in a single, virtual day. To adapt, many programs began using social media to showcase their culture, with urology programs increasing their social media presence from 26-50% pre-2020 to 51-70% in 2021 (Ho, P., et al. 2021). However, this growth occurred without established guidelines or best practices for social media use as a recruitment tool. As social media's role in recruitment will continue, it is essential for programs to evaluate the effectiveness of their social media strategies. Addressing this practice gap will enable programs to optimize outreach and attract candidates who align with their values and culture.

Agenda

Min 0-10: Team Introductions. Interactive poll to engage the audience.
Min 10-15: Review basics of Instagram.

Min 15-20: Review content topics for posts. Hands-on review examples of posts.
Min 20-35: Small group activity: Each participant will write a caption for a post and share in small groups.
Min 35-40: Review content and optimal times for posting. Explain what candidates are looking for.
Min 40-55: Small group activity: Practice crafting social media posts focused on highlighting strengths of their program. Return to the large group to share.
Min 55-65: Review Privacy Issues and Don'ts of Social Media. Engage participants in interactive activity.
Min 65-80: Break out into groups and create a timeline for posting. Presenters will go around to small groups to answer questions and assist if needed. Small groups will share the timeline they created with the large group.
Min 80-90: Question and discussion.

Scientific Citations

1. Ho, P., Margolin, E., Sebesta, E., Small, A., & Badalato, G. M. (2021). #AUAMatch: The Impact of COVID-19 on Social Media Use in the Urology Residency Match. Urology, 154, 50–56. https://doi.org/10.1016/j.urology.2021.05.019

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10. Tiana S. Woolridge, Cooper Bloyd, Madelynn Taylor et al. The Impact of Social Media Presence on Primary Care Sports Medicine Fellowship Recruitment: A Cross-Sectional Study, 05 July 2024, PREPRINT (Version 1) available at Research Square https://doi.org/10.21203/rs.3.rs-4468497/v1

11. AMA Code of Medical Ethics 2.3.2 Professionalism in the Use of Social Media.https://code-medical-ethics.ama-assn.org/ethics-opinions/professionalism-use-social-med

Title
Looking Back, Looking Forward: Have We Moved the Needle in Training the Competent Integration of Pharmacotherapy and Psychotherapy?

Primary Category
Teaching, Supervision, Pedagogy

Presenters
David Mintz, MD, Austen Riggs Center
Michelle Riba, MD, MS, University of Michigan
Sarah Schreiber, MD, University of California, San Diego

Educational Objectives
At the conclusion of this workshop, participants should be able to:
1) Describe ways in which the practice of integrated psychotherapy and pharmacotherapy is a distinct competency, as proposed in the original 5 psychotherapy competencies defined by the ACGME.
2) Review strategies for optimal teaching and supervision of integrated psychotherapy/pharmacotherapy in residency
3) Discuss implications of a survey of Psychiatry Residency Training programs regarding the current state of training in integrated psychotherapy/pharmacotherapy
4) Understand the trainee's perspective on skillset acquisition and identity formation with regards to integrated psychotherapy/pharmacotherapy
5) Develop strategies to identify and address obstacles to best training practices for integrated psychotherapy/pharmacotherapy

Abstract
When the psychotherapy competencies were first inscribed into the ACGME program requirements in 2001, they included a requirement to teach the combination of pharmacotherapy and psychotherapy as a distinct competency. Due to the burden of teaching 5 distinct psychotherapies to the level of competency, this requirement was dropped in the 2007 iteration of the ACGME standards. Subsequently, scholarship regarding the pedagogy of teaching combined treatment came largely to a halt. Two decades later, there is little consensus in psychiatry residency training as to the importance of combined treatment as a distinct competency nor to best practices in teaching this competency.

Absence of a significant focus on combined treatment is a potentially meaningful oversight, given that the majority of residents who intend to practice psychotherapy will also be practicing combined pharmacotherapy. National data suggests that 46% of psychiatrists provide some psychotherapy, and that, of those visits involving psychotherapy, 73% also included medication management (Tadmon & Olfson, 2022). As

such, it may be that we are not adequately preparing our residents for their actual, real-world, post-graduate practice.

In this workshop, we will explore current patterns/trends in the teaching of combined treatment in psychiatric residency, including new data from a survey of Residency Training Directors. We will consider various structural approaches to support the teaching of integrated psychotherapy/pharmacotherapy (e.g. the nature of psychotherapy didactics and supervision) as well as considering specific educational content that supports the residents' mastery of combined treatment. We will also consider the residents' perspective as learners. Through small and large group processes, we will work at developing a degree of consensus regarding what might be best practices in the teaching of combined pharmacotherapy/psychotherapy.

Practice Gap

All programs teach the skills of psychotherapy and of pharmacotherapy, and there is some consensus about best practices in each of these domains. There is, however, little guidance about the optimal teaching of the integration of these two psychiatric disciplines and great heterogeneity between programs in teaching combined/integrated treatment. Given that the vast majority of psychiatry graduates who go on to practice psychotherapy will be combining this practice with prescribing, programs must better attend to this training.

Agenda

00:00-00:05 Introduction (Dr. Mintz)
00:05-00:15 How we teach the integration of psychotherapy and pharmacotherapy: Results of a PD survey (Dr. Schreiber)
00:15-00:30 Brainstorming best practices:
1) What should we teach? 2) How should we supervise (Small Group)
00:30-00:45 Teaching combined treatment to the level of competency (Dr. Riba)
00:45-01:00 Shifting gears: Supervising the integration of pharmacotherapy and psychotherapy (Dr. Mintz)
01:00-01:10 Competency and professional development: The trainee perspective on learning the integration of pharmacotherapy and psychotherapy (Dr. Schreiber)
01:10-01:25 Identifying and addressing barriers to implementing best practices (Large group discussion)
01:25-01:30 Wrap up and evaluation

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Title
Taking it to the Streets: Increasing Experiential Learning for Residents

Primary Category
Program Administration and Leadership

Presenters
David Nissan, MD, Naval Medical Center-San Diego
Daniel Knoepflmacher, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Hal Kronsberg, MD, Johns Hopkins Medical Institutions
Frances Hessel, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry
Alice Kisteneff, MD, Naval Medical Center-San Diego

Educational Objectives
Attendees will be able to assess the gaps in their programs preparation of their graduates to practice in settings that meet the needs of their specific communities
Apply strategies/practices to overcome obstacles to implement community based rotations (e.g. billing, supervision, safety)
Implement strategies to develop academic and experiential programming that increases their trainee's experiences working with culturally diverse and underserved populations
Develop a culturally responsive curriculum that improves their trainees understanding of the communities being served.

Abstract
Residency programs at academic medical centers have unique strengths including faculty expertise and institutional excellence. At the same time, these programs may struggle to provide residents with formal opportunities to engage directly with communities outside the hospital or clinic walls. Community settings offer a valuable opportunity for residents to learn from specific populations historically underserved by local medical centers and gain an experiential understanding of social determinants of health. We present different strategies from three residency programs across the country striving to address these gaps in service and training through educational programming designed to improve community impact and promote trainee growth in culturally responsive care. Each program created a unique experience linking community needs with educational goals.

NewYork-Presbyterian/Weill Cornell Medicine psychiatry residents work with a diverse population of patients coming from the entire New York City region, but have less built-in experience in community and public psychiatry settings. To address this gap, the residency introduced a new program providing PGY1's with location-based learning opportunities offered by several organizations serving marginalized populations. This provided new direct exposure to disparate settings including the state hospital, a harm

reduction site providing space for safe injections, supportive housing, the city jail complex on Rikers Island, and Fountain House (a clubhouse model for people living with serious mental illness). Residents can pursue clinical rotations at these community sites later in training and the initial experiences provide firsthand knowledge about community resources they can share with patients seen in the hospital.

To address the psychiatric needs of a local operational community and give residents an experience essential to military medicine, the psychiatry residency program at Naval Medical Center San Diego established a rotation embedded with the Naval Special Warfare community. This rotation provides streamlined access to psychiatric services for an operationally active combat command with a unique culture. Residents work with service members striving to continue service despite psychiatric symptoms and learn to balance patient autonomy and confidentiality. In the last three years, graduating residents identified the rotation as instrumental to understanding the nuances of operational psychiatry, improving cultural competence with our active duty population.

The Child/Adolescent Psychiatry Fellowship at Johns Hopkins University crafted a year-long longitudinal elective to meet the unique needs of children in East Baltimore living under significant psychosocial strain, providing care in homes and schools throughout the city. Fellows joined the Child Mobile Treatment team, where they provided clinical care for children at high risk for out-of-home placement, flexibly delivered outside of the traditional clinic space. This rotation paired a unique clinical experience with a learning experience that emphasized both hands-on and more abstract explorations of the social determinants of health, the history of Baltimore, and the complex relationship between Johns Hopkins and the community.

Using the three models above, this workshop will provide attendees with a flexible toolkit of strategies designed to be used by disparate residency programs interested in developing experiential training opportunities for residents to learn about community and psychiatry in unique settings.

Practice Gap

Residency training programs based in large, tertiary academic medical centers benefit from robust research opportunities, access to subspecialty expertise, and diversity in patient population, but vary in opportunities to work with specific populations and practice settings that psychiatry trainees may encounter after training. Ensuring residents are exposed to these opportunities is crucial to rounding out the training of contemporary psychiatry residents so that they can meet the wide-ranging needs of our changing nation.

Agenda
0-5 minutes: Brief welcome; polling audience about backgrounds, specific interest in our topic
5-15 minutes: Intro, objectives, outline, 3 different examples of community-based learning
15-30 minutes: Weill Cornell
30-45 minutes: NMCSD
45-60 minutes: JHU
60-80 minutes: small group exercise, discussion
80-85 minutes: question and answer
85-90 minutes: time for feedback survey (additional questions)

Scientific Citations
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Title
The Reviews Are In! Learning the Art and Science of Peer Review

Primary Category
Research and Scholarship

Presenters
Rashi Aggarwal, MD, Hofstra Northwell-Staten Island University Hospital
Adam Brenner, MD, UT Southwestern Medical Center
Enrico Castillo, MS, MD, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)
Andreea Seritan, MD, University of California, San Francisco

Educational Objectives
1. Understand the role of peer reviewers for education journals
2. Practice a step-by-step approach to the manuscript review process, using a checklist
3. Explore common dilemmas encountered in the manuscript review process

Abstract
Academic psychiatrists are often called upon to serve as peer reviewers for education journals. Reviewing is an important faculty development opportunity, which allows reviewers to gain a working knowledge of acceptance and rejection criteria, while also improving their skills in academic writing. Additionally, serving as peer reviewers for education journals enhances networking and deepens connections to the national academic psychiatry community. More importantly, peer reviews provide learning opportunities for willing authors. Peer reviewers serve as (often anonymous) mentors who help authors improve their manuscripts and grow in the process. In this workshop, participants will learn strategies for effective manuscript review, common pitfalls, and tips of the trade from editors of the journal Academic Psychiatry and experienced peer reviewers.

Practice Gap
The peer review process can be confusing and generate a lot of feelings. What if I give a bad review? How do I know if I'm asking the right questions? How do I know what the journal wants from me?

AADPRT Is on one of the sponsoring organizations for the journal Academic Psychiatry. Members of the Editorial Board want to share with AADPRT members greater insight into the peer review process.

Agenda
10 min Introductions, participants' goals
10 min Didactic presentation: Why/how to become a reviewer, effective manuscript review, ACPS manuscript review checklist
15 min Small group activity #1 (review 2 Abstract examples)
10 min Large group report out
15 min Didactic presentation: Reviewer tips, reasons for rejection
10 min Small group activity #2 (review Methods)
10 min Small group activity #3 (review Tables, Figures, Refs)
10 min Large group report out; Wrap-up, lessons learned

Scientific Citations
1. Aggarwal, R., Louie, A.K., Morreale, M.K. et al. On the Art and Science of Peer Review. Acad Psychiatry 46, 151–156 (2022). https://doi.org/10.1007/s40596-022-01608-1

2. Burke D. Best practices in table design. Science Editor. 2021;44(4):122-5.

3. Advice from a Master Peer Reviewer (Academic Medicine Podcast with Carl Stevens, seven-times winner of the Academic Medicine Excellence in Reviewing Award). Aug 2018. https://academicmedicineblog.org/advice-from-a-master-peer-reviewer/

4. Molassiotis A, McCarthy A, Charalambous A, Gibson F, Lopez V, Beaver K. Common reasons why an academic paper is rejected: views from the editors. Eur J Oncol Nurs. 2019;40:v-vi.

5. Song E, Ang L, Park JY, Jun EY, Kim KH, Jun J, Park S, Lee MS. A scoping review on biomedical journal peer review guides for reviewers. PLoS One. 2021 May 20;16(5):e0251440. doi: 10.1371/journal.pone.0251440. PMID: 34014958; PMCID: PMC8136639.

AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
The Time is Now - Barriers and solutions for an ACGME requirement in Reproductive Psychiatry – Presented by APA Council on Women's Mental Health

Primary Category
Curriculum

Presenters
Ludmila De Faria, MD, University of Florida College of Medicine
Nicole Cirino, MD, Baylor College of Medicine
Jennifer Payne, MD, University of Virginia Health System
Rachel Zhuk, MD, Icahn School of Medicine at Mount Sinai
Mariella Suleiman, MD, Icahn School of Medicine at Mount Sinai

Educational Objectives
1. Define reproductive psychiatry and its historical context within the field of psychiatry.
2. Describe three reasons that it is imperative that psychiatry residents acquire basic knowledge and skills in this area.
3. Identify barriers to including reproductive psychiatry in every U.S. resident training program.
4. Define potential solutions to these barriers that can be implemented by individual residency programs in the short term (over the next 12 months).
5. Develop an effective strategy for AADPRT to drive adoption of an ACGME requirement in reproductive psychiatry, with support from the APA, MONA, NCRP, PSI, ISRP and Repro Psych Trainees.

Abstract
Despite the recognition of unique characteristics of psychiatric illness in women as far back as ancient Greece, the field of psychiatry has been slow to recognize the importance of including women, especially pregnant women in our scientific studies. However, every psychiatrist will treat perinatal, premenstrual and perimenopausal patients. 86% of women in the US will become mothers, and approximately 20% will experience a peripartum mood episode. [1] In the United States, there only exists a handful of fellowship programs and no formal requirement for residency training in women's psychiatric illness. [2] To prepare future psychiatrists, psychiatry education should include the diagnostic tools and evidence-based treatments derived from rapidly expanding research in the field of reproductive psychiatry.

More than half of psychiatry residencies report they do not offer any training in perinatal mental health disorders. [3] They note a major barrier is lack of qualified faculty, which creates a vicious cycle. [4] There is a significance shortage of psychiatrists willing to care

for women facing psychiatric problems related to reproductive transitions, and the victims are our female patients. [2] Patients may face discharge from established care upon becoming pregnant, long waitlists leading to delays in treatment, and increased burden of illness with long-term complications not only for the patient but also for her entire family. The shortage contributes to undertreatment of perinatal psychiatric disorders, which is the leading underlying cause of pregnancy-related mortality in the United States. [5]

The APA Council on Women's Mental Health, in collaboration with Marce of North America (MONA), North American Society for Psychosocial Obstetrics & Gynecology (NASPOG), Postpartum Support International (PSI), and the National Curriculum in Reproductive Psychiatry (NCRP) have come together with a shared goal: the time to act is now. We must assure that every psychiatrist can safely treat women across the reproductive lifespan. An ACGME requirement in reproductive psychiatry would create an educational floor and raise the quality of psychiatric care for all women.

Carefully chosen leaders in the field will lead this interactive discussion to identify program specific barriers and solutions. This workshop will establish the scope of the problem, identify barriers to implementation, provide existing resources and develop strategies to bolster reproductive psychiatry education within programs today. Given these tools, we will outline an effective path toward a standardized ACGME requirement in reproductive psychiatry.

Practice Gap

All women of reproductive age treated by psychiatrists should have access to appropriate guidance regarding how the female sex influences their psychiatric condition and informs treatment. Psychiatric illness is among the top reasons for maternal mortality across the United States, yet 3 in 4 women do not receive treatment. [6]

There is currently no requirement in psychiatric residency training programs to include training in psychiatric conditions related to pregnancy, postpartum, menses or menopause – despite a significant increase in scientific discovery in these areas. There is an urgent need for residency education to include a reproductive psychiatry curriculum. Although several programs have women's mental health tracks or fellowships, a minority of U.S. psychiatrists offer treatment for pregnant and postpartum women. [7] There is a strong desire among trainees for more resources and opportunities.

Agenda

I. The Problem – (Didactic) 15 minutes
a. Background:

i. Define Reproductive Psychiatry: perimenstrual, perimenopausal, perinatal, infertility and other gynecologic conditions.
ii. Clinical scope of the problem: Prevalence, Morbidity/Mortality, Lack of access
iii. Landscape: Introduce national organizations/stakeholders and steps they are taking in this area (APA/MONA/Lifeline4MOMS/ NASPOG/PSI/NCRP/Repropsych trainees)
iv. Why an ACGME requirement?
II. Benefits: (Group Discussion) 10 minutes
III. Barriers: (Break into small groups – present these to large group) 20 minutes
IV. Break: 5 minutes
V. Solutions – 20 minutes
a. APA Council introduces resources and how they are used by successful programs. Didactic (10 minutes)
b. Small group break out – Other potential solutions (10 minutes)
VI. Concrete Next Steps – Call to Action- Large Group Discussion 20 minutes
a. Short term -What can you do in your program now to prepare for the requirement?
b. Longer term
i. AAPRT's role in recommendation to the ACGME
ii. Role of other APA and other key organizations

Scientific Citations

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6. Byatt N, Levin LL, Ziedonis D, Moore Simas TA, Allison J. Enhancing Participation in Depression Care in Outpatient Perinatal Care Settings: A Systematic Review. Obstet

Gynecol 2015;126(5):1048-58 doi: 10.1097/AOG.0000000000001067[published Online First: Epub Date]|.

7. Koire AM, R. Women's Mental Health: Current and Future Training Pathways. Psychiatric News 2024;59(8)

Title
What Stories can Teach us

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Ayame Takahashi, MD, Southern Illinois University School of Medicine
Craigan Usher, MD, Oregon Health Sciences University
Geraldine Fox, MD, University of Illinois College of Medicine at Chicago
Karina Espana, BS, MD, Oregon Health Sciences University

Educational Objectives
1. Use children's literature to teach multiple aspects of development and examine with trainees disruptions to normal development, including the emergence of developmental disabilities, mental health disorders, and trauma;
2. Incorporate narrative medicine techniques to improve trainee engagement and reflection of themselves and of their patients;
3. Use excerpts from books embroiled in school library ban controversy to reflect with trainees on how cultural issues may impact their patients, promoting empathy and connection with patients young and old.

Abstract
Once upon a time, there were 4 little children growing up in separate parts of the world over different periods of time. Despite the differences in backgrounds, they all loved stories. In medical school, it was the love of stories that led them to psychiatry. The story is the heart of the profession, in no other medical field is the story so central to the ability to hold and to heal.

Medical Humanities and Narrative Medicine help improve observational and listening skills and the development of projective empathy. In working with people from diverse backgrounds, we need to broaden our perspectives. Psychiatrists who work with children, teens, and family also need to have a window into multiple developmental stages. Literature is one way of opening that window.

This workshop is organized into 3 developmental stages. We begin with an introduction to children's books and will view some videos of a young child reading with her parent, examining how exploration of the world, curiosity, and relational connection are facilitated through reading. We will then move to adolescence and young adulthood, with a focus on controversial/banned books. Several different "frames" for how these books can be used for teaching will be demonstrated, including how one can explore identity, find purpose, meaning, and manage alone-ness through sometimes controversial texts.

In the final stage of this workshop, we will read excerpts from these controversial stories using close reading techniques, reflect upon the characters' voices and experiences, and discuss how we might each incorporate narrative medicine into our teaching and practice.

Practice Gap

In a world of electronic health record (EHR) templates, billing requirements and pressures to produce RVU's, psychiatry residents and attendings are increasingly pressed for time. Teaching in the clinical setting is often done "on the fly" as doctors are not paid to for the time they may spend thinking deeply about patients. Templates and algorithms encourage reductionism wherein patients may become symptom lists and evidence-based interventions, sometimes difficult to tell apart in their daily notes. This type of excessive focus on billing "bottom lines" is frequently mentioned as a source of burnout among physicians.

Narrative medicine has emerged as a field which tries to combat the loss of the individual's story. Medical Humanities is a related field which has similar goals, incorporates arts into the practice of medicine, ultimately preserving our collective humanity in the service of healing.

Agenda

Chapter 1- Early childhood and school-age- 20 minutes- popular children's books for teaching development will be shared. A couple of short video clips of a young child reading with her parent will be shown, the parent-child interaction will be discussed.
Chapter 2- Adolescence and young adulthood 30 minutes- use of banned and controversial books for teaching about adolescent and societal issues will be discussed.
Chapter 3- Adulthood (The Pedagogy) -30 minutes- breakout groups will read a short vignette from a controversial book- will discuss prompts written by the leaders .
Conclusion- 10 minutes- Large group discussion from the smaller break-out groups, how to take this back to home institution.

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2. Content and outcomes of narrative medicine programmes: a systematic review of the literature through 2019. CDF Remein, E Childs, JC Pasco, L Trinquart... - BMJ open, 2020 - bmjopen.bmj.com

3. Narrative medicine: Re-engaging and re-energizing ourselves through story .Andre F Lijoi https://orcid.org/0000-0002-1198-5584 alijoi@yorkhospital.edu and Ana D

TovarView all authors and affiliations. Volume 55, Issue
https://doi.org/10.1177/0091217420951039

4. Storytelling in medical education: narrative medicine as a resource for interdisciplinary collaboration HC Liao, Y Wang - International journal of environmental research and ..., 2020 - mdpi.com https://www.mdpi.com/1660-4601/17/4/1135

5. A novel narrative medicine approach to DEI training for medical school faculty. S Holdren, Y Iwai, NR Lenze, AB Weil... - ... learning in medicine, 2023 - Taylor & Francis

Title
What you don't ask...Vignettes for teaching religious and cultural aspects of clinical practice

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Richard Camino-Gaztambide, MA, MD, Medical College of Georgia at Augusta University
Arushi Wadhwa, DO, Medical College of Georgia at Augusta University
Argyro Athanasiadi, MD,
Timothy Lee, MD, Medical College of Georgia at Augusta University

Educational Objectives
1. Help training directors, faculty, and trainees utilize tools and techniques for inquiring patients about their R/S and cultural worldviews.
2. To train faculty and trainees on utilizing tools like the FICA and cultural interviews as essential for patient assessment and treatment approaches.
3. Teach residents to analyze patients' lack of improvement or non-compliance from a biopsychosocial perspective, including assessing patients and their family's R/S and cultural worldviews.

Abstract
Religious and cultural beliefs are critical aspects of patients' lives, significantly influencing their perspectives on health, illness, and treatment. However, psychiatric residency programs often lack formal training that addresses the integration of these elements into clinical practice. This workshop aims to bridge this educational gap by equipping residents with the skills to explore patients' spirituality and cultural background as part of a comprehensive clinical assessment.

The integration of religious and cultural dimensions is essential in psychiatric care, as patients' spirituality frequently shapes their treatment preferences and influences their

mental health outcomes. Spirituality can serve as a coping mechanism, providing patients with a sense of hope and purpose, especially in the face of chronic medical illnesses or mental health crises. Additionally, family involvement, often intertwined with religious beliefs, plays a crucial role in patients' decision-making processes. Understanding the cultural context, including familial dynamics and religious values, can help clinicians navigate treatment barriers, such as medication non-adherence.

For patients with chronic illnesses, demoralization—a state characterized by helplessness and hopelessness—can exacerbate their mental health challenges. Religion and family support can be sources of strength, offering comfort and resilience during such periods. As described by Weingarten, "compassionate witnessing" is a social and cultural process that sustains hope in patients.6 Building on this concept, focused bedside interviews can further mobilize specific existential postures of resilience, thereby reinforcing patients' capacity to cope .7 In the context of Consultation-Liaison, incorporating questions about religious beliefs, spiritual practices, and familial support into routine clinical interviews, residents can create a more holistic treatment plan tailored to each patient's unique cultural context.8

This workshop will demonstrate practical approaches for integrating spiritual and cultural inquiries into patient assessments, highlighting how these interventions can come naturally and become essential to residents' clinical training. We will present short mock video interviews done by our residents, where an initial brief interview with a simple algorithm, where the learner chooses a next step from two choices, and a positive outcome or negative outcome will be presented depending on the choice. For example, in cases of medication non-adherence, exploring underlying spiritual or cultural beliefs could reveal crucial insights into the patient's resistance and guide more effective treatment strategies. We recommend that these short videos or the program develop their own written vignettes without prompting a prior discussion on culture or religion to provide a more 'real' context.

Ultimately, teaching residents to appreciate and incorporate religious, spiritual, and cultural aspects into psychiatric care can lead to more compassionate, patient-centered interventions. Attendees will learn to engage patients in conversations about their beliefs and values, fostering an environment of trust and understanding that can enhance treatment adherence and improve outcomes. By normalizing these conversations within psychiatric residency training, residents will be better equipped to address the complex interplay between mental health, spirituality, and culture, thereby enhancing the quality of care for diverse patient populations.

Practice Gap

It is well-documented that religion, spirituality, and culture influence a person's worldview and decision-making.1 Likewise, social stigma or self-stigma can have a significant impact on patient compliance with treatment and affect treatment outcomes.12 Lack of family involvement can add to the roadblocks of patients' recovery.3 A recent study of residents in psychiatry, internal medicine, and family medicine found that although residents had a positive view of the role of spirituality/religion (R/S) and influence on patient care, "they often lacked the knowledge and skills to address these issues."4 Providing residents with short vignettes in an algorithmic fashion can enhance and provide a more 'real' (and fun) way to teach religious and cultural aspects of clinical practice that can flow 'naturally' in the clinical setting.5

Agenda

1. Introduction model- (5 min)
a. A brief review of R/S and culture.
b. Settings of vignettes include outpatient and CL situations. *
2. Video Vignette 1: Initial visit- (20 min) **
1. Audience participation response for diagnosis and initial treatment
2. Vignette 1: F/U visit- analyze the patient's response and choose from two courses of action.
3. Vignette 1: Final visit- discuss final outcomes of each.
4. R/S and cultural considerations of Vignette 1.
3. Video Vignette 2 and 3 will follow the same order as the first vignette. (40 min)
4. Open discussion Panel and Audience. (15 min)

* Vignette will have one of two outcomes depending on choice.
**Resident presenters will lead each vignette discussion.

Scientific Citations

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Workshop Session #2

Title
Beyond the Clinic: Infusing Advocacy into Residency Curriculum

Primary Category
Curriculum

Presenters
Kai Anderson, MA, MD, Central Michigan University College of Medicine
Joseph Kim, BA, MD, Albert Einstein College of Medicine/Montefiore Medical Center
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center
Abi Bala, MD, MPH, Central Michigan University College of Medicine
Janice Cho, MD, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)

Educational Objectives
1. Define advocacy and the different levels of advocacy
2. Explore advocacy curricula in four different training programs
3. Engage in creating an advocacy curriculum strategy to implement at your home institutions
4. Discuss common challenges and strategies to overcome identified barriers to incorporating advocacy curricula in psychiatry residency

Abstract
Advocacy is an essential part of a physician's role. The AAMC adopted into its definition of professional responsibilities that "physicians should advocate for social, economic, educational and political changes that ameliorate suffering and contribute to human wellbeing." The ACGME in psychiatry considers advocating for quality patient care and improving patient care systems a competency under systems-based practice. Unfortunately, many physicians, including training program directors, have never received formal training on advocacy, how to engage in advocacy initiatives, or how to teach about advocacy to residents. This lack of expertise and comfort with this topic hinders many residency training programs from establishing curricula that address this physician's responsibility. This interactive workshop will define different advocacy levels, including patient-centered, community-centered, and state-level advocacy. We will share how four training programs nationwide have addressed the need to incorporate advocacy initiatives in their residencies and fellowship programs. A psychiatry resident will share their experiences engaging in advocacy activities during residency and describe how their training program supported this interest. In break-out groups, we will develop an advocacy plan to help attendees brainstorm how to identify collaborators, initiatives, and

educational opportunities within their residency training programs. Finally, we will discuss the challenges and limitations of implementing this kind of curriculum into psychiatry training programs and collaborate on creative solutions.

Practice Gap

In psychiatry residency programs, the emphasis is often on clinical skills, diagnosis, and treatment, with less focus on developing advocacy skills. Some key gaps in residency training, as it relates to training physicians to be advocates, include limited training and education on healthcare policy, systems, and the broader social determinants of health.

Advocacy requires effective communication with diverse stakeholders. Psychiatry residency programs may not expose trainees to professional advocacy organizations or offer opportunities for hands-on advocacy experience. There are few formal mentorship opportunities focused specifically on advocacy during residency.

To address these gaps, advocacy training should be integrated into residency curricula. Our goal is to provide a framework on how to integrate advocacy curricula in residency programs.

Agenda

1. Define advocacy in psychiatry (15 min)
2. Discuss different ways to incorporate advocacy curricula in psychiatry training programs
    a. Liaison with Community-Based Organizations (8 min)
    b. Op-Eds (8 min)
    c. Resident Perspective (8 min)
    d. National/Regional Advocacy (8 min)
3. Small Group: Create advocacy curriculum strategy & implementation framework (15 min)
4. Large Group Debrief (10 min)
5. Discuss challenges to incorporating advocacy curricula (10min)
6. Discussion / Q & A (8 min)

Scientific Citations

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Title
Confronting Microaggressions and Gender Bias: Trainees and Faculty as Allies

Primary Category
Curriculum

Presenters
Ailyn Diaz, MD, Penn State University, Hershey Medical Center
Shaheen Darani, MD, AADPRT Affiliate Members
Vivian Tran, DO, Creighton University School of Medicine (Phoenix) Program
Tolu Odebunmi, MBBS, MPH, University of Minnesota
Peter Ureste, MD, University of California, Riverside School of Medicine

Educational Objectives
Through participating in this workshop, attendees will be able to:
1. Define microaggressions and macroaggressions within academic medicine, describe their physical and psychological impact, and identify barriers preventing individuals from responding as bystanders.
2. Practice various frameworks (Yale ERASE, Georgetown “Stop, Talk, and Roll,” UCSF verbal assault protocol) for responding to microaggressions in the clinical learning environment.
3. Develop and adapt a response protocol tailored to their respective home institutions to address microaggressions and promote actionable allyship.
4. Empower attendees to address gender bias in psychiatric residency programs.

Abstract
This workshop will address the persistent issue of microaggressions in the clinical learning environment, particularly for historically marginalized patients and physicians underrepresented in medicine. Despite existing bystander training, high rates of microaggressions continue to go unreported, with up to 90% of residents experiencing microaggressions in patient care (3) Microaggressions can also extend to gender bias, affecting women in residency training disproportionately (1,2). To bridge this practice gap, we must move beyond awareness to foster a culture of empowerment and actionable allyship.

In this workshop, we will discuss the history and definitions of micro/macroaggressions and their lasting impact on physical and mental health. Participants will engage with existing frameworks such as the Yale ERASE model, Georgetown's "Stop, Talk, and Roll," and the UCSF verbal assault protocol, learning to respond to microaggressions effectively (4). Through interactive polling, individual reflection, role-playing, and group discussions, attendees will identify microaggressions they have experienced or witnessed and explore

strategies for responding with a special emphasis on gender bias. The session will culminate in developing and adapting a response protocol suited to participants' home institutions, enabling them to practice active allyship and contribute to a more inclusive clinical learning environment.

Practice Gap

Microaggressions in academic psychiatry represent a significant barrier to creating an inclusive and supportive learning environment. Although the ACGME has established cultural competency requirements, microaggressions persist, leading to negative physical and psychological effects on vulnerable individuals, specifically women. Current training often fails to provide practical and actionable frameworks for addressing these incidents with around 25% of residents reporting a lack of training on how to identify and address microaggressions (1). Additionally, gender bias may favor males in leadership positions (2). This workshop aims to address this gap by introducing participants to concrete response protocols and fostering a culture of allyship in academic psychiatry. By equipping participants with the skills to address microaggressions proactively, we aim to enhance the learning environment and support the well-being of those experiencing microaggressions and gender bias.

Agenda

Minutes 0-20: Didactic Presentation
Presenters will provide background on the history and impact of microaggressions in academic psychiatry. They will introduce key frameworks (Yale ERASE, Georgetown “Stop, Talk, and Roll,” and UCSF verbal assault protocol) for addressing these challenges.
Minutes 20-45: Small Group Breakout #1
Attendees will identify microaggressions they have encountered or witnessed and discuss current response strategies. They will conceptualize an ideal response protocol for their environments.
Minutes 45-55: Large Group Discussion
Groups will share insights and themes from their discussions. Presenters will guide a conversation around common barriers and potential solutions.
Minutes 55-75: Small Group Breakout #2
Attendees will explore existing frameworks through a case vignette and discuss adapting these frameworks in their home programs, creating tailored action plans.
Minutes 75-90: Wrap Up and Reflection
Presenters will lead a reflection on implementing actionable allyship in clinical environments. Participants will share adapted protocols and discuss integration into their programs.

Scientific Citations

1. Karen K. Hoi, Lulia A. Kana, Gurjit Sandhu, Reshma Jagsi, Suzy McTaggart, Jessa E. Miller, Erin L. McKean; Gender Microaggressions During Virtual Residency Interviews and Impact on Ranking of Programs During the Residency Match. J Grad Med Educ 1 August 2022; 14 (4): 398–402. doi: https://doi.org/10.4300/JGME-D-21-00927.1

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Title
Developing Teachers from Learners: How Clinician Educator Tracks can cultivate resident leaders in education and support a department's teaching mission

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Winston Li, BA, MD, University of North Carolina Hospitals
Mallory Cash, MD, UT Southwestern Medical Center
Michael Weber, MD, University of North Carolina Hospitals
Adriane dela Cruz, MD, PhD, UT Southwestern Medical Center

Educational Objectives
1. Analyze the components of an established Clinician Educator Track at two different psychiatry residency programs.
2. Analyze how a Clinician Educator Track can contribute to the educational mission of a psychiatry department, including both graduate and undergraduate medical education.
3. Identify and analyze strengths, weaknesses, opportunities and threats to developing a de novo Clinician Educator Track at one's home institution.

Abstract
The participation of resident physicians in teaching is an expected and essential component of academic medical centers and their associated residency programs. As residents progress in their training, they impart their knowledge and skills to more junior learners. Effective teaching of one's knowledge represents the highest achievement in the ACGME milestones of most competencies. However, even trainees who have the skills and aptitude to teach may run into roadblocks to exercise those talents, such as a lack of available time, meaningful teaching opportunities, or structured training and mentorship.

To address these challenges, we present how Clinician Educator Tracks can serve to develop the next generation of educational leaders. These tracks offer the structured development, formal mentorship, and dedicated time and opportunities to overcome barriers to development as a teacher. We analyze the components of established Clinician Educator Tracks at two different residency programs, and how the design of each component works within the larger framework of the residency and the department's overall teaching mission. In addition to the direct benefit to the residents in the track, we present benefits towards other parts of the department's teaching mission. For example, Clinical Educator Track resident have taken meaningful, enhanced roles in teaching medical students and junior residents, thus furthering the undergraduate and

graduate medical education mission. The presence of the Track has been a pearl for residency recruitment and a topic of interest among residency applicants. Finally, the track has spurred scholarly collaboration among faculty and residents, and led to productivity in the form of papers, posters, and educational initiatives. Overall, the track promotes the overall educational community of the department and has been a pipeline towards retention as educator faculty in the department.

Finally, workshop participants will have the opportunity to conduct a strengths, weaknesses, opportunities, and threats (SWOT) analysis of their home institution's educational landscape, with an aim towards establishing a Clinician Educator Track de novo at their home institution.

Practice Gap

While resident physicians are expected to teach medical students and other trainees on clinical services, there is often little formal training in residency on teaching. For those interested in pursuing academic careers, there is often a scarcity of formal programming or mentorship towards this path. Even a resident with teaching skills and training may find challenges in available time and opportunities to pursue those interests.

This program seeks to showcase the benefits of Clinician Educator Tracks towards addressing these challenges. We offer analysis of the components of such tracks at two different residency programs, ways these tracks can benefit a department's educational mission and faculty scholarly activity, and practical advice for programs looking to start such a track.

Agenda

5 min: Introduction of speakers and roles
5 min: Introduction of practice gap and challenges of resident development as educators
30 min: Analysis of existing Clinician Educator Tracks at two different psychiatry residencies, including components, personnel, and schedules, and how these tracks support the department's educational mission.
25 min: Breakout groups with SWOT analysis of their home institution's educational landscape
and how a Clinician Educator Track could be helpful towards those needs.
10 min: Large-group brainstorming and problem-solving on starting a Clinician Educator Track
15 min: Wrap-up, Questions, and Evaluation

Scientific Citations

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
In the Director's Chair: Developing "Good Enough" Psychotherapy Supervisors

Primary Category
Faculty Development

Presenters
Anne Ruble, BA, MD, MPH, Johns Hopkins Medical Institutions
Danielle Patterson, MD, Indiana University School of Medicine
Alyson Gorun, MD, BA, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Katherine Kennedy, MD, Yale University School of Medicine
Randon Welton, MD, Northeast Ohio Medical University

Educational Objectives
By the end of this session attendees will be able to:
- Describe the need and benefits of psychiatrists supervising psychotherapy in psychiatry residency training
- Understand the "Good Enough" Supervision model as an option for training psychotherapy supervisors in a residency training program
- Evaluate various modalities for training psychiatrists to become psychotherapy supervisors in residency programs
- Develop shared resources to overcome the obstacles psychiatrists face when they would like to become psychotherapy supervisors

Abstract
Psychiatrists wishing to become psychotherapy supervisors face many obstacles. Productivity requirements and poor reimbursement disincentivize many. Early career psychiatrists may feel unqualified to supervise psychotherapy because of limited training and experience. Prior generations of psychiatry residents often had numerous psychiatric psychotherapy supervisors they could emulate. In many parts of the nation finding adequate role models has become prohibitively difficult. We can no longer count on the success of a "See one, Do one, Teach one" approach in many residency programs. A deliberate approach to training psychotherapy supervisors must be developed.

Attendees will discuss the utility of various training methods including experience, reading classic and modern literature, instruction by experts, peer instruction, and personal psychotherapy.

A needs survey was sent to a variety of clinicians expressing an interest in developing their skills as psychotherapy supervisors. Respondents included many who were relatively new to psychotherapy supervision (28%) and those with over a decade of

experience (28%). Many (37%) rated themselves as less than "Somewhat Effective" as a psychotherapy supervisor demonstrating a need to increase skills and confidence. When asked what their goals would be in attending a psychotherapy supervisor training workshops responses included: Develop my skills as a supervisor – 84%, Train residents to provide psychotherapy – 74%, Network and peer support – 42%.

To improve confidence and competence in psychotherapy supervision, we created virtual, hour-long, monthly workshops consisting of a didactic portion followed by a question-and-answer period or break-out group discussions. Topics included "Supervisory relationships", "Setting goals for supervision", "The frame of supervision", "Addressing racial issues in supervision", and "Handling challenges in supervision".

After the last training session, a second survey was sent out. Nearly half of the respondents had attended at least 4 of the workshops. Half of respondents reported that the workshops were "Helpful" or "Very Helpful" in increasing their comfort and effectiveness as supervisors. Almost half reported that they "Often" or "Almost Always" used ideas/suggestions from the workshops.

We will conclude with further lessons learned from the sessions and seeking the audience's ideas on next steps to better train psychotherapy supervisors in their individual training programs.

Practice Gap

Psychotherapy is becoming an increasingly infrequent component of psychiatric practice. Up to half of psychiatrists may no longer provide psychotherapy. As their experience with psychotherapy diminishes, many psychiatrists feel inadequate to teach or supervise psychotherapy, which perpetuates the mistaken belief that psychotherapy is no longer an essential component of being a psychiatrist. Reversing this trend requires psychiatrists to once again embrace the role of psychotherapy supervisors, and supervisors are an essential part of residency training. Training and retaining an adequate number of psychotherapy supervisors is an ongoing concern of residency programs.

Agenda

- Introductions – 5 mins
- Importance of psychiatrists supervising psychotherapy in residency training – 5 mins

Didactic

- Obstacles and barriers to psychiatrists supervising psychotherapy in residency training – 10 mins

Large Group Discussion

-Comparing various methods to train psychiatrists to become supervisors based on the resources and needs of your program or community – 20 mins

Small Group Discussion
- Reviewing the initial Needs Survey results from clinicians seeking to improve their ability to supervise psychotherapy – 5 mins

Didactic
- Good Enough Psychotherapy Supervision Virtual Sessions – format – 5 mins

Didactic
- Good Enough Psychotherapy Supervision Virtual Sessions – topics – 10 mins

Didactic
- Reviewing survey results after clinicians attended the Good Enough Psychotherapy Supervision Virtual Sessions – 5 mins

Didactic
- Next Steps and Suggestions for increasing the confidence and competence of psychiatrists to provide psychotherapy supervision in residency training. – 15 mins

Small Group Discussion
- Return to large group to share ideas regarding the next steps and suggestions generated in small groups – 10 mins

Large Group Discussion

Scientific Citations
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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
It Takes More Than Implicit Bias Training: Using Self-formulation and Critical Pedagogy to Teach Structural and Spiritual Perspectives on Oppression.

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Samuel Dotson, BS, MD, Northeast Georgia Medical Center Program
Rahel Bosson, MD, Massachusetts General Hospital
Lucy Ogbu-Nwobodo, MD, University of California, San Francisco
Joseph Stoklosa, MD, Massachusetts General Hospital
DeJuan White, MD, Emory University School of Medicine

Educational Objectives
Through participating in this workshop, attendees will be able to:
1. Explain the potential limitations of behavioral interventions in dismantling systems of oppression, and practice methods of making critical theory and structuralism practical for learners.
2. Identify existing opportunities in their own programs for incorporating the transcendence-agency model of formulation, and analyze potential challenges that their institutional culture and structure could present to teaching the structural perspective.
3. Create community and social psychiatry training experiences that integrate psychological approaches with a variety of sociological and spiritual perspectives including critical pedagogy, transformative adult learning theory, and engaged spirituality from diverse religious traditions.

Abstract
Although the institutionally-focused structural perspective on health inequities is becoming increasingly prominent in the psychiatric literature, limited guidance exists for educators seeking to make this complex social theory practical in resident didactics. Many institutions prefer the interpersonally-focused behavioral theory of implicit bias, which can often be reduced to a simple, check-box exercise for institutional leaders trying to signal a surface commitment to diversity, equity, and inclusion. In addition to the acknowledgement of unconscious bias, however, dismantling systems of oppression requires conscious efforts and critical reflections on worldviews and power structures. By linking structural and spiritual perspectives to ACGME milestones on wholistic case formulation, educators can find space in their curricula for a variety of active learning exercises that expand resident perspectives and challenge their preconceived sociopolitical notions. In this workshop, learners will first be exposed to the often-overlooked tension that exists between behavioral and structural perspectives on social

issues. Journal clubs examining RCTs focused on housing first and individual placement and support are initially used to introduce this tension to learners in a concrete and familiar format. Attendees then progress to a more nuanced and personal approach to case formulation that replaces the categorical 4 Ps model with a dimensional one grounded in four key concepts borrowed from the literature on sociology, philosophy, and engaged spirituality (e.g., Engaged Buddhism, Catholic Liberation Theology). Finally, Open Dialogue approaches are reviewed as a way to navigate these difficult and emotionally-laden conversations that often touch on deeply held political and personal beliefs for residents. Throughout the workshop, a variety of interactive learning exercises will be modeled that promote self-formulation, critical reflection, and perspective taking. Attendees will leave with an appreciation for the overarching strategy of teaching structuralism alongside behavioral perspectives, along with some practical and specific tactics for their teaching toolkits.

Practice Gap

The use of the implicit association test (IAT) has greatly advanced discussions about racism and oppression in medical organizations. This test, however, focuses on the interpersonal aspects of racism and can neglect the institutional aspects highlighted by structuralism and critical theory. This is partially because social perspectives on injustice lack an equivalent series of simple exercises that can illustrate their explanatory power. Learners are therefore often taught the underlying concept of power structures in a vague way without opportunities to apply their knowledge to advocacy, research, or clinical care. In addition, two other important gaps in psychiatric education are a lack of social research literacy and an inherent difficulty in differentiating the non-biological aspects of case formulation. Combining principles of sociology and various spiritual perspectives using the transcendence-agency model can remedy all three practice gaps by providing practical exercises in self-formulation, sociology research analysis, and critical reflection.

Agenda

Introduction (30 Minutes)
-5 Minutes: Introduce speakers, review objectives, and conduct a KW(L) needs assessment (Poll Everywhere)
-10 Minutes: Mini-didactic contrasting the behavioral and sociostructural perspectives
-15 Minutes: Exercise 1 – “Structural Journal Club: Can You Really Randomize People to That?” (small groups)
The Transcendence-Agency Model (20 Minutes)
-10 Minutes: Mini-didactic on the challenges of teaching wholistic formulation and introducing the concepts of transcendence, immanence, agency, and determinism
-10 Minutes: Exercise 2 – “Probe the Perspective, Plot the Person” (think-pair-share)

Facilitating Difficult Conversations in a Polarized Political Climate (25 Minutes)
-5 Minutes: Mini-didactic discussing the use of open and democratic dialogue techniques to bring out diverse perspectives
-20 Minutes: Exercise 3 – "The Resistant Resident and the Political Program Director" (small groups, report back)
Conclusion (15 Minutes)
-15 Minutes: Question and answer session, finish (KW)L (Poll Everywhere), and complete evaluations

Scientific Citations

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Title
Program Directors are People Too! Helping Program Directors Leverage Resources to Assist the Struggling Learner

Primary Category
Program Administration and Leadership

Presenters
Ahmad Hameed, MD, Penn State University, Hershey Medical Center
Aum Pathare, MD, Penn State University, Hershey Medical Center
Rashi Aggarwal, MD, Hofstra Northwell-Staten Island University Hospital
Dallas Hamlin, MD, Penn State University, Hershey Medical Center

Educational Objectives
1. Compare and contrast various roles training directors assume in competent management of a residency program.
2. Compose a framework describing how a training director collaborates with an assistant PD and chief resident to assist learners in difficulty
3. Reflect on best practices to actualize when a trainee is struggling to meet expected milestones.

Abstract
Recent match data shows that there were 382 general psychiatry programs participating in the main residency match in 2024 (Bartek, 2024). However, the average tenure for a general training director is only 7 years, implying a turnover rate of over 10% per year across specialties (ACGME, 2022). A training director's position combines the roles of an administrator, educator, supervising clinician, role model and mentor, which are legitimized through institutional and external bodies (Kumar, 2019). These positions can lead to parallel but occasionally conflicting objectives, including to public health and patient safety, which need to be addressed pragmatically but coherently. The concept of dual agency is not unfamiliar to psychiatrists, who often serve in multiple complementary roles in the healthcare system, but has not been explored in the context of the training director role. We will highlight how program directors should focus on educational and administrative support from the Chair of the Department, APD and the Chief Resident in navigating these issues to avoid miscommunication and implement a uniform yet flexible policy. We will articulate a framework for best practices derived from general systems theory and informed by psychotherapeutic principles of communication, combining case-based discussions, surveys, and cooperative generation of recommendations. This will allow attendees to confidently move forward in their multi-modal role as training director. We hope this approach will lead to decrease in training director burnout, as well

as improved processes in dealing with concerns with professionalism across the spectrum.

Practice Gap

There are limited formal trainings available for new training directors focused on numerous roles they play apart from an educator including administrative and management roles. Our workshop will focus on use of concepts from management theory to empower training directors to work collaboratively with their team including assistant PDs and chief residents to assist learners in difficulty. This workshop will use case-based vignettes, audience polling, and group discussion to review best practices for effective management as a new training director.

Agenda

• Introduction and Framing to Workshop- (small groups) (5 mins) Ahmad Hameed M.D
• Case 1: Learner Difficulty in Clinical Competencies (Clinical) (25 min) Aum Pathare M.D
- Review vignette/discussion (10 mins)
- Poll (2 mins)
- Guidance on how to mentor a learner who is not achieving competencies (10 mins)
- Wrap-up (3 min)

• Case 2: Resolving Discord among the Resident Cohort (Mentorship) (25 min) Dallas Hamlin M.D
- Review vignette/discussion (10 min)
- Poll (2 min)
- Trainee experience of interacting with a PD in different roles and relevant psychology (10 min)
- Wrap-up (3 min)

• Case 3: When all fails (Administrative) (25 min) Rashi Aggarwal M.D and Ahmad Hameed M.D
- Review vignette/discussion (10 min)
- Poll (2 min)
- Strategies and administrative steps used when learner continues to not meet ACGME competencies (10 min)
- Wrap-up (3 min)

• Conclusions, Action Items and Questions (10 min)

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Race Against the Machine: Navigating AI in Psychiatry to Craft a New Curriculum

Primary Category
Curriculum

Presenters
Dale Peeples, MD, Medical College of Georgia at Augusta University
Liz Gass, MD, MPH, University of Washington, Boise
Ronke Babalola, MD, MPH, Hackensack Meridian Health-Ocean Medical Center
Manassa Hany, MD, Zucker School of Medicine at Hofstra/Northwell
Simarpreet Kaur, MD, Nassau University Medical Center Program

Educational Objectives
1. Briefly review core terminology and concepts with a focus on large language models and how to access them.
2. Analyze the literature related to curriculum development in medical education, ethics of AI use in medicine, and current clinical applications of AI in psychiatry.
3. Utilize this background information on AI to identify elements that need to be incorporated into a psychiatry residency training curriculum.
4. Discuss potential promises and pitfalls of the use of AI by residents and students.
5. Collaboratively create a template for adapting existing curricula to enable residents to evaluate, implement, and leverage existing and forthcoming AI technologies.

Abstract
The rapid rise of AI large language models (LLMs) like ChatGPT, Google Gemini, and Microsoft Copilot has transformed various sectors, including education and healthcare. While students have quickly adopted these technologies (1,2,3), medical educators have been more cautious. As residents increasingly utilize AI in both academic and clinical settings, program directors must ensure ethical use and critical appraisal of these tools in clinical care, research, and education (4).

Potential applications of AI, as highlighted by the AADPRT AI Taskforce, in psychiatric clinical care abound. Already, AI is being integrated into electronic medical records for documentation, data collection, and psychiatric illness identification. These uses raise ethical concerns about patient privacy, the doctor-patient relationship, and protecting underrepresented communities. Trainees need curricula to help them navigate these challenges and to make informed decisions about adopting new technologies (5).

Beyond the current applications, many more loom. Numerous publications advertise potential psychiatric applications of AI-based tools, but only a fraction of these tools and models make their way into clinical practice (6,7). This gap between research

performance and real-world impact highlights the need for better generalizability, interpretability, and clinical translational relevance. As AI products proliferate and their purported applications are described in both scientific literature and the commercial market, psychiatrists must have a framework for evaluating these models' creation, limitations, and potential harms (8). Like other elements of practice-based learning and improvement, the development of this framework must begin in medical training. Undergraduate medical education is beginning to recognize and meet this need, and our graduate medical education programs must follow (9).

Although program directors are beginning to grapple with these issues, few feel prepared to provide relevant leadership and teaching to their trainees. This workshop, aligned with the theme "Magpadayon, leading and educating amidst change," aims to engage AADPRT members in identifying essential elements for a psychiatry residency curriculum on AI. We will work towards developing consensus on major teaching domains (9, 10), potentially including ethics (11), clinical applications, data analysis, and AI-driven healthcare changes. The goal is to create a shared understanding of the scientific knowledge and clinical reasoning skills necessary to equip trainees to adapt to technological change for the coming decade.

We invite participants to collaborate in designing a curriculum that addresses these needs, ensuring that future psychiatrists can effectively and ethically leverage AI tools while remaining vigilant to their limitations and potential risks. The results of this collaboration will be used to inform the creation of a model curriculum that will be added to the AADPRT VTO

Practice Gap

In keeping with the 2025 Annual Meeting Theme, we address an area of rapid technological change poised to disrupt the practice of medicine. The application of artificial Intelligence (AI) to medicine and psychiatry is steadily growing, but AI as part of residency education has been woefully neglected. MedEdPortal contains three curricula mentioning AI, none of which focus on psychiatry or teaching AI as part of a GME curriculum. The AADPRT VTO has no curriculum resources on AI. AADPRT has acknowledged a need for more information on AI through the establishment of the AI Taskforce. This workshop, put forward by the curriculum committee, will begin to fill that practice gap by collaboratively identifying what trainees need to know about AI.

Agenda

15 minutes: Presenters will discuss the background of AI-LLM's, briefly review applications in psychiatry, raise ethical considerations regarding AI use, and discuss the literature on AI curricula in medical education, both at the UME and GME levels.

30 minutes: Attendees divide into small groups to discuss subject content needed for an AI psychiatry curriculum (eg- clinical applications of AI, ethics in AI use, research limitations).
15 minutes: Small groups will share ideas with all attendees. Group discussion will identify and rank the most pressing issues related to psychiatric training.

15 minutes: Small groups discuss how to incorporate topics into training (eg- discrete seminars, inclusion in other seminar topics, clinical applications, or independent projects), and how much time could be reasonable to allot to education on AI.
15 minutes: Close with general discussion, survey participants on AI in psychiatry, and organize for ongoing work on AI Curriculum.

Scientific Citations

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Title
Shrink Think: Interactive Games to Build a Psychiatric Interviewing Curriculum

Primary Category
Curriculum

Presenters
Dean Atkinson, BS, MD, McGovern Medical School at UTHealth
Jeffrey Woods, MD, McGovern Medical School at UTHealth
Christina Danna, MD, McGovern Medical School at UTHealth
Gabriella Thiessen, MD, University of Virginia Health System

Educational Objectives
At the conclusion of this session, the participant will be able to:
1. Articulate the importance of the psychiatric interview in skillfully and sensitively navigating the patient experience.
2. Practice natural gates by improvising transitional phrases to gracefully maneuver the psychiatric interview through the game “Psych Connector.”
3. Discover creative ways to assess for auditory hallucinations, suicidal ideation, and substance abuse through the game “Psychobabble.”
4. Investigate opportunities to integrate educational games into teaching psychiatric interviewing techniques to trainees.

Abstract
The psychiatric interview is one of the most important tools available to psychiatrists, as it allows the clinician to skillfully and sensitively navigate a patient’s experience. Although psychiatry relies heavily on the interview, few specific teaching tools exist to help resident trainees learn interviewing techniques. With auditory hallucinations, for example, trainees often rely on standard screening questions, for example, “Do you hear voices?” Sometimes a patient may not have enough insight to identify hallucinations as “voices,” or perhaps the auditory hallucinations experienced are not voices at all. While straightforward, stock questions often fail to uncover the truth of a patient’s experience. To equip future psychiatrists to navigate the psychiatric interview with dexterity, educators may present curriculum in a way that is engaging, accessible, and relevant to patient care. In this session, we will introduce participants to two interactive classroom games. First, the game “Psychobabble” challenges participants to think outside the box when assessing psychiatric symptoms, especially symptoms typically screened with stock questions. Second, the game “Psych Connector" invites participants to improvise transitional statements to gracefully maneuver the psychiatric interview using natural gates. Learners will work in groups to play these two educational games in a friendly and collaborative environment. The overall experience is intended to stretch a participant’s

imagination and create a joyful synergy between refining interview techniques and enjoying the games. Moreover, this session will discuss the practical efficacy of these games as teaching tools, as demonstrated in the initial study of "Psychobabble," which found that the teaching tool may more than double a learner's self-reported competence in assessment of psychiatric symptoms. This session will provide participants the opportunity to experience these games as learners and to reflect on integrating these educational games to complement other clinical curriculum for trainees.

Practice Gap
Although psychiatry relies heavily on the interview, few specific teaching tools exist to help resident trainees learn interviewing techniques. This workshop will teach two such specific teaching tools in an interactive game format which can be incorporated easily into a curriculum.

Agenda
1. Introduction and Overview
2. Small group activity: "Psychobabble"
3. Full group discussion and debrief of "Psychobabble"
4. Overview of the main psychiatric interviewing gates
5. Small group activity: "Psych Connector"
6. Full group discussion and debrief of "Psych Connector"
7. Final Q&A

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Title
Supporting Resident Creation of Therapeutic Spaces for Underrepresented Groups

Primary Category
Curriculum

Presenters
Megan Ann Mendoza, BA, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives
Upon completion of this workshop, participants will be able to: 1. Analyze the current state of cultural humility and group psychotherapy in psychiatry training generally and within participants' specific home programs, as well as identify any gaps between current and optimal practice, 2. Describe the development and outcomes related to a group intervention for graduate and medical students historically underrepresented in medicine, and 3. Describe the development and outcomes related to a group intervention for black-identifying adolescents and their caretakers, and 4. Utilize strategies to support residents' development of clinical training experiences focused on skills in culturally sensitive care and group psychotherapy

Abstract
Cultural humility is defined as a lifelong commitment to self-evaluation and to developing partnerships with communities on behalf of individual populations (Lombadero et al, 2023). Though the term is now used across medical education, inclusion of cultural humility in medical training is a relatively new phenomenon. While many interventions have focused on theory rather than practice, recent studies show that culturally sensitive care improves ethnic minorities' health care outcomes (Joo & Liu, 2020). Residents have become more interested in learning how to effectively treat historically underserved populations, though do not always feel equipped to do so, with cultural psychiatry teaching in psychiatry residency often being limited (Weissman et al, 2001; Venkataramu et al., 2021). Secondly, resident interest in advocacy has grown, as advocacy becomes increasingly recognized as an integral part of psychiatric practice and is a sub-competency of systems based practice through the ACGME. Thirdly, training in psychotherapy – particularly group psychotherapy – is a strong interest of trainees, despite training in this modality being limited in many psychiatry residency programs (Salgado & von Doellinger, 2024).

Group psychotherapy tailored to the needs of underrepresented populations is a promising clinical intervention which addresses these three areas in residency education. Underrepresented populations are especially vulnerable to mental illness, especially

underrepresented women in medical school, graduate school and MD-PhD programs (Wilkens-Yel et al, 2022). Positive racial socialization may buffer discrimination faced by youth of color and therefore limit insults to mental health (Asabere et al, 2024). Counter-spaces present academic and social safe spaces that allow underrepresented students to process and receive validation for frustrations, share stories of isolation, microaggressions and challenge deficit notions of people of color, as well as to create a positive racial climate (Ong, 2018). The formation of counter-spaces is an act of advocacy that heralds change, given the growing diversity of medical professionals.

Specific training in the delivery of group interventions geared towards underserved patient populations is limited for trainees. Residents interested in learning about and implementing such clinical activities require specific support from faculty. Practice based learning, in the spirit of Magpadayon, involves a duty to improve and grow with time as the population demographics change. Our workshop will address this need by providing guidance for faculty and training directors to support residents interested in learning more about cultural psychiatry and group psychotherapy. Prior to the 2022-2023 academic year, within the NewYork-Presbyterian Psychiatry Department, no group spaces linked to race or the combination of gender and race existed. We will describe the creation of two such groups, including one resident-led group geared towards supporting women graduate students historically underrepresented in medicine, and another resident-led group geared towards supporting black-identifying youths and their caretakers. Small group exercises will also be conducted to give participants an interactive training in conducting these groups. We will also poll attendees on comfort levels with and current practice gaps in cultural and group psychiatry training, as well as conduct large group discussions on navigating challenges that arise when creating such a training experience.

Practice Gap

Culturally sensitive care improves ethnic minorities' health care outcomes (Joo & Liu, 2020). Resident interest in learning effective treatments for historically underserved populations has grown, though teaching in cultural psychiatry is often limited and residents do not always feel adequately trained in this (Weissman et al., 2001; Venkataramu et al., 2021). Residents are also interested in learning about psychotherapy, particularly group psychotherapy, which also has limited training in programs (Salgado & von Doellinger, 2024). Group-based interventions geared towards underserved patient populations is emerging as an effective strategy, though specific training in this is limited for trainees. This program closes the gap between current and optimal education by presenting two innovative resident-led psychotherapeutic groups focusing on ethnic minority populations. To forge ahead with change and enhance training in these areas in

the spirit of Magpadayon, psychiatry residency programs must learn how to meet the needs and training interests of residents accordingly.

Agenda

10 minutes: Introduction and Background, including polling of attendees (current comfort with and level of training in cultural and group psychotherapy versus desired)
10 minutes: Mini-didactic on the history, development, and implementation of group psychotherapy for black-identifying youth and their caregivers
10 minutes: Mini-didactic on the history, development, and implementation of group psychotherapy for women-identifying medical and graduate students historically underrepresented in medicine
25 minutes: Interactive small break-out groups, where participants will engage in an experiential practice of interventions utilized in one of the outlined group interventions
10 minutes: Interactive small group discussion of experiential group intervention
10 minutes: Reconvene in large group to discuss highlights from small group exercise
15 minutes: Wrap-up, including reviewing take-home points, question and answer

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Welcoming Gen Z: Considerations in Training the “Anxious Generation”

Primary Category
Wellness, Burnout, Resilience

Presenters
Jessica Obeysekare, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program
Amy Meadows, MD, MS, University of Kentucky
Raphaela Fontana, DO, Prisma Health/University of South Carolina School of Medicine - Greenville
Douglas Glenn, BS, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Educational Objectives
1. To sensitively review studies on characteristics and learning styles of Gen Z, without perpetuating generational stereotypes
2. To review evidence regarding the impact of smartphones on cognition
3. To provide a space for a group discussion and share our ideas about ways to support our Gen Z residents and to not contribute to the smartphone cognitive impact

Abstract
Our new Gen Z residents may arrive with less experience navigating in-person social situations and less “soft skills” and a higher propensity for depression and anxiety (3). Some believe this is directly related to smartphone and social media exposure during sensitive time periods during puberty and due to a corresponding reduction in time building in-person relationships (3). Jonathan Haidt, author of The Anxious Generation, notes that typical in-person interactions within a social community depend on body language, occur in smaller groups and in sequence, and occur in communities with high barriers to entry (3). We believe that these characteristics are also typical in a doctor-patient relationship. In contrast, communication through online networks lack body language, often occur with one message potentially reaching hundreds (or more) people, can occur asynchronously, and take place in spaces with lower barriers to entry/exit. Coming to age as a “digital native” has given Gen Z ample practice in building connections through online networks, but this may be at the cost of practice in navigating in-person interactions and is hypothesized to contribute to increased rates of anxiety, depression, and loneliness seen in this generation.

As the smartphone is a defining characteristic of this generation, we will spend more time considering smartphone use during training. While smartphones can be seen as another medical tool which facilitate communication within/between teams and allow easy access to medical literature and calculators, there are multiple potential downsides. A 2023 report showed the median number of notifications per day on teenager's smart phone was 237 (4). Distraction with a smartphone during a lecture has been shown to decrease learning (5) and the presence of a smartphone is associated with lower cognitive performance on attention and concentration measures (6).

Considerations:

1. To prevent paging apps from competing with the hundreds of other notifications received during the day on a smartphone, consider separate pagers or a dedicated workphone.

2. To allow residents to use "do not disturb" settings on their smartphones, we could try to not have the expectation to residents that they need to be available to answer text messages from their team and attendings. Instead, communication could be solely through the paging app.

3. Due to evidence for undeveloped social skills, residents may benefit from more extensive "interviewing workshops" and supportive psychotherapy training.

4. As the presence of smartphones is associated with decreased attention and learning, consider clearly stating expectations around technology use during didactics and while interviewing patients.

5. Residents struggling with decreased efficiency due to spending excess time on their phone may benefit from keeping their workflow disconnected to their phone. For example, using a dictation microphone instead of a dictation app may prevent residents from becoming distracted by social media notifications while dictating.

Practice Gap

According to the Pew Research Center, "Generation Z," also referred to as "digital natives," are people born between 1997-2012 (1). As the first iPhone was released in 2007, Gen Z is the first generation to go through puberty with handheld smartphones. Gen Z exhibits important differences in characteristics and learning styles compared to Millennials, with multiple studies citing "underdeveloped social skills" in Gen Z (2). As we welcome our first classes of Gen Z into residency programs, we should be aware of potential generational differences and evaluate our curricula and policies to best suit our learners.

Agenda

Agenda:
0-5: Introductions
5-15: Review of studies on characteristics of Gen Z
15-25: Group discussions re: PD/APD observations with this cohort
25-35: Review of studies on impact of smartphones
35-55: Small group brainstorming ways to mitigate negative effects of smartphones and enhance learning environment for Gen Z
55-80: Sharing ideas from small groups and reviewing ideas from the facilitators
80-90: Wrap up & evaluations

Scientific Citations

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
What Would You Do? How Structural Competency Can Help Train Psychiatry Residents to Navigate Complex Consultation-Liaison Psychiatry Cases

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Jai Gandhi, MD, Baylor College of Medicine
Samuel Greenstein, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Anita Kumar Chang, DO, The Ohio State University College of Medicine
Patrick Ho, MD, MPH, Dartmouth-Hitchcock Medical Center

Educational Objectives
1. Review the evidence base on how unconscious bias directly impacts healthcare decisions and patient outcomes.
2. Apply structural competence and humility to the formulation of complex consultation-liaison psychiatry cases and recognize how this improves patient outcomes.
3. Develop a unique approach to patient care through the use of the structural vulnerability checklist.

Abstract
Maya Angelou is often quoted for her wisdom with the words, “Do the best you can until you know better. Then, when you know better, do better.” This approach to bettering oneself is highly relevant to training the next generations of psychiatrists, not only in the clinical setting but as citizens of the larger world.

C-L psychiatrists work in close collaboration with primary medical providers, and often use a biopsychosocial framework that highlights unique patient vulnerabilities to both medical and mental illness (Engel 1977). This framework allows for C-L psychiatrists to appreciate the impact of social determinants of mental health and the biological contributions to psychiatric symptoms. Yet, this approach may limit the immense scope of potential interventions that may benefit any individual patient.

The COVID-19 pandemic exposed these limitations, and had deeply negative effects on marginalized and minoritized populations, already vulnerable to numerous adverse health outcomes. Research demonstrated people living in the most impoverished, crowded, and racially polarized counties experienced substantially higher rates of COVID-19 infection and death (Chen 2021). Structural competency demands C-L psychiatrists to “recognize ways that institutions, neighborhood conditions, market forces, public policies, and health care delivery systems shape symptoms and diseases” (Metzl 2013). Structural

competency aims to better illuminate the frameworks we utilize in C-L psychiatry, and simultaneously provide a new method of creative problem solving to improve patient outcomes. This structural competency generalizes out to the general education of our psychiatry residents.

Dr. Samuel Greenstein, C/L Fellowship Director at Zucker Hillside Hospital - Northwell Health, will open the session with an interactive question, prompting examination of the pre-existing biases, and frameworks, we may use as psychiatric providers. He will transition into a didactic session examining the role of bias in provision of care, and introduce how bias interfaces with the concept of naturalizing inequality. Dr. Jai Gandhi, member of the APA Council of Minority Mental Health and Health Disparities, will then examine the definition of structural competency, and its deep relevance to our work in training psychiatrists, utilizing an interactive question to provoke reflection on our role. Afterwards, we will break into groups to discuss patient cases each of the participants have encountered where social structures may have played a role in patient care and patient outcomes. Dr. Anita Chang, member of the ACLP Bioethics Special Interest Group, will present on the medical lens often utilized on the C-L psychiatry rotation and how to advance our formulation of patient care through a conversation about structural vulnerability and an anti-racist approach to clinical care (Legha and Miranda, 2020). Dr. Patrick Ho, president elect of the New Hampshire Medical Society and an assistant program director of Dartmouth-Hitchcock Medical Center's psychiatry residency program, will close the session by introducing a concrete tool to utilize in their clinical practice and in training future psychiatrists.

Practice Gap

The application of the concepts across the structural competency framework remain woefully underutilized in didactic curricula and among patient encounters (Castillo 2020). This glaring deficit may account for experiences of moral distress among psychiatrists' uncertain how to approach or think about the social determinants grossly impacting their patients ability to recover from illness. The structural competency framework illustrates the connections between research, institutions, policy, and their patients' wellness, as well as the levels of intervention available for psychiatry training programs, psychiatry trainees, and psychiatry faculty (Mathis 2019). The structural competency framework provides a language by which to discuss the glaring social inequity affecting so many patients, and empowers psychiatrists to take action - in feasible and practical ways (Shim 2021).

Agenda

I. 5 minutes: Interactive Question
   a. What Does Structural Competency Mean: Word Cloud

II. 10 minutes: Unconscious Bias/Implicit Bias
    a. Introduce Naturalizing Inequality
III. 10 minutes: Structural Competency and Psychiatry Training on the C-L service
    a. Interactive - Role of Psychiatrist: Word Cloud
IV. 10 minutes: Small Groups - Talk about cases and experiences where you think structures may have played a role in patients' care
    a. Illustrate structures
V. 5 minutes: Present Small Group Findings
VI. 10 minutes: Adding Structural Vulnerability and Anti-Racist Approach to Clinical Care
VII. 10 minutes: Small Groups - Discuss handout on applying anti-racism to clinical care
VIII. 10 minutes: Case to use Structural Vulnerability
IX. 15 minutes: Q&A
X. 5 minutes: Participant evaluations

Scientific Citations

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Workshop Session #3

Title
A Constant Amidst Change: The Y model as an integrated framework for teaching psychotherapy competencies

Primary Category
Curriculum

Presenters
Alena Balasanova, MD, University of Nebraska Medical Center College of Medicine
Matthew Kelly, MD, University of Nebraska Medical Center College of Medicine
Anne Ruble, BA, MPH, MD, Johns Hopkins Medical Institutions
David Mintz, MD, Austen Riggs Center - NOT ACCREDITED
Eric Plakun, MD, Austen Riggs Center - NOT ACCREDITED

Educational Objectives
1. Understand the role of psychotherapy in psychiatry residency
2. Describe common elements of effective psychotherapies utilizing the Y Model
3. Discover Methods of effectively teaching the Y Model to residents and fellows
4. Develop strategies for teaching faculty how to incorporate the Y model into resident and fellow supervision

Abstract
This workshop will begin with a review of the history of the Y Model by one of its creators as well as a brief summary of its components and evidence base. This will be followed by breakout discussion groups in which attendees will have the opportunity to discuss ways of applying the Y Model toward creating or enhancing existing psychotherapy curricula. After this interactive learning activity, the panel will present an innovative 12-week Psychotherapy Course developed at the University of Nebraska Medical Center. This curriculum employs a flipped classroom model facilitated by four MD faculty members in the Department of Psychiatry. Residents learn about the common factors as well as foundational concepts in CBT, supportive, and psychodynamic psychotherapy. One of the goals of the course is to role model physician engagement in psychotherapeutic work, as well as instill a sense of professional responsibility in residents to provide psychotherapeutic treatments to their patients during and upon graduation from residency. Finally, the workshop will end with a panel discussion and Q&A session with participation from the Y Model's originators.

At the conclusion of this workshop, training directors will have a better understanding of the Y Model and how to incorporate it into existing therapy training paradigms, thereby closing the gap between actual and best practices for teaching Residents and Fellows the important skill of psychotherapy.

Practice Gap

In 2001, the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee added psychotherapy as a core clinical competency. Despite the renewed emphasis on psychotherapy as an essential component of modern psychiatric practice in the last two decades, educational experiences vary widely across United States residency programs creating a discrepancy between optimal teaching and actual learning. In one study, for example, only a minority of chief residents (31%) surveyed reported that core psychotherapy competencies were well-integrated into their residency curricula. In order to bridge this gap, the Y Model offers an efficient, evidence-based, and integrated approach to teaching psychiatry residents core psychotherapy skills. The incorporation of this model into current training programs is likely to enrich residents' and fellows' psychotherapy experience and develop competency in psychotherapeutic modalities which have proven efficacy in the treatment of common mental disorders.

Agenda

00:00-00:05 Introduction of presenters
00:05-00:10 Common factors and relationship to Y Model
00:10-00:25: The Y Model Framework
00:25-00:30 Introduction of breakout group activity, distribution of handouts, explanation of prompts for activity
00:30-00:50 Breakout group activity
00:50-00:55 Full group debrief of group activity
00:55-01:05 Presentation of example curriculum developed and implemented using the Y model at an under resourced psychiatry residency in the Midwest
01:05-01:20 Wrap-up and Q&A Panel
01:30-01:30 Evaluations and spillover Q&A
Total time = 90min

Scientific Citations

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Title
Constructive Feedback in 5D: Program Improvement Using Appreciative Inquiry and Shared Task Tracking

Primary Category
Program Administration and Leadership

Presenters
Brian Kurtz, MD, Cincinnati Children's Hospital Medical Center
Brian Evans, DO, University of Cincinnati
Lucia Wang, MD, Cincinnati Children's Hospital Medical Center
Cristin McDermott, MD, University of Connecticut Health Center

Educational Objectives
By the end of this workshop, participants will be able to:
1. Review current processes used by programs to discuss program feedback from trainees
2. Identify the five D's of the Appreciative Inquiry process
3. Describe how Appreciative Inquiry can be used to brainstorm organizational change with trainees
4. Incorporate the use of a dynamic tracker in developing and implementing actionable items
5. Access a tracker template that can be customized and used at home institutions

Abstract
Feedback conversations are widely recognized as important despite ongoing struggles with its facilitation, including those that concern program improvement. There are a variety of ways in which feedback can occur between program leadership and trainees, but the productivity of these conversations can be lost in the shuffle with other competing demands in academic medicine. Thus, the very discussions with trainees about a program's growth opportunities can be a main area of improvement themselves. This further highlights the significance of artfully navigating differing opinions, using skills that promote a collaborative dialogue that leads to an actionable agenda.

In our roles as program directors, education leaders, and chief residents, we invite programs to learn about a specific technique and a tangible tool when addressing program feedback: 1) Appreciative Inquiry when facilitating feedback discussions, followed by 2) a dynamic tracker as a guide and record of actionable items. By targeting key areas of effective feedback communication, our goal is to foster trust through successful dialogue and bidirectional accountability between leadership and trainees.

Practice Gap

Despite its importance, it is not easy to simultaneously navigate program feedback and foster trust. Trainees and program leadership may have all the best intentions for organizational change; however, some of these ideas can be lost to ineffective communication and implementation. Trainees often offer newer perspectives, while training directors have greater access to institutional memory and knowledge of system limitations. This discrepancy, along with power differentials and competing priorities, can lead to conversations that fall short of the productivity all parties may hope for.

Agenda

Welcome and introduction (5 min)
Large-group discussion of collaborative processes programs are currently using (10 min)
Introduction to Appreciative Inquiry (15 min)
Break-out #1: Appreciative Inquiry guided by worksheet with specific prompt (15 min)
Large-group review and questions about Appreciative Inquiry (10 min)
Introduction to tracker and integration into actionable items (10 min)
Break-out #2: Tracker incorporation (10 min)
Conclusion with discussion and questions (10 min)
Evaluation form (5 min)

Scientific Citations

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LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Developing a Community-Based Psychiatry Training Elective by Partnering with a Church-Affiliated Mental Health Clinic

Primary Category
Program Administration and Leadership

Presenters
Sidney Hankerson, MD, MBA, Icahn School of Medicine at Mount Sinai
Lena Green, DSW, LCSW, Icahn School of Medicine at Mount Sinai
Antonia New, MD, Icahn School of Medicine at Mount Sinai

Educational Objectives
(1) Apply principles of community-engaged research to psychiatry residency training;
(2) Utilize community partners to help psychiatry residents build upon community strengths in providing clinical services;
(3) Assess how multi-level frameworks and be applied to health disparities populations

Abstract
The Psychiatry Residency at the Icahn School of Medicine at Mount Sinai (ISMMS) is implementing a new curriculum and clinical opportunity to educate residents to deliver culturally sensitive mental health services in community settings. The curriculum includes didactic components and an opportunity for trainees to engage in a year-long rotation at the HOPE (Healing On Purpose and Evolving) Center in Center Harlem to deliver direct patient care under the supervision Drs. Hankerson, New, and Green. Didactic training includes culturally tailored psychoeducation, study of culturally informed methods of mental health diagnosis and care delivery and understanding of the impact of systemic racism on psychological and psychiatric vulnerabilities, among other topics. During the pilot project year, 2 psychiatrist trainees will provide direct services at the HOPE Center. All 35 trainees in the residency program will participate in workshops, Healing Conversations, and Self-Care Fairs. The pilot training program will inform ongoing refinement of the curriculum, which is intended to serve as a national model. By providing clinical services free of charge, the HOPE Center's services are expressly intended to meet the needs of low-income New Yorkers in Harlem. The Center's core values include "respecting and responding to innovators [as Center participants are called] power to create the life they deserve." To ensure that Center programming is data-driven and responsive to community needs, the Center recently conducted bi-annual needs assessment surveys, securing responses from 300 local resident to drive planning and program refinement. This elective will primarily serve low-income New Yorkers who reside in Central and East Harlem. Central Harlem is a majority Black/Latinx population: 55.3% Black/AA, 23.9% Latinx, and 3.5% Asian. East Harlem is also a majority Black/Latinx population: 44.9% Latinx, 31.6% Black/AA, and 7.6% Asian. Poverty rates in East and Central Harlem are more than 1.5 times that of

NYC overall (31% and 34%, respectively). Building on principles of community-engaged research, the objectives of the pilot psychiatry community-based residency

training program are to: prepare psychiatrists to deliver the highest quality mental health services to individuals and families with low-income; and develop a replicable model of training and care delivery informed by culturally sensitive, tailored approaches to evidence-based treatment.

Practice Gap
There is a gap in translating principles of community-engaged research into clinical practice among psychiatry residents to address population-based mental health disparities

Agenda
Opening: Presentation will begin with a newscast video describing the creation and programming offered at the HOPE Center Harlem

Dr. Hankerson will review national data about mental health treatment disparities, rationale and principles of community engaged research, and an overview of the rationale for embedding psychiatry residents into community settings

Dr. Green provide a detailed description of the rationale and services offered at the HOPE Center, review details of the Mount Sinai-HOPE Center PGY4 HOPE Center elective, and review clinical and programmatic outcomes of residents who have completed the elective

Dr. New will discuss how the Mount Sinai-HOPE Center elective addresses key learning gaps in psychiatry residency training, and share perspectives of how to implement successful programs for Program Directors

Closing: Presenters summarize key take aways and open for Q&A from audience

Scientific Citations
Chaudhary AMD, Naveed S, Saboor S, Safdar B, Azeem MW, Khosa F. Gender and Racial Disparities among US Psychiatry Residents: A Review of Trends. Psychiatr Q. 2022 Mar;93(1):97-105.

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Title
From Mundane To Memorable: Enhancing Program Meetings Through Creativity, Theming and AI

Primary Category
Faculty Development

Presenters
Cathleen Cerny-Suelzer, BA, MD, Case Western Reserve University/University Hospitals of Cleveland Program
Victoria Kelly, MD, University of Toledo
Andrew Hunt, MD, Case Western Reserve University/University Hospitals of Cleveland Program
Julia Shekunov, MD, Mayo School of Graduate Medical Education
Ayame Takahashi, MD, Southern Illinois University School of Medicine

Educational Objectives
Participants will identify key points from Priya Parker's "The Art of Gathering" and discuss how these concepts can be applied to enhance the effectiveness and engagement of psychiatry training meetings.
Participants will list examples of themed training program meetings that apply principles of gathering to create meaningful experiences.
Participants will review how artificial intelligence can be a useful tool in accelerating planning and taking meeting themes and ideas to the next level.
Participants will formulate and workshop 1-2 ideas they can execute to elevate an upcoming program meeting beyond the ordinary.

Abstract
In psychiatry training, many program meetings and events are routine and cyclical but recommended or mandated by the ACGME and local GME leadership. These events create challenging administrative burdens. For example, all training programs must conduct Clinical Competency Committee meetings at least twice annually to determine milestones for their trainees. Every program is responsible for completing annual program reviews. Yearly preparation for the PRITE exam occurs. Faculty professional development sessions must take place. Often these meetings, events, or didactics are stale, costly of time and effort, and lacking in inspiration. The goals are accomplished only on the most basic of levels. We can do better!

Starting with recognition of the higher goals of psychiatry training - the ACGME competencies - we can utilize creativity, themes, gamification, and inspiration from Priya Parker's "The Art of Gathering" to make our routine meetings more engaging and fun. Residency and fellowship training events can be crafted into a series of gatherings that will result in the transformation of trainees into competent psychiatrists and faculty into enthusiastic educators. Further, we can leverage AI tools, such as ChatGPT, to bring

more of ourselves to planning, save time, & get over creativity hurdles to make gatherings truly transformative.

In this workshop, participants will be asked to evoke their recollections of successful gatherings and contrast these with less successful ones. From this experience, we will extrapolate common features of successful events, and discuss application to perfunctory meetings and psychiatry training events. The presenters will share their experiences of designing, planning, and executing successful gatherings, and what they have learned collectively from a decade-plus of psychiatry training events. We will discuss theming, gamification, role play, and team building to enhance medical education. In small groups, participants will hone their purposes, practice generous authority, and use ChatGPT to efficiently design an upcoming event or elevate a previously planned event.

Practice Gap

Residency programs struggle under an administrative burden to meet their required annual training needs for trainees and faculty, while also developing vibrant environments of inquiry that promote belonging, innovation, and resilience. This workshop will help participants learn how to infuse creativity into required and routine training program events, meetings, didactics, and professional development sessions to elevate them beyond the ho-hum. Through theming, attention to the purpose of the meeting, gamification, and free artificial intelligence (AI) tools, participants will gain the means to engage and stimulate their stakeholders in their residency and fellowship training missions. Participants will also develop their “generous authority” (citation 1) leadership skills as hosts of these training events.

Agenda

-Introduction - 5 mins
-The large group shares examples of bad and boring events - 5 minutes
-Presenters summarize the main points from “The Art of Gathering” and the large group will share examples of successful and meaningful gatherings they have attended or held - 10 minutes
-Presenters give several examples of creative meetings they have organized - 15 minutes
-Presenters demonstrate ChatGPT AI's potential role in event planning, workshop participants practice the tools - 10 minutes
-In small groups, participants will design or upgrade a training meeting/event using tools and tips provided - 40 mins
-Questions, wrap-up & evaluation - 5 minutes

Scientific Citations

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Organizational strategies to reduce physician burnout and improve professional fulfillment. Kristine Olson MD, MSc, Daniel Marchalik MD, Heather Farley MD, Shannon M. Dean MD, Elizabeth C. Lawrence MD, FACP, Maryam S. Hamidi PhD, Susannah Rowe MD, MPH, Joanne M. McCool MSOD, Cormac A. O'Donovan MD, Mark A. Micek MD, MPH and Miriam T. Stewart MD. Current Problems in Pediatric and Adolescent Health Care, 2019-12-01, Volume 49, Issue 12

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LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
From Tarasoff to Parkland: opportunities in forensic curriculum development

Primary Category
Curriculum

Presenters
Megan Mroczkowski, MD, New York University School of Medicine
Erick Hung, MD, University of California, San Francisco
Alissa Peterson, MD, University of California, San Francisco
Caitlin Costello, MD, University of California, San Francisco

Educational Objectives
At the end of this workshop, participants will be able to:
1. Summarize the ACGME requirements for Forensic Psychiatry in both Psychiatry and Child and Adolescent Psychiatry Residencies.
2. Describe the current state of the literature in forensic curriculum in both Psychiatry and Child and Adolescent Psychiatry residencies.
3. Appreciate the myriad ways in which the ACGME forensic psychiatry requirement may be met in both Psychiatry residencies and CAP fellowships with three national examples.
4. Connect with other programs with the goal to collaborate and share resources to meet this ACGME requirement.
5. Identify means to utilize telepsychiatry to expand capabilities to areas with fewer forensic psychiatry resources.

Abstract
ACGME requires that Psychiatry Resident experience in forensic psychiatry must include "experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency." ACGME requires Child and Adolescent Psychiatry Fellows experience in "legal issues relevant to child and adolescent psychiatry, which may include forensic consultation, court testimony, and/or interaction with a juvenile justice system." This requirement, open to broad interpretation, can be met in myriad ways. Programs vary widely in faculty experience in forensic psychiatry and local resources to accomplish this requirement. This workshop will present three examples of forensic curriculum across two institutions. Specifically, the forensic curriculum in an Adult Psychiatry Residency and a CAP fellowship at a large, tertiary care university hospital on the West Coast will be described and compared to the CAP fellowship curriculum at a large, public hospital on the East Coast. This workshop will provide a forum for participants to discuss current forensic curriculum at their institutions and brainstorm creative, virtual means to share resources across institutions and locales to meet this requirement.

Practice Gap

ACGME requires that Psychiatry Resident experience in forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency. ACGME requires Child and Adolescent Psychiatry Fellows experience in legal issues relevant to child and adolescent psychiatry, which may include forensic consultation, court testimony, and/or interaction with a juvenile justice system. This broad tent is met through a variety of methods, each optimizing a program's local resources and expertise. This workshop aims to provide several examples of forensic psychiatry training within both Psychiatry residency and CAP fellowship so that participants can optimize their program's forensic curriculum. Creative, virtual means to attain this requirement will be discussed, with a focus on resource sharing across institutions, cities, and regions.

Agenda

Welcome and introductions (5 minutes)
Presentation 1 (10 minutes)
Dr. Mroczkowski will review the current state of the literature in forensic psychiatry curriculum.
Presentation 2 (10 minutes):
Dr. Hung will discuss strategies for forensic psychiatry teaching in adult residency programs.
Presentation 3 (10 minutes):
Dr. Costello will outline a framework for addressing current issues in juvenile justice and common barriers to implementing a forensic curriculum.
Presentation 4 (10 minutes):
Dr. Peterson will discuss challenges around areas of law and justice in the current sociopolitical environment and the relevant considerations to attend to when implementing forensic curricula.
Break-out group 1 (20 minutes):
Small group discussion on home institution resources and connections across institutions
Presentation 5 (10 minutes): Dr. Chamberlain will provide demonstrations of current and emerging technologies in forensic teaching and unique features of the forensic psychiatry fellowship.
Q&A and wrap-up (15 minutes)

Scientific Citations

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Title
Minority faculty's Double-Edged Sword: Sharpening Support, Dulling Burnout

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

Presenters
Ronke Babalola, MD, MPH, Hackensack Meridian Health-Ocean Medical Center
Michael Stoyer, PhD, Nova Southeastern University (Orlando)
Neha Sharma, DO, Tufts Medical Center Program (Boston)

Educational Objectives
1. Identify and analyze the factors contributing to burnout among minority faculty.
2. Evaluate current institutional practices for supporting minority faculty.
3. Develop strategies to mitigate burnout and consider action plans for implementing comprehensive support programs that address the needs of both minority faculty and URiM trainees.
4. Explore methods for fostering cross-cultural mentorship and allyship within medical institutions.

Abstract
The persistent underrepresentation of minority faculty in academic medicine has significant implications for healthcare equity, medical education, and research diversity. There is a greater need to examine the experiences of minority faculty and the challenges they face. Campell et al. (2021) found that minority faculty experience unique stressors contributing to burnout, including feelings of isolation, lack of mentorship, and the burden of cultural taxation. Participants reported feeling pressured to represent their entire racial or ethnic group, leading to emotional exhaustion and decreased job satisfaction. Furthermore, minority faculty often face disproportionate expectations to engage in diversity-related service activities, such as serving on diversity committees or mentoring minority students (Rodriguez et al., 2022). While these activities are crucial for institutional diversity efforts, they can impede career advancement by taking time away from research and other scholarly pursuits.

Researchers have identified strategies to support minority faculty success and retention in academic medical institutions. Vargas et al. (2023) proposed a comprehensive approach to supporting underrepresented minorities in medicine. Their study emphasized the importance of institutional commitment, targeted mentorship programs, and creating inclusive environments that value diversity. The authors outlined a multi-level framework that includes individual support (e.g., skill-building workshops), departmental initiatives (e.g., diverse hiring practices), and institutional policies (e.g.,

anti-discrimination enforcement) to create a more supportive ecosystem for minority faculty. Lawrence et al. (2024) showed that well-structured mentorship initiatives significantly improved retention rates among minority faculty over a five-year period. Mentees in the initiatives were 40% more likely to remain in academic medicine compared to those without structured mentorship. Additionally, participants reported increased job satisfaction, higher rates of promotion, and greater success in securing research funding. Furthermore, Desai et al. (2023) introduced a framework for allyship in academic medicine, outlining how non-minority colleagues and leaders can actively contribute to creating more inclusive and supportive environments. The framework emphasizes self-education about systemic racism, amplifying minority voices, and using one's privilege to advocate for change. The authors argue that effective active allyship can help distribute the burden of diversity work and create a more equitable academic environment, and Vargas and Saetermore (2023) argue that non-minority educators' allyship can come with less risk on the journey to antiracist institutional transformations.

Collectively, these studies underscore the complex challenges faced by minority faculty in academic medicine, including burnout, cultural taxation, and systemic barriers to advancement. However, they also point to promising strategies for improvement, such as institutional commitment to diversity, equity, and inclusion; targeted mentorship and support programs; and the cultivation of allyship among non-minority colleagues. This workshop will have participants identify factors contributing to minority faculty burnout, identify intersectional approaches to alleviate the burden, and begin to develop actionable policy plans to advocate for implementation in their institutions.

Practice Gap

The support of Underrepresented Minorities in Medicine (URiM) trainees is crucial for fostering diversity and inclusion in healthcare. However, this responsibility often falls disproportionately on minority faculty, leading to burnout and negatively impacting both educators and trainees. Current practices fail to address the unique challenges faced by minority faculty, including increased mentoring responsibilities, cultural taxation, lack of institutional recognition, and limited resources. Many institutions lack comprehensive strategies to distribute the responsibility of supporting URiM trainees across all faculty while providing targeted support to minority faculty. This gap in practice results in unsustainable support systems for URiM trainees and contributes to the ongoing burnout crisis among minority faculty in medical education.

Agenda

1. Introduction and overview of burnout among minority faculty (10 minutes)
2. Small group discussions: Sharing experiences and observations (10 minutes)
3. Presentation/large group discussion: Factors contributing to burnout and their impact (15 minutes)
5. Strategy development: Team brainstorming and design (15 minutes)

6. Expert feedback and refinement of strategies (15 minutes)
7. Action plan development (15 minutes)
8. Conclusion and next steps (10 minutes)

Scientific Citations

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2025 ANNUAL MEETING

Title
Navigating Conflicts in Professional Settings: Preparing Residents for the Inevitable

Primary Category
Curriculum

Presenters
Adriane dela Cruz, MD, PhD, UT Southwestern Medical Center
Kari Whatley, MD, University of Texas Austin Dell Medical School
Jennifer O'Donohoe, MD, University of Utah School of Medicine
Fatma Ozlem Hokelekli, MD, PhD, UT Southwestern Medical Center
Melissa Dalhoe, MS, University of Minnesota

Educational Objectives
At the end of this workshop, participants will be able to:
-Describe the rationale for including training in conflict negotiation for psychiatry trainees
-Recognize conversations and conflicts that we often avoid or handle poorly
-Describe resources and strategies for teaching conflict negotiation skills to psychiatry trainees
-Outline a plan for implementing a training in conflict negotiation in their home program

Abstract
The Accreditation Council for Graduate Medical Education (ACGME) explicitly names interpersonal and communication skills as one of the six domains of physician competence in psychiatry (3). Interpersonal and communication skills are necessary when navigating complex situations, uncertainty, and conflict in the workplace. Skills include taking a personal inventory of your communication style and motives, creating a safe space for dialogue, sharing your perspective, hearing the other side's perspective, finding common ground, and negotiating resolution (5, 6, 7). These skills are not only helpful for efficient and effective clinical practice with patients and families, interprofessional teamwork, and system-level advocacy, but these skills have also been found to reduce burnout for residents in training (2, 3,8). With little published about psychiatry residency program training approaches to teaching this skill set, educators wanting to incorporate this into their residency curriculum are faced with the challenge of sifting through the many frameworks for managing conflict (e.g., Thomas Kilmann Conflict Model, Shannon-Kim 4-Step Conflict Dialogue Model, and Crucial Conversations) (5, 6, 7). Therefore, this workshop aims to support educators by providing rationale and direction for how to integrate training on conflict management into a psychiatry residency program. Representative of four different academic institutions, workshop facilitators skilled in teaching conflict management will host an experiential workshop where participants will be invited to first identify conflict and use

conflict management skills, and second, begin to build a curriculum for their training program.

Practice Gap

Navigating conflict and effectively communicating are essential skills for physicians. [1] Communication issues at work can increase resident burnout.[2] The ACGME Psychiatry Milestones measure trainees' ability to communicate with patients and families in settings with a high degree of uncertainty and conflict. They also examine interprofessional and team communication and the ability to resolve conflict. [3] However, no guidelines or curricula exist to teach psychiatric trainees the skills needed to successfully address conflict in the clinical environment. This workshop provides samples of conflict management and communication curricula from four different institutions. These curricula have been adapted from pediatrics, surgery, and from well-established business models. [4,5] The curricula include evidenced-based practices such as the Thomas-Kilmann modes of conflict, strategies from Crucial Conversations, and conflict resolution hierarchy. [5, 6, 7] A curriculum in conflict management will ensure that trainees develop the communication skills necessary to navigate challenging clinical and professional situations.

Agenda

This 90-minute workshop will include large group didactic sessions/discussion and small-group activities.
Minutes 0-20: Introductory didactic on the rationale for explicitly teaching conflict negotiation in psychiatry training programs, approaches to identifying conflict and high-stakes conversations, conflict negotiation approaches (GPRI, conflict negotiation styles), and sample implementations
Minutes 20-40: Small Group One—icebreaker and sample conflict negotiation task taken from curricula developed by presenters
Minutes 40-50: Large Group Debrief conflict negotiation task
Minutes 50-70: Small Group Two—participants will work in small groups to develop a curriculum on conflict negotiation to implement at their home institution
Minutes 70-85: Large Group Debrief of facilitators and barriers of implementing conflict negotiation curricula
Minutes 85-90: Wrap Up and Survey Completion

Scientific Citations

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Psychiatry Underrepresented in Medicine Mentorship Program (PUMP): Mentoring the Mentors

Primary Category
Faculty Development

Presenters
Nkechi Conteh, MBBS, MPH, Boston University Medical Center
Isaac De La Bruere, MD, Boston University Medical Center

Educational Objectives
1. Compare and contrast different models of mentorship and identify which applies to different situations
2. Describe essential facets of mentoring residents with multiple minoritized identities.
3 Discuss the most reported challenges to URiM resident recruitment from residents' perspective.
4. Identify innovative strategies to support URiM resident resilience in the setting of limited resources
5. Develop a plan to avoid pitfalls in the mentorship of URiM residents that can be implemented in their programs.

Abstract
Mentorship of residents is critical to developing a successful career in medicine. Residents who are underrepresented in medicine (URIM) are significantly less likely to establish a mentorship relationship compared to their peers. Studies have shown that URIM residents prefer to have racially concordant mentors who are more likely to understand the unique challenges that URIM residents face. However, evidence also suggests that both URIM faculty and residents experience higher levels of isolation and lower career satisfaction. A significant contributing factor to these negative experiences is the lack of racial diversity within academia and the physician workforce. Most mentorship programs are tailored toward research or career development, and there is limited literature on formalized mentorship programs that are geared toward improving wellness and resilience.

Moreover, numerous studies have underscored the necessity of training potential mentors to ensure the effectiveness of the mentoring experiences. Other crucial factors for the recruitment and retention of URIM physicians include tangible institutional and departmental support, tailored mentoring programs to address specific challenges within a system, and the availability of racially or ethnically concordant mentors. The Boston Medical Center Psychiatry URIM Program (PUMP) is a pilot program that pairs URIM residents with URIM faculty for community support and provides the URIM faculty with training in essential mentoring skills. In this project, we evaluated whether PUMP

enhances URiM faculty mentoring skills and URiM residents' training experiences and what strategies worked best for addressing challenges in the mentoring relationship.

Practice Gap

According to the AAMC report on Diversity in Medicine in 2019, physicians identified as underrepresented in medicine (URiM) made up 30% of the full-time medical faculty workforce in the United States in 2018. Though medical school enrollments have shown increased diversity in race and ethnicity, this has not translated to increased diversity in academic faculty. URiM residents continue to have higher attrition rates in residency. One proposed mechanism for improving the retention of trainees in academic medicine has been mentorship, which is associated with increased career satisfaction, scholarly productivity, and preparedness. Studies have shown that URiM residents prefer to have URiM mentors who are more likely to understand the unique challenges faced in training. However, URIM faculty are less likely to receive non-research or career-based mentoring training. This session will focus on mentoring tailored to promote wellness and resilience and address areas of need identified by URIM trainees.

Agenda

1. Welcome: Introduction and Objectives - 5 minutes
2. Presentation on challenges and attrition among URiM residents – 10 minutes
3. Cases

a. Case 1 Mentoring across Gender differences:

i. Small group discussion - 10 minutes

ii. Report to the larger group and Q&A -15 minutes

. b. Case 2 Intersectionality and Mentoring (QUEER/BIPOC/Immigrant)

i. Small group discussion- 10 minutes

ii. Report to larger group and Q&A - 15 minutes

c. Case 3- Addressing Unproductivity in Gen Z terms

i. Small group discussion -10 minutes

ii. Report to larger group and Q&A - 15 minutes

4. Discussion of Boston Medical Center PUMP survey results - 10 minutes
5. Addressing challenges in the mentoring relationship by a participating resident – 20 minutes

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Restorative Justice Practices in Graduate Medical Education

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Peter Ureste, MD, University of California, Riverside School of Medicine
Martha Vargas, MD, University of California, San Francisco
Adaobi Nwabuo, MBBS, MPH, Yale University School of Medicine
Sandy Ngo-Moubarek, MD, University of California, Davis
Poh Choo How, MD, PhD, University of California, Davis

Educational Objectives
1. Identify the foundational principles of restorative justice, including its origins in Indigenous cultures and its relevance to psychiatry residency programs.
2. Experience the application of restorative justice principles by participating in a community circle on the topic of learner mistreatment.
3. Discuss the practical application of restorative justice in addressing mistreatment and fostering inclusivity within psychiatry residency programs.

Abstract
This workshop will introduce participants to RJ theory, encouraging discussions on its practical application by examining its use in three psychiatry residency training programs. These include during intern orientation to identify support as they transition to residency, response to harm after residents experienced hate speech from patients during an inpatient rotation, and resident conflict. Additionally, participants will engage in a community circle—a specific RJ practice to build community and support (3). The session will conclude with a dialogue on potential opportunities and practical implementations of RJ within participants' institutions. The workshop aims to facilitate experiential learning by utilizing interactive teaching methods, including small and large group discussions and participation in a community circle.

Practice Gap
Resident mistreatment remains a persistent issue in graduate medical education. A 2020 systematic review and meta-analysis reported a high prevalence (64.1%) of intimidation, harassment, and discrimination among resident physicians, with verbal, physical, and sexual abuse being the most common forms (1). Psychiatry residents also face harmful or derogatory comments from peers, supervisors, staff, and physicians from other specialties (2). One suggested approach to tackle this issue is adopting restorative justice (RJ) practices (3, 4, 5). Originating in the 1990s from global Indigenous traditions and the criminal justice system, RJ was introduced in the criminal justice system and has since expanded to various sectors, including K-12 and higher

education, social work, and, more recently, academic medicine and healthcare. RJ emphasizes community as an interconnected web, where individual actions affect the entire group. It offers a framework for strengthening communities, preventing harm, and fostering inclusive, secure learning environments (3).

Agenda

00:00-00:05 (5 min) Welcome, introductions, D.C. land acknowledgment
00:06-00:15 (10 min) RJ origins and foundational principles
00:16-00:20 (10 min) Examples of RJ in practice from three residency programs
00:21-00:25 (5 min) Activity set-up: Community guidelines, talking pieces, circle values
00:26-01:15 (45 min) Community Circle
1:16-1:30 (15 min) Large group discussion: Potential opportunities and challenges with RJ implementations within participants' institutions

Scientific Citations

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Title
Socially responsive graduates: implications for faculty and trainees

Primary Category
Faculty Development

Presenters
Zheala Qayyum, MD, Children's Hospital Program/Boston, MA
Tracey Guthrie, MD, The Warren Alpert Medical School of Brown University
Gerrit van Schalkwyk, MD, Naval Medical Center-San Diego
Susan van Schalkwyk, PhD, AADPRT Affiliate Members

Educational Objectives
1. Participants will be able to articulate the concept of socially responsive medicine curricula and its implications for residency training.
2. Participants will be able to navigate tensions between advocacy for change and maintaining other educational priorities.
3. Participants will be able to identify and articulate common issues and opportunities for improvement across various faculty levels
4. Participants will collaborate with peers to discuss challenges and share solutions related to faculty experiences and institutional change.

Abstract
Socially responsive medicine involves identifying and working to change the circumstances that may impact the health of a group or community. To develop a clinical workforce that is up to the task requires innovation across the spectrum of medical education (2). This has implications for faculty who are required to implement these innovations (3). The process may be transformative, but there is also the potential for tension and conflict (4). Trainees are rightly empowered to advocate for meaningful change but may lack sensitivity to the limitations of institutional resources and flexibility. Junior faculty may experience an uncomfortable adjustment as they shift from being in a position to advocate for a more socially responsive curriculum, to abruptly being responsible for the design and implementation of such a curriculum. More senior faculty may experience tensions between supporting critical change while also holding to the importance of other educational priorities and maintaining a scholarly focus (5). For transformation to be effective, system wide changes are required to provide the necessary resources and context for all to thrive while true change is effected. This workshop will address the experiences of faculty at each of these levels provide opportunities for attendees to reflect on their own experience, and be equipped with language, strategies and tools for enabling change within their own systems.

Practice Gap

There is limited information about how to best train future generation of physicians to be not only socially aware but also to critically think about and address the healthcare needs of the diverse patient populations they serve. This includes not just the 'why' but also the 'how' of addressing issues such as the social determinants of health, collaborating in interdisciplinary teams, developing leadership and communication skills, and effectively advocating for their patients. This must start with medical educators who themselves will have to learn (1), and then navigate the challenges and tensions that arise for them and for their learners (2).

Agenda

00:00 – 00:10: Introductions, overview
00:10 – 00:25: Interactive PPT session: Defining social responsiveness
00:25 – 00:45: Small group engagement: Reflections on enabling social responsiveness (reflections on responsibility and barriers)
00:45 – 01:00: Facilitated plenary feedback (Synthesis of small group report out and discussion)
01:00 – 01:15: Large group engagement: Managing the 'tensions' (Elicit ideas from the groups of how people are making sense of the challenges)
01:15 – 01:30: Bringing it all together: language, strategies and tools (Synthesize the wisdom in the room)

Scientific Citations

1. Paton, M., Naidu, T., Wyatt, T. R., Oni, O., Lorello, G. R., Najeeb, U., ... & Kuper, A. (2020). Dismantling the master's house: new ways of knowing for equity and social justice in health professions education. Advances in Health Sciences Education, 25, 1107-1126.

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Title
Standardized Letters of Recommendation are here to stay: do we move fast or slow to the SLOE?

Primary Category
Recruitment and Selection

Presenters
Anna Kerlek, MD, The Ohio State University College of Medicine
Lindsey Pershern, MD, Baylor College of Medicine
Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa

Educational Objectives
At the end of this workshop participants will:
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 in our ever-evolving field, 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.

The Association of Directors of Medical Student Education in Psychiatry (ADMSEP), with input from members of the American Association of Directors of Psychiatric Residency Training (AADPRT), created a Psychiatry-specific SLOR template to be 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 Match 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.

In this workshop, participants will become familiar with the latest psychiatry 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
AADPRT members contributed to the creation of the Psychiatry Standardized Letter of Recommendation (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. The creation of the SLOR was a strategy that will be evaluated annually and updated based on feedback from the Psychiatric community, particularly AADPRT members. In the ever-changing healthcare landscape, the goal of the SLOR is to highlight characteristics and qualities of applicants in order to best shape the future of our field. 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
--5 min introduction/poll
--15 min overview: history of Psychiatry SLOR, how it compares to SLOR/SLOEs in other fields, review of our form
--20 min small group: review LOR examples to identify and consider potential introduced biases and impact on the applicant.
--5 min large group discussion
--5 min didactic: current landscape of SLOE recommendations and considerations of evolution of the current format
--20 min small group: discuss/debate the SLOR and SLOE and advantages/disadvantages of each in reviewing applications for training. Will then discuss and determine steps/strategies to move to the next stage, while considering barriers and strategies within their educational role/context
--15 min large group discussion: small groups will report on their discussion and strategies. Each participant will be encouraged to identify one goal to implement in their training selection process in their home institution
--5 min wrap-up and evaluation

Scientific Citations
Carrico CWT, Lourenco AP, Jambhekar K. Development and Assessment of Early Utilization of the Standardized Letter of Recommendation for Use in the Radiology Residency Match. Acad Radiol. 2022;29(10):1583-1589. doi:10.1016/j.acra.2022.02.004

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Workshop Session #4

Title
Coaching in Residency: An Essential Component within CBME

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

Presenters
Sallie DeGolia, MD, MPH, Stanford University School of Medicine
Anita Kishore, MD, Stanford University School of Medicine
Alissa Rogol, JD, MD, Stanford University School of Medicine
Sam Saenz, MD, Stanford University School of Medicine

Educational Objectives
Participants will be able to:
1. Recognize how a coaching program fits into Competency-based Medical Education
2. Identify the goals, benefits and elements of a psychiatry coaching program
3. Appreciate the challenges of implementing a coaching program and ways to address them
4. Strategize how to implement such a program into your own residency structure

Abstract
A well-conceived coaching program can represent part of a carefully designed competency-based assessment program. Coaching is becoming more recognized within medical training (Theeboom, Beersma, van Vianen 2013) as an important component of skill and professional development with particular focus on deliberate practice. By positioning itself in a work-based setting, coaching is more responsive than mentoring as a way to meet the needs of adult learners through observing, engaging in reflective, bidirectional feedback, and actively resetting goals. Through this process, coaching can engage learners as co-producers of their own education and competency, leading to the development of lifelong learners who can self-regulate their own learning (Konings et al 2016). Furthermore, with longitudinal coaching, a psychologically-safe space can be developed and has been shown to be particularly effective in reducing the pervasive imposter syndrome among medical learners by increasing self-enhancing attributions and strong self-efficacy beliefs while decreasing the tendency to cover up errors and fear of negative evaluation (LaDonna et al 2018; Zanchetta et al. 2020). Coaching has also enhanced faculty wellness through feeling a sense of belonging and being valued in multiple communities, offers the opportunity to develop multidimensional learning and skill development, and enhanced their professional identity formation – particularly as educators (Selling et al. 2023). In short, coaching impacts all learners – trainees and faculty alike.

The goal of Stanford Psychiatry's coaching program is to facilitate a continuous improvement cycle where the coach and resident partner. Through an empowering and learner-focused approach, coaching will build capacity instead of dependency, and move all learners towards mastery, while fostering an inclusive environment of belonging-- devoid of shaming or "othering" for those who may not be as skilled. Within our context, coaching has been particularly important as we increase diversity in our program and department and emerge from a global pandemic which has created undo strain on residents and impacted community cohesion.

To meet the demands of CBME and ensure all residents are ready for independent practice and perform at the top of their abilities as well as engage faculty to become better educators, we have developed a coaching program that encompasses direct observation, goal setting, formative feedback, and mentoring within the work setting.

We will provide a brief overview of coaching – a definition, how it fits into CBME, the evidence and how it works. We will also differentiate coaching from other roles such as supervision, mentorship, teaching, advocacy, and therapy. This will be followed by small group breakouts for programs to identify how such a program might be integrated into their residency structure. Finally, we will present Stanford's Coaching Program and discuss options for funding such a program and how to manage specific challenges that have arisen. We will end with a general Q&A session and wrap up with asking each participant to write down a specific action plan that they would like to implement on returning to their program.

Practice Gap

With the shift to competency-based training emphasizing performance outcomes over time, program directors and clinical faculty seek to optimally assess residents' readiness for independent practice. Though Direct observation represents the ideal assessment method (Holmboe 2015, Iobst et al. 2010) with effective, bidirectional formative feedback as a necessary intervention to improve performance, it has been challenging to implement because of a lack of faculty time and/or skill as well as potential stress for the learner (Fromme, Karani and Downing 2009). In addition, lack of financial compensation for time spent observing trainees, faculty scheduling challenges, competing demands, and difficulty incorporating direct observation into an existing structure creates significant barriers to implementing direct observation (Madan, Conn, Dubo, Voore and Wiesenfeld 2012).

Agenda

5min | Welcome & Introductions | Interactive | SDG
5min | What is coaching to YOU | Interactive | AR
15 min | What is Coaching? | Mini-Lecture | SDG
20min | Coaching into your residency | Small Group Breakouts | AK

15 min | Stanford's Coaching Program | Mini-Lecture | SDG
20 min | Q&A/Explore barriers | Interactive | ALL
10 min | Goal setting | Interactive | All

Scientific Citations

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Title
Crispy to Cool: Using Emotional Intelligence to Combat Burnout in Leadership

Primary Category
Wellness, Burnout, Resilience

Presenters
Jessica Obeysekare, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program
Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Educational Objectives
At the conclusion of this session, the participant will:
1. Reflect upon the literature regarding the prevalence of burnout in psychiatry leadership and the relationship between burnout and emotional intelligence.
2. Complete a self-assessment regarding emotional intelligence.
3. Learn about skills that foster emotional intelligence.
4. Apply learned skills in a team-based simulated scenario.
5. Consider ways to promote the growth of emotional intelligence skills in their home institution.

Abstract
As physicians navigate the complexities and demands of modern medicine, physician burnout continues to be an increasing problem in the United States (1). The impact of burnout on the physician workforce is substantial (2). Burnout among program directors and assistant/associate training directors, while not as alarming as rates of burnout among physicians-in-training, is commonly associated with the desire to resign and a struggle to find meaning in the highly demanding position of Training Director or Associate Training Director (3).

During this session, the presenters will introduce participants to using improved Emotional Intelligence (EQ) skills as a potential strategy for combating burnout and for inspiring meaning in their training leadership role. Emotional Intelligence (EQ) is the ability to have insight about yourself as well as others and the ability to manage your behavior and relationships. Developing these skills has positive effects on how relationships and connections are built through enhancing positive communication, effectively managing conflicts, and reducing burnout, and could be a helpful tool in reducing burnout and in nurturing resilience in training directors and associate training directors.

The association between EQ and burnout has been studied previously, with most research affirming an inverse association between the two (4). Despite this, EQ has not been considered a vital component in the medical training of physicians. Given that the complex role of training directors and associate training director necessitates building relationships, solving crises, securing jobs for residents and maintaining well-being of trainees (4) in addition to all the other administrative responsibilities in this role, enhancing EQ could predictably support professional development for psychiatric training leadership. There is evidence that leading with EQ ensures relationship and rapport building, positive communication, effective conflict management, and a reduction in burnout (5).

In this workshop we will explore the research between EQ and burnout and will describe examples of EQ-building skills. The participants will then divide into small groups for small group reflective activities to self-assess and then to apply EQ skills. Finally, participants will discuss ways that these skills could be incorporated into their home institutions to help support leaders in psychiatric residency training.

Practice Gap

Despite physician burnout growing at an alarming rate, there are limited effective interventions to blunt this trend. Concerns about burnout led the Accreditation Council for Graduate Medical Education (ACGME) to require residency Program Directors to develop policies and procedures to encourage optimal resident and faculty well-being; however, the ACGME does not address the health and wellness of Program Directors other than ensuring access to education and screening materials as faculty members (3). Emotional Intelligence (EQ) is the ability to have insight about yourself as well as others and the ability to manage your behavior and relationships. While it is likely that training directors have inherent or developed high EQ, intentional growth of these skills could be considered as a helpful tool in reducing burnout and nurturing a long and meaningful career for leaders in psychiatric training.

Agenda

0-3 minutes: Introduction
3-13 minutes: Brief overview of the literature demonstrating the prevalence of burnout in psychiatry leadership
13-25 minutes: Discuss Core Emotional Intelligence (EQ) Skills for Personal Growth
25-40 minutes: Complete a self-assessment regarding emotional intelligence
40-60 minutes: Introduce and practice EQ skills in a small group
60-75 minutes: Large group discussion reflecting on this experience.
75-80 minutes: Postcards: Please reflect and write what you would like to remember about your emotional intelligence skills after attending this workshop? Write your own address and we will send it back to you in 3 months.
80-85 minutes: Questions

85-90 minutes: Evaluation

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LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Empowering Change in Psychotherapy: Innovative Psychodynamic Teaching Strategies for PGY3 & 4 Residents

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Richard Summers, MD, Perelman School of Medicine University of Pennsylvania
Scott Campbell, MD, Perelman School of Medicine University of Pennsylvania
Marla Wald, MD, Duke University Medical Center
Judith Lewis, MD, University of Vermont Medical Center

Educational Objectives
1. Identify three challenges to teaching psychodynamic thinking and deepening resident skills in the PGY3 and PGY4 years of the psychiatry residency in an evolving medical education landscape.
2. Recognize the six mechanisms of change present in psychodynamic therapy and describe basic skills for engaging and leveraging these mechanisms.
3. Become familiar with materials participants can bring back to their home programs on teaching mechanisms of change useful for resident training and fostering the development of future psychotherapy educators.

Abstract
This workshop will help training directors enhance psychodynamic training in the PGY3 and 4 years of their programs by experiencing the value of learning about the six evidence-based change processes that occur in psychodynamic therapy. By adopting a common-sense, jargon-free approach, we aim to modernize psychodynamic education, making it more accessible, engaging, and relevant for a wide range of clinical settings.

We discuss current challenges to psychodynamic training, the need for inclusive, contemporary teaching practices and demonstrate teaching about change through brief presentation, video clips, break-out groups, and participant discussion. The take-home kit includes content material overviewing these change processes (both written and powerpoint) and a catalog of public-domain videos to support teaching. We focus also on using this approach to develop the next generation of psychodynamic faculty who are less steeped in the psychoanalytic traditions than their predecessors.

Practice Gap
Psychodynamic therapy training is popular among residents and residency applicants, enhances skills in a variety of clinical settings, and is an ACGME requirement. But, a generation of older psychotherapy faculty, often psychoanalysts, are retiring; historical and bias-laden psychoanalytic concepts are often difficult to grasp and/or clash with a more contemporary understanding of race, culture, gender and identity; and there is a

need to develop more engaging, “experience near” and jargon-free conceptualizations and teaching techniques for the current generation of learners.

Focusing on change in psychodynamic therapy, and teaching residents (and younger faculty) about how to make it happen, makes learning psychodynamics salient, digestible, teachable, and ultimately, perhaps measurable.

Agenda
5 Minutes – Introductions and disclosures
5 Minutes – Grappling with the challenges of psychodynamic training from a new Program Director’s perspective (Campbell)
5 Minutes – Innovative approaches to teaching psychodynamics in the PGY3 and 4 years (Lewis and Wald)
20 minutes – Change mechanisms in psychodynamic therapy: An evidence-based framework (Summers)
5 minutes – Video Clip #1
10 minutes – Small break-out groups/pair share to discuss and identify mechanisms of change in video clip #1 (Faculty)
5 minutes- Report out to large group (Faculty)
5 minutes – Video clip #2
15 minutes – Large group discussion of video clip #2 (Faculty)
10 minutes - Large group discussion about opportunities and barriers to implementation of this curriculum (Faculty)
5 minutes - Workshop evaluation

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https://doi.org/10.1176/appi.ajp.2021.21040338

Title
Integrating Lifestyle Interventions into Psychiatric Residency Training

Primary Category
Curriculum

Presenters
Ramaswamy Viswanathan, MD, SUNY Downstate Medical Center
Steve Sugden, MD, MPH,
Gia Merlo, MBA, MD,

Educational Objectives
1. Describe how dietary changes improve mood and enhance remission rates from depression and may prevent the risk of cognitive disorders.
2. Identify evidence-based connectedness strategies that support mental health.
3. Evaluate the evidence for the efficacy of increasing exercise and other physical activity for people with psychiatric disorders.

Abstract
Lifestyle medicine is a burgeoning evidence-based modality. Lifestyle psychiatry targets health behavior change, brain health, and patient well-being through the lens of the biopsychosocial-lifestyle model of health. More importantly, this new biopsychosocial-lifestyle lens turns the focus on contextual, social-environmental, and social-economic position factors as they govern lifestyle behaviors. Lifestyle psychiatry is not based in complementary or alternative medicine, but rather, it employs a conventional medicine lens to psychopathology. Lifestyle treatment modalities can be beneficial whether a person wants to focus on well-being, use lifestyle as an adjunct treatment for diagnosed psychiatric disorders, or a primary modality for mental health disorders when they are mild to moderate without safety concerns. Overall, this session will introduce the clinical applications of lifestyle psychiatry, integrate the foundations of lifestyle medicine, neuroscience related to personality and individual factors, cognitive-behavioral approaches, positive psychology, psychopathology, neurobiology, and health neuroscience. We will discuss how lifestyle approaches can be taught in psychiatry residency training.

Practice Gap
Despite the growing number of medications, psychotherapeutic and other interventions, many patients with mental illnesses do not sufficiently improve. Psychiatric patients also suffer from increased physical morbidity and shorter lifespan. Many psychiatrists and trainees are not aware of evidence-based literature that shows incorporating lifestyle interventions significantly improves both physical and mental health; that there are well-designed clinical trials showing that, some of which also show brain imaging and neurochemical, and other biologic changes that may underlie these improvements. Most residency training programs do not include lifestyle interventions in their curriculum. Thus many trainees graduate without the knowledge and skill set needed to incorporate lifestyle medicine in their treatment approach. They are not aware of nuanced and specific interventions related to physical activity, sleep, nutrition, gut microbiota, chronic inflammation, stress amelioration, positive social connectedness, and avoidance of harmful substances.

Agenda
15 minutes: Introduction and importance of lifestyle in psychiatry
10 minutes: Inflammation and Neuroplasticity
25 minutes: Nuts and Bolts of Lifestyle Psychiatry along the six pillars, including nutrition, physical activity, connectedness, stress, sleep, and toxic substance exposure
15 minutes: An unmet need: integrating lifestyle training into psychiatry training
25 minutes: Questions and Answers

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Title
It's not always an imposter syndrome: Tolerating uncertainty in psychiatry.

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Paul Baker, MD, The Warren Alpert Medical School of Brown University
Samir Patel, MD, The Warren Alpert Medical School of Brown University

Educational Objectives
By the end of this workshop, participants should be able to:
1. Anticipate common sources of uncertainty in psychiatric training and its effects on residents.
2. Utilize principles of adult learning to engage residents in reflecting on their own experiences of uncertainty and developing professional identity.
3. Apply lessons in managing uncertainty to curricula within participants' own programs.

Abstract
Uncertainty is ubiquitous within psychiatry. Trainees must learn to tolerate clinical uncertainty, a skill that is directly correlated with general self-efficacy. Trainees must also learn to differentiate between the limitations of their individual knowledge and that of the field as a whole. Under a model of competency-based education, learning how to manage uncertainty needs to be made more explicit than has been the case historically. Since comfort with uncertainty does not correlate with the choice of medical specialty, we cannot expect psychiatry residents to have a greater "innate" capacity to manage uncertainty. This workshop will describe an experiential learning model implemented in our residency program with the explicit goal of cultivating residents' resilience by improving their capacity to tolerate uncertainty. In collaboration with the residents, we identified several common sources of uncertainty in training and practice. These include the power differential inherent in the supervisor-trainee relationship, the impact of race, class and politics in clinical encounters, ego-vulnerabilities within trainees, the desire for personal fulfillment from clinical encounters, and so on. These sessions were deliberately held with the entire residency cohort, as research suggests that discussing uncertainty between peers of different levels of training can boost reflection and manage stress associated with uncertainty. This series has been well-received by residents, resulting in an expansion of the series after its initial pilot year. Time in the

workshop will be used to model how this experiential learning is conducted with residents.

Practice Gap
Learning to tolerate uncertainty is a vital part of medical and psychiatric education. Despite the importance of this developmental task, there is limited research on the ways in which residents learn to manage uncertainty in their clinical work and professional identities. Lessons in tolerating uncertainty are often implicit rather than explicit and highly dependent on individual supervisor-trainee relationships. When residents are unable to tolerate their feelings of uncertainty and its attendant shame, they may be at higher risk to engage in unprofessional behavior in training and clinical practice.

Agenda
5 minutes: Welcome and Introduction.
15 minutes: Review of the impact of uncertainty and the need to develop new strategies to help residents tolerate uncertainty.
15 minutes: Small group discussion – how to discuss identity and power in training and supervision.
15 minutes: Large group debrief and further discussion.
15 minutes: Small group discussion—teaching residents to manage “the what-ifs?” in clinical practice.
15 minutes: Large group debrief.
10 minutes: Closing comments and evaluation.

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Title
Organizational Equity: Building More Equitable Training Programs

Primary Category
Program Administration and Leadership

Presenters
Belinda Bandstra, MA, MD, University of California, Davis
Lillian Houston, MD, Southern Illinois University School of Medicine
Kai Anderson, MD, MA, Central Michigan University College of Medicine
Enrico Castillo, MD, MS, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Educational Objectives
Upon completion of this session, participants will be able to:
1. Define organizational equity.
2. Describe examples implemented at AADPRT to improve equity in its leadership structure.
3. Identify opportunities within your institution to enhance organizational equity.
4. Develop a plan to apply organizational equity principles to your residency program, department, or institution.
5. Discuss challenges of implementing an equitable structure at your institution.

Abstract
How do you select your chief residents? How do you select applicants for awards? How do you select members for a committee? How are opportunities distributed in your organization? Distinct from “diversity” and “inclusion,” with which it is sometimes conflated, “equity” is defined by the World Health Organization as “the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).” The inquiry into the presence of unfair, avoidable or remediable differences among groups, and the effort to decrease those differences, is important for the work of organizations. In the business world, organizational equity defines the relative distribution of power and resources among key internal organizational stakeholders, including directors, executives, managers and all other employees (Bantukul et al. 2021). Within those contexts, organizational equity audits involve collecting and systematically reviewing a range of data sources, such as information about employee recruitment, hiring, retention and advancement, employee pay and benefits, employee experiences, engagement and satisfaction, and leadership prioritization and resource commitment, to leverage accountability in making progress toward greater equity (Capper et al., 2020). The American Association of Directors of Psychiatric Residency

Training developed an organizational equity committee in 2022, in an effort to intentionally identify and address questions of equity in its own leadership and constituency. This interactive workshop aims to define the concept of organizational equity and share the process and findings of AADPRT's Organizational Equity Committee in its first two years of existence. We will discuss an approach to implement concepts of organizational equity in attendees' home institutions and spheres of influence. We will create a plan to apply this framework in individual training programs and departments. Finally, we will discuss challenges of implementing such structures in our organizations.

Practice Gap

We are at a pivotal moment when health inequities are at the center of many conversations. While the term equity is often used, its precise meaning is frequently misunderstood. Furthermore, while many champion equity at broad societal levels, attaining equity in local contexts can be difficult to achieve. Organizational equity is a useful framework to implement a fair and just distribution of power in leadership and resource allocation. This framework has been essential in organizations like AADPRT and can be incorporated into psychiatry departments and residency training programs to improve opportunities and outcomes for institutions and communities. This workshop will teach attendees how to implement organizational equity in a psychiatry department and training program.

Agenda

Introductions and small group discussion of organizational equity followed by large group debrief - 15 minutes
Mini-didactic on the concept of organizational equity - 10 minutes
Small group case discussion - 15 minutes
Mini-didactic on AADPRT's organizational equity efforts - 15 minutes
Think-Pair-Share on ways to improve organizational equity at participants' home institutions - 15 minutes
Large group debrief - 10 minutes
Final thoughts/questions - 10 minutes

Scientific Citations

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Overcoming Communication Challenges During the Disciplinary Process: Guidance for New PDs

Primary Category
Program Administration and Leadership

Presenters
Bini Moorthy, MD, University of Missouri-Kansas City School of Medicine
Kim Lan Czelusta, MD, Baylor College of Medicine
Akhil Anand, MD, Case Western Reserve University/University Hospitals of Cleveland Program
Narpinder Malhi, MD, Christiana Care Health System

Educational Objectives
1. Review guidelines in the assessment and management of residents with difficulties
2. Discuss challenges in recognizing and dealing with professionalism lapses in trainees
3. Identify barriers regarding communications about the disciplinary process with faculty and residents
4. Discuss strategies in mitigating adverse outcomes

Abstract
Professionalism is a core ACGME requirement that must be taught, assessed, and remediated for residents to meet professional standards during training. Assessing, monitoring, teaching, and remediating a resident with professionalism concerns can be overwhelming for Program Directors. Although professionalism can feel intuitive and obvious, it is also complex and one of the most time-consuming and challenging core competencies to address. Programs cannot assume that all residents and faculty agree about what professionalism entails. In addition, Program Directors often need to have difficult conversations with faculty and residents during and after a resident disciplinary action. Balancing transparency about the disciplinary process and confidentiality for the resident can be exceedingly difficult and lead to unintended consequences. Content and timing of communications is critical in mitigating fear amongst residents and negative ACGME survey results. Program director's communication, whether verbal, written and/or nonverbal, can have several interpretations with suboptimal outcomes. Program directors can face burnout and often need support and guidance while navigating the disciplinary process. The focus of our workshop will be to review the steps in the assessment and management of residents with difficulties. We would like to highlight the hidden challenges of the Program Director's communications related to the disciplinary process and explore strategies to mitigate adverse outcomes.

Practice Gap

This workshop is designed to increase the knowledge and skill of participants by reviewing the options available to residency programs' when dealing with a difficult resident situation. Professionalism is the most challenging learning deficits to identify and address. Program Directors (PDs) can be caught off guard and ill-prepared to handle such situations. PDs are expected to communicate with the residents, faculty and GME, in an effective manner. PDs can face scrutiny during this process and should be aware of the hidden threats involved. PDs must balance transparency and confidentiality while considering the resident's needs to ensure a fair and equitable process. Our workshop will address how to best handle communication challenges, maintain professional balance and integrity of the program. Using a case-based, interactive format, we hope to generate discussion from participants and share our experiences on effective strategies for management and communication when addressing professionalism issues.

Agenda

Objectives and introduction - 5 minutes
Overview of the assessment and management of residents with difficulties - 15 min
Case presentations - 15 minutes
Small group discussion- 25 minutes
Large group discussion - 15 minutes
Final thoughts on best practices - 15 minutes

Scientific Citations

Ehmann, M. R., Murano, T., Sullivan, C., Egan, D. J., Nazario, S., & Regan, L. (2024). Remediation Methods 2.0 for Professionalism and Interpersonal and Communication Skills Milestones: An Update. Journal of Graduate Medical Education, 16(2), 128-132.

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Title
Sustaining Inclusion: Charting Psychiatry's Future After SCOTUS Rulings

Primary Category
Recruitment and Selection

Presenters
Lauren Hanna, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Min Hyung (Arlene) Lee, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program
Brian Hodge, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program
Sarah Marks, MD, MS, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives
1. Understand and appreciate the importance of sustaining diversity in medical education and residency training to ensure culturally competent care and address healthcare disparities in diverse populations
2. Explain the key aspects of recent anti-DEI legislation and how it impacts recruitment practices
3. Appreciate how your program's underlying vision and mission should drive recruitment practices (tying recruitment practices with deliberate program goals)
4. Engage in group discussions to identify and formulate practical strategies for residency programs to continue upholding mission-aligned admissions practices that support DEI goals in the post-ruling landscape

Abstract
The 2023 Supreme Court ruling has created uncertainty and challenges for residency programs seeking to foster diverse and inclusive training environments. By placing new constraints around the consideration of race in admissions processes, the decision could potentially reduce the diversity of incoming residency classes. This workshop aims to review the impact of the Supreme Court ruling on race-conscious admissions and foster discussion on navigating its implications for residency program recruitment. Participants will explore how two different residency programs have adapted their admissions processes to align with their mission of maintaining a diverse cohort and will develop actionable plans for fostering diversity within their own residency classes and recruitment practices. Through interactive group activities and discussions, attendees will collaboratively devise strategies to sustain diversity, equity, and inclusion in residency programs in the wake of anti-DEI legislation.

Practice Gap
On June 29, 2023, the Supreme Court ruled on Students for Fair Admissions vs. Harvard and Students for Fair Admissions vs. University of North Carolina, fundamentally altering race-conscious admissions practices by finding that considering race or ethnicity in admissions violated the Equal Protection Clause of the 14th Amendment. Prior to this ruling, affirmative action policies were implemented to actively consider race in admissions to increase diversity and equity within educational institutions. Despite the ruling, it remains essential for residency programs to find ways to uphold their mission-aligned admissions processes and crucial that programs evaluate their current admissions practices to assess how they can effectively promote diversity and equity under the new legal constraints.

Agenda
20 min – Workshop introduction and presentation on history of structural racism, affirmative action, and recent anti-DEI legislation
25 min – Small group activity on mission-aligned recruitment practices
25 min – Small group discussion on barriers to and practical strategies for continuing to uphold anti-racist and DEI-driven recruitment practices
20 min – Large group discussion

Scientific Citations
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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
The Challenge of Identifying Fraudulent AI-generated Scientific Literature

Primary Category
Curriculum

Presenters
Madhavi Nagalla, MD, Western Michigan University School of Medicine
Bryan Makowski, MD, Western Michigan University School of Medicine
Heide Rollings, MD, Pine Rest Christian Mental Health Services

Educational Objectives
1] Demonstrate knowledge of the capacity for ChatGPT and other artificial intelligence tools to create realistic fraudulent articles.
2] Critique the limitations of Chat GPT and integrate this knowledge into the analysis of scientific literature.
3] Explore the potential of artificial intelligence tools to craft apparently authentic appearing scientific misinformation and how this could impact medical communication.

Abstract
The ACGME identifies one of the core milestones of psychiatric training as "Evidence Based and Informed Practice". This includes the capacity of residents to identify the "best available evidence" and the capacity to "Critically appraise and apply evidence even in the face of uncertainty and conflicting evidence"(1). With the advent of AI produced misinformation which can appear authentic even to experts in the field, the process of searching the internet for evidence from scientific studies is now potentially marred by misinformation(2). Misinformation in medicine is not a new phenomenon, however the unique aspect of AI to bring the appearance of expertise to misinformation with minimal time investment has not been well explored. Additionally, surveys show that physicians lack education in AI (3). Our session emphasizes that physicians should have training in how to critically assess the capabilities, benefits, limitations, and risks of AI in clinical practice.

This workshop will present a recent paper published in Journal of Medical Internet Research (4) and explore a paper about Pharmacogenomics testing written entirely by AI (5). Participants in the workshop will review the fraudulent paper produced by ChatGPT and then engage in a group discussion focused on the potential impact AI could have upon medical communication and also strategies to identify and address AI generated materials.

Practice Gap
The ACGME identifies one of the core milestones of psychiatric training as "Evidence Based and Informed Practice". This includes the capacity of residents to identify the

"best available evidence" and the capacity to "Critically appraise and apply evidence even in the face of uncertainty and conflicting evidence". With the advent of AI produced misinformation which can appear authentic even to experts in the field, the process of searching the internet for evidence from scientific studies is now potentially marred by misinformation. Recent surveys show that physicians lack education about AI. Our workshop focuses on filling this gap in training by educating learners regarding the capabilities, benefits, limitations, and risks of AI in clinical practice.

Agenda

Minutes 0-10: Review of AI generated content
Minutes 10-15: Small group discussion of AI generated content.
Minutes 15-25: Large group discussion of AI generated content.
Minutes 25-45: Presentation. The presenters will briefly introduce some basic principles of ChatGPT's function and discuss the prompts to produce the fraudulent paper.
Minutes 45-55: Large group discussion on methods to detect and avoid publishing AI produced content as human produced and how to avoid clinical decision making using fraudulent data.
Minutes 55-60: Bathroom and leg stretching break.
Minutes 60-70: Presentation. The presenters will briefly discuss some potential implications of AI produced misinformation.
Minutes 70-90: Large group wrap up and questions with a focus to brainstorm strategies that programs/faculty/trainees can take to identify and address AI generated materials .

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Title
The Life Cycle of A Chief Resident: From Selection To Development

Primary Category
Program Administration and Leadership

Presenters
Jennifer Ferrer, MD, Kaiser Permanente Southern California Program
Kathlene Trello-Rishel, MD, UT Southwestern Medical Center
Joseph Dragonetti, MD, Wake Forest University/Baptist Medical Center
Zhongshu Yang, MBBS, PhD, Kaiser Permanente Northern California Program (San Jose)
Angela Song, MD, MPH, Kaiser Permanente Northern California Program (San Jose)

Educational Objectives
Upon completion of this workshop, participants will be able to:
Develop a guideline for the Chief Resident selection process in Psychiatry using a DEI perspective
Identify common Leadership Competencies relevant to Chief Residents in Psychiatry and consider how they can be taught, applied and assessed in one's Home Institution.
Utilize a framework for Leadership Development in Chief Residents including both knowledge (content) and experiential (process) aspects of training

Abstract
In line with the ACGME's recognition of how increasing diversity in the physician workforce positively impacts health care access and patient outcomes, our workshop intends to support and promote a more standardized selection process of more diverse chief residents with key recommendations in mind including an open call for applications, standardized/structured interviews and the formation of a diverse selection committee to conduct a transparent selection process based on explicitly defined criteria (5).

After the identification of a Chief Resident, a deliberate approach to leadership skill development is essential. A curriculum that utilizes both didactic and experiential approaches is recommended. Didactic instruction is effective for imparting content knowledge that can help residents understand common leadership challenges and their solutions. However, this instruction will have a low yield for skill development unless paired with supervised leadership practice where residents practice application of leadership principles learned. Available evidence suggests that small group teaching, project-based learning, mentoring, and coaching are valuable components of leadership curricula and longitudinal curricula are more likely to be successful (2).

Appropriate skills are essential in order to measure the impact of leadership training. Residencies in various specialties have proposed and studied different competencies,

grouping them into categories such as self-care, professionalism, interpersonal skills, emotional intelligence, and coaching/supervision. (3,4) Some of the psychiatry residency milestones have leadership skills included in their description (usually in level 5), highlighting important areas that may deserve further emphasis for junior leaders in psychiatry. Additionally, there are certain competence domains that become more important as psychiatrists transition into leadership roles: whereas many trainees are focused on the medical knowledge and patient care domains, the domains of systems-based practice, professionalism, and interpersonal and communication skills become much more important and foundational for those in leadership roles. Frameworks for developing a broadly applicable psychiatry-specific leadership competencies will be reviewed.

Practice Gap

There are no clear best practices of chief resident selection, training and development. One key area warranting increased attention with opportunity for further study is addressing equity and bias in CR selection (1).

The importance of leadership skills for chief residents is undeniable. The ACGME acknowledges that the role and relative emphasis of leadership training will vary among programs and residents. Therefore, there are few requirements for leadership training for psychiatry. Curricula that facilitate leadership skill development are variable across programs, many gaps exist in understanding the value and best ways to teach leadership training (2).

Another challenge for programs is the establishment of a framework including the key dimensions for appropriate competencies that can be used to guide and measure the impact of chief resident training. Effectively developing chief residents early in their chief year sets a foundation for success.

Agenda

Introduction/Poll/Didactic: 10 min Chief Resident Interview and Selection Process using a DEI framework
Small Group: 10 min Discuss Chief Resident Interview and Selection Process at own Institutions. Share additional DEI practices to be implemented
Large Group: 10 min Share insights from small group discussion.
Didactic:10 min Chief Leadership Competencies and Applications in the Real World
Small group 15 min Discuss Leadership challenges that Chief Resident can face utilizing an assigned case scenarios- 3-4 examples (or can use own scenario). Case Scenario examples: Resident being bullied 2/2 race or sex orientation. Supporting impaired learners. Change Management- how to navigate being the “mediator” or “liaison” between admin leadership and the residents.
Large Group: 10 min Key Takeaways from small group discussion

Didactic: 10 min Best Practices for Developing a Chief Resident Leadership Development Curriculum. Utilize mentoring/coaching as a way to foster Leadership Development.
Conclusion/Q&A/Survey: 15 minutes

Scientific Citations

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Title
The many faces of PD burnout: what it looks like, how to prevent it, and how to rekindle the flame

Primary Category
Wellness, Burnout, Resilience

Presenters
Brendan Scherer, MD, San Mateo County Behavioral Health and Recovery Services.
Theadia Carey, BS, MS, MD, Authority Health/Michigan State
Sai Vedanti, MD, Authority Health/Michigan State

Educational Objectives
Participants will be able to describe signs and symptoms of burnout
Participants will appreciate the negative impacts of burnout on training environments: budgets, morale, turnover rates, reduced educational success
Participants will reflect upon the ways that burnout will present to various disciplines, including resident/fellows, APDs, themselves, and DIOs/Chairs and how someone in each role might respond
Participants will become familiar with the evidence and resources showing what can be done to help minimize program director burnout
Participants will develop a wellness/recovery action plan for their own potential burnout, with suggestions to various members of the training environment for what should be done

Abstract
This workshop focuses on what we know about burnout in program leadership (PDs/APDs), how that will present to people at different levels of training/hierarchy, and will provide some guidelines for what can be done to recognize, address and mitigate burnout. Burnout includes a triad of symptoms, including depersonalization, emotional exhaustion, and a decreased sense of personal accomplishment. Some work has been done to determine the prevalence of burnout in program directors, though much is yet to be learned. The factors that play a role in the higher rate of burnout in physicians will be covered briefly, and the audience will be asked to assess itself for aspects of burnout. The symptoms of burnout, while experienced internally, will manifest to trainees, APDs/colleagues, and chairs/DIOs in a variety of ways. The panel will review, by current stage in training, what is known about the presentations of burnout in that sphere. Factors that are known to help prevent burnout will be reviewed, and individual experiences of burnout and mitigation strategies will be discussed. This will facilitate several small group exercises, in which the skills to address burnout in colleagues will

be practiced and then cross-hierarchical personalized wellness plans, incorporating individual actions and desired institutional changes, will be developed

Practice Gap

While there is increasing knowledge about the prevalence of burnout in program directors, and the corresponding impact this has on the training program and institutions (increased turnover, increased anxiety in fellows and residents, increased costs, increased burnout in other providers), there has been limited effort to explore the way burnout manifests in interdisciplinary and hierarchical systems, nor guidelines of what people should do, depending on their role, in response to PD burnout. Here we look at what symptoms of burnout might present as to residents/fellows, Assistant/Associate Program Directors, DIOs, and PDs themselves, and provide guidance on how to appropriately prepare and respond.

Agenda

Kahoot with questions about prevalence and impact of burnout (5-10 minutes)
Introduction: Burnout: how it will manifest to residents, PDs, APDs, and DIO. Emphasis on job turnover, academic deterioration, economic loss to the system, institutional knowledge loss, worsened morale. (10 minutes)
1-question audience poll on their burnout/Word cloud from audience on their burnout sources (5 minutes)
Information on resources/resiliency for burnout/impairment. Actions the resident, APD or DIO can take if burnout noted. Role of emotional intelligence. Discuss what successful program directors say has enabled longevity. (10 minutes)
Small groups: role play providing feedback to the PD about their signs of burnout. (10 minutes)
Cross-hierarchy discussion of pre-communication about burnout. How to be vulnerable, facilitate de-idealization, and be a good role-model (10 minutes)
Small groups: develop a personal PD wellness action plan, focusing on internal and systemic strategies. Report outs. (15 minutes)
Advocacy for AADPRT Wellness curriculum.
Questions/answers.

Scientific Citations

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ACGME Databook 2022-2023.

Workshop #5

Title
A Balancing Act: Supporting Parenthood in Psychiatry Training

Primary Category
Program Administration and Leadership

Presenters
Xiaoyi Yao, MD, Columbia University/New York State Psychiatric Institute
Destiny Price, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry
Jonathan Heldt, MD, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)

Educational Objectives
-Identify the major challenges facing both trainee-parents and psychiatry program directors regarding parenthood in training, including call and clinical coverage, the need to extend training, lactation availability, accommodations for childcare, and negative perceptions from peers and faculty
- Describe ACGME, ABPN, and institutional policies regarding parental leave and policies regarding extending training due to parental leave
- Evaluate strategies to appropriately accommodate parent-trainees that mitigate burden faced by other trainees and that reduce the likelihood of training extension

Abstract
In August 2024, a US Surgeon General Advisory highlighted declining mental health and well-being among parents as a critical public health issue. Navigating early parenthood presents challenges such as sleep deprivation, role tension, and work-life integration for all parents, but they are particularly acute for resident and fellow physicians who face the unique demands of medical training. Medical training has historically been overrepresented with men and provided limited support for parent-trainees. As women now represent half of medical trainees and as family and parenting structures change, there is a growing tension between the needs of parent-trainees and ACGME and institutional requirements for training. One survey of a large GME institution found that approximately 40% of trainees expected to have children during training [Blair et al.], while another study found that over 60% of trainees felt the need to delay childbearing due to concerns about clinical demands, finances, access to childcare, burdening colleagues, and extending training. Parents in non-traditional family structures, including LGBTQ and single parents and parents who adopt or foster children, face additional stressors. Complicating this landscape are the growth of residency unions with more

generous parental leave policies and a lack of standardization and transparency for parental leave policies in psychiatry residency and fellowship programs, despite evidence that paid parental leave is associated with positive health outcomes for both parent and child, with one recent study among residents demonstrating an inverse relationship between the length of leave and parental burnout.

There is evidence that psychiatry program directors could be better equipped to face the unique needs and challenges of trainee-parents. In a recent survey of psychiatry program directors, 57% agreed that trainees could benefit from more leave, 33% reported a lack of knowledge around ACGME, ABPN, and hospital policy and 25% endorsed difficulty finding coverage for trainees on leave. This workshop explores the most common challenges program directors face regarding supporting and accommodating parent-trainees. Attendees will be introduced to up-to-date research on the challenges facing parent-trainees and ACGME and ABPN policies regarding parenthood in training. A case-based format will be used to help participants develop strategies regarding:

- Coverage of clinical duties (and whether clinical duties need to be “repaid” or repeated) and pager/inbox coverage

- Designing call schedules to accommodate parental leave while not overburdening other trainees

- Designing clinical schedules that limit the need to extend training while meeting ACGME requirements (e.g. advantages and disadvantages of built-in redundancy for core ACGME requirements in trainee schedules)

- Supporting academic careers and mitigating negative perceptions of parent-trainees by peers, supervisors, and training directors

- Schedule accommodations (e.g. for childcare, medical appointments, and lactation) during and after pregnancy

- Counseling residents on parental-leave policies and accommodations

- Supporting the needs of gender/sexual identity, family structure, financial status, and adoption/fostering

- Fostering an institutional culture that supports parent-trainees

Addressing the unique challenges facing parent-trainees warrants institutional, program, and interpersonal interventions. This session will help programs think systematically about the approach and to develop strategies supporting the well-being of trainees embarking on parenthood.

Practice Gap

In 2024, a US Surgeon General Advisory called attention to rising stress and declining well-being among parents. In addition to the universal stressors of early parenthood, residents who become parents during training face unique and complex challenges, including a lack of clarity around parental leave policy and pressures around clinical requirements, scheduling and call duty. Additional factors impacting the experience of resident-parents include availability of affordable childcare, lactation resources, and perceptions of colleagues and supervisors. Parents in non-traditional family structures are further subject to bias. While a recent study of shows that most psychiatry program directors agree residents would benefit from more parental leave and accommodations, there are there are few resources available to assist programs to approach supporting trainees in a systematic way.

Agenda

0:00- Introduction
0:03- Poll Questions: Assess learner needs. Review results to tailor subsequent discussions.
0:08- Didactic: Review of common challenges faced by trainees planning and entering parenthood during training.
0:25- Small Group Breakout: Case-based discussions of resident facing a combination of challenges described above. Discuss considerations and strategies to navigate these challenges.
0:50- Large Group Report-Out: Small-groups share their approach. Generate discussion with group brainstorming.
1:10- Reflections/Q&A
1:25- Feedback survey

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Title
A Peer-to-Peer Anti-Bias Language Workshop: An Interactive Demonstration

Primary Category
Curriculum

Presenters
Rachele Yadon, MD, University of Kentucky
Theadia Carey, BS, MD, MS, Authority Health/Michigan State
Morgan Faeder, MD, PhD, Western Psychiatric Hospital
Sarah Oros, MD, University of Kentucky
Nazeeha Micciche, MD, University of Kentucky

Educational Objectives
• Highlight the impact of providers' language biases on patient care and the need for further formal education as part of psychiatric residency curriculum.
• Describe the development of a psychiatry specific workshop on biases in patient care and its implementation as part of the didactic curriculum.
• Review changes in resident biases following implementation of the workshop as measured on a validated instrument for measuring biases in healthcare workers.
• Demonstrate the feasibility of the implementation of a peer-to-peer anti-biased language workshop.
• Facilitate reflection and discussion around the impact of biased language expressed in a patient hand-off role play and written clinical case.

Abstract
Unconscious bias can lead to health inequalities by leading to differences in the treatment of patients based on factors such as race, gender, weight, age, language, income, and insurance status. This workshop is an interactive demonstration of the work described in last year's First Place AADPRT Outstanding Poster "Anti-Bias Workshop Implementation in Psychiatry Didactics: Measures of Bias Awareness and Mitigation Practice." The poster presented a study aimed at identifying gaps in knowledge about stigmatizing language in clinical practice and assessing the usefulness of interventions such as didactic sessions in training clinicians to systematically replace biased verbal and written language. For this project, an existing anti-bias workshop was adapted to be specific to psychiatric practice, including changing powerpoint slides, clinical vignettes and role play activities. Residents who participated on the research team were then trained to facilitate the updated workshop for their peers, and then the workshop was implemented as part of the didactics curriculum for all psychiatry trainees. In this

demonstration, participants will get the opportunity to engage with the role play, clinical cases and discussion questions developed for the workshop.

This workshop is a live, interactive demonstration of the major components of the Anti-Bias Language Workshop. This demonstration will include the role play of poignant and realistic examples of how biased language can be present in our communications about patients and impact patient care. This will be followed by discussion around written clinical cases and the opportunity to work in small groups with a Mindful Language Toolkit to make improvements in the language used in written patient summaries.

Implementing an anti-bias language workshop as part of the psychiatry didactics curriculum has shown that residents learn bias mitigation practices in oral and written communication. This can lead to less stigmatizing language and improve overall patient care. The facilitated discussion around the impact of biased language will help to illustrate the relevance and salience of these discussions in resident training as well as demonstrate the ease and feasibility of peer-to-peer facilitation of this workshop in didactics. A live demonstration with role-play, small and large group discussion and review of the Mindful Language Toolkit resource aims to empower programs to adopt this workshop into their curriculums.

Practice Gap
Unconscious bias can lead to health inequalities by leading to differences in the treatment of patients based on race, gender, weight, age, language, income, and insurance status. Clinical documentation not only influences treatment but can lead to a cascade of biases by influencing other clinicians' decisions and judgments. Attitudes towards patients are worse when using stigmatizing language vs neutral language. Given the particular vulnerability of patients seeking mental health care, implementation in psychiatry resident training is critical. There is a need for incorporation of this curriculum in a form that is feasible, approachable and engaging.

Agenda
15 Minute Introduction to the Workshop Protocol and Review of Screening and Feedback Data from Residents.
15 Minute Role Play Demonstration and Large Group Discussion
10 Minute Small Group Clinical Case Review
5 Minute Large Group Discussion
10 Minute Large Group Review of the Mindful Language Toolkit
10 Minute Small Group Activity: Rewriting the Case
10 Minute Large Group Share
10 Minute Large Group Discussion: What about challenging cases and therapeutic discharge?

5 Minute Feedback Survey

Scientific Citations

Raney J, Pal R, Lee T, Saenz SR, Bhushan D, Leahy P, Johnson C, Kapphahn C, Gisondi MA, Hoang K. Words Matter: An Antibias Workshop for Health Care Professionals to Reduce Stigmatizing Language. MedEdPORTAL. 2021 Mar 2;17:11115. doi: 10.15766/mep_2374-8265.11115. PMID: 33768147; PMCID: PMC7970642.

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Kontos N, Taylor JB, Beach SR. The therapeutic discharge II: An approach to documentation in the setting of feigned suicidal ideation. Gen Hosp Psychiatry. 2018 Mar-Apr;51:30-35. doi: 10.1016/j.genhosppsych.2017.12.007. Epub 2017 Dec 22. PMID: 29309988.

IRB Protocol # 84878 201984878

AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Educational Consultations: Strategies to Help Faculty Incorporate Active Learning and Justice, Equity, Diversity, and Inclusion into Didactics and Clinical Teaching

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Laurel Pellegrino, MD, University of Washington Program
Gabriella Stamper, MD, PhD, Cleveland Clinic Foundation
Chris Nguyen, MD, University of Washington Program
Molly Howland, MD, Cleveland Clinic Foundation
Sara Ochoa, MA, University of Washington Program

Educational Objectives
By the end of this session, participants will be able to:
1. Identify barriers to increasing active learning and incorporation of Justice, Equity, Diversity, and Inclusion topics in didactics and on clinical rotations
2. Describe methods to provide collaborative consultation to faculty on their teaching in multiple settings
3. Practice applying these strategies in role plays to a case example with common roadblocks
4. Plan how to apply these strategies at their home institutions.

Abstract
Psychiatry residents learn through a combination of 48 months of clinical rotations and 600-800 hours of didactic teaching as mandated by the ACGME. The best framework to provide teaching depends on the content and the educational setting (Harms 2019), requiring faculty to be facile in their technique. Teaching needs to respond to the evolving needs of programs, advances in active teaching methods (Sandrone 2020), and evolving psychiatric knowledge, such as more nimbly discussing issues of justice, equity, diversity, and inclusion (JEDI). Faculty who precept rotations and teach didactics offer a rich array of expertise and perspectives but may have varied training in educational methods and time availability. Time limitations commonly prohibit faculty from creating educational content that is cohesive across topics and fully updated (Mennin 2021).

This workshop follows a 2024 workshop that presented three didactic curriculum “underhaul” strategies, including a didactic consult service. This year, we expand on the concept of an education consult service by demonstrating how to provide consultation for faculty on both clinical rotations and in didactics, emphasizing the incorporation of active learning and JEDI concepts, and discussing the challenges and successes of executing a consult service. To do this, we present strategies to provide targeted didactic

and clinical consultations, including clinical teaching models, the development and use of faculty didactic "toolkits," and structured templates to use in consultations. In small groups, participants will have an opportunity to role play applying these models to a case example and gather ideas on how to normalize the role of consultations, increase buy-in, and perform them collaboratively at their home institutions.

Practice Gap

Resident learners expect to be taught in increasingly active ways that incorporate equity, diversity, and inclusion concepts (JEDI). However, many faculty continue to teach using outdated strategies due to roadblocks such as familiarity, inertia, time constraints (Irby, 2008) and limited resources to revamp their teaching techniques. Faculty may avoid incorporating JEDI concepts due to lack of knowledge about how they are relevant to their topic, lack of expertise in this area, and fear of offending someone (Nguyen 2024). We propose concrete strategies to empower and support faculty in improving their educational didactics and efficiently teaching on clinical rotations to cater to changing learner needs. Our strategies are collaborative to avoid alienating faculty who are donating their time.

Agenda

- 5 min: Welcome and introductions
- 10 min: Large group discussion on barriers to giving actionable feedback to faculty on their didactic and clinical teaching
- 20 min: Brief didactic on providing targeted didactic and clinical consultations to faculty to improve active learning and incorporation of EDI
- 20 min: Small group discussion and role play on applying these techniques to a case example, using toolkits and templates provided
- 10 min: Brief didactic on getting buy-in from faculty and resident stakeholders
- 10 min: Small group discussion on applying these strategies to a case example
- 10 min: Large group discussion about how to incorporate these strategies at participants' home institutions
- 5 min: Evaluations

Scientific Citations

Harms S, Bogie BJM, Lizius A, Saperson K, Jack SM, McConnell MM. From good to great: learners' perceptions of the qualities of effective medical teachers and clinical supervisors in psychiatry. Can Med Educ J. 2019 Jul 24;10(3):e17-e26. PMID: 31388373; PMCID: PMC6681934.

Irby D. Teaching When Time is Limited. BMJ. 2008 Feb;336(7640):384-387.

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Nguyen, G.C., Pellegrino, L.D., Ochoa, S.M., Lee, J., McCall, C., Ravasamy, R. (2024). Disrupting Psychiatry Didactics: Creation of a Lecturer Toolkit to Include Topics of Equity, Diversity, and Inclusion. 2024 Jul 1. doi: 10.1007/s40596-024-02003-8. Online ahead of print.

Sandrone S, Berthaud JV, Carlson C, Cios J, Dixit N, Farheen A, Kraker J, Owens JWM, Patino G, Sarva H, Weber D, Schneider LD. Active Learning in Psychiatry Education: Current Practices and Future Perspectives. Front Psychiatry. 2020 Apr 23;11:211.

AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Freudenfreude*: Finding and Sustaining Joy and Generativity in Mentorship

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Iljie Fitzgeralnd, MD, MS, UCLA-Olive View Psychiatry Residency
Joseph Stoklosa, MD
Michael Peterson, MD, PhD,
Christian Saavedra Chavez, MD, UCLA-Olive View

Educational Objectives
(1) Examine their personal values and how and where they are reflected in different aspects of their professional roles,
(2) Recognize and reflect on their specific sources of joy as mentors and mentees,
(3) Identify current and potential professional relationships and opportunities that could yield generativity and joy

Abstract
It may not be surprising to Program Directors and Associate Program Directors that there is significant attrition amongst our colleagues in educational leadership positions often leaving after only a few years. We carry the weight of many responsibilities in our professional roles, from navigating departments and institutions and all their attendant politics to staying on top of the requirements of all the acronyms (ACGME, ABPN, NBME, ERAS, GMEC, DIO etc.), in addition to the expected teaching and guiding of residents and developing of faculty educators, and much more. However, an encouraging source of inspiration for those of us who continue onward and who hope for sustainability in this kind of work can be gained from the experiences and wisdom of role models who have happily led training programs for decades and who identify social and interpersonal aspects in particular as enhancing their professional satisfaction and well-being. Mentoring and supporting our trainees and faculty are essential elements of our roles, and modeling and channeling this commitment for learners and colleagues can inspire and create meaningfulness in generativity. As we empower others to succeed, so too can we experience joy in contributing to their journeys, or joy in their joy, or freudenfreude.

Across the spectrum of experience, we can ask ourselves: how can we create and support joy - for our trainees? For our faculty? For ourselves? Considering these questions through the lens of one's individual values can be both personally affirming and professionally generative. When we intentionally bring the concept of values to the forefront, we can identify our own highest priorities and sources of joy. These can be

somewhat tangible, such as family, or friendship, or health – or slightly more abstract, such as kindness, or altruism, or social justice. Examining where our values take root in our work while identifying barriers to leaning into our values helps us make choices for ourselves and with our mentees that enhance our sense of connection and nourish generativity, and then, hopefully, a subsequent joyful and well-earned appreciation of accomplishing something meaningful together. Generativity in mentorship can take many forms, from brainstorming in the moment, to collaborating on educational projects, to sponsoring efforts on broader initiatives, to supporting career advancements and academic promotions. Please join us if you're interested in identifying and appreciating your values, and recognizing and building the opportunities to be the giver and receiver of freudenfreude as both mentee and mentor in your own professional journey!
*finding pleasure in another person's good fortune, inspired by the German word for "joy"

Practice Gap
A considerable number of Program Directors (PD) and Associate PDs in psychiatry report that they are considering resigning, and many stay in these roles for only a few years. Others who enjoy sustained longevity in these positions describe interpersonal components of their roles as being key to professional satisfaction and well-being. Positive mentoring relationships have also been identified as critical to the success of academic faculty. This workshop aims to help participants reinforce meaning and encourage joy to support success in their professional roles by way of authentic interpersonal connectedness and mentorship.

Agenda
5m: Introductions, stage-setting
15m: Review on values and real-time interactive Menti poll
8m: Pair-share of an experience where participants experienced freudenfreude as a mentor, or created freudenfreude as a mentee
7m: Large group discussion on values, mentorship, freudenfreude in work
10m: Freudenfreude from two perspectives: PD and trainee
5m: Menti poll on current obstacles to creating or sustaining joy for self and/or mentees
5m: Narrative (vulnerability): A journey from obstacle to freudenfreude
5m: Narrative (vulnerability): In an obstacle now, working hopefully toward freudenfreude
5m: Pair-share identifying and discussing obstacles to generating professional freudenfreude
15m: Small group sharing of current obstacles to generating freudenfreude as a mentee or mentor, and collaborative problem-solving
8m: Large group sharing on themes from small group discussion
2m: Wrap-up

Scientific Citations

1. De Golia SG, Houston LJ, Madaan V, et al.: The burden of leadership: a survey of burnout experiences among psychiatry program directors. Acad Psychiatry. 2022.

2. Yager J, Anzia JM, Bernstein CA, et al.: What Sustains Residency Program Directors: Social and Interpersonal Factors That Foster Recruitment and Support Retention. Acad Med. 2022

3. Chopra, V, Arora VM, Saint S. Will You Be My Mentor?- Four Archetypes to Help Mentees Succeed in Academic Medicine. JAMA Intern Med. 2018

4. Lagina M, Grum C, Sandhu G, Ruff AL. Sources of Joy In Medical Educators as Described by the PERMA Model. Teach Learn Med. 2022

5. https://www.nytimes.com/2022/11/25/well/mind/schadenfreude-freudenfreude.html

Title
IMGs in Psychiatry: Leadership, Education, and Workforce Integration

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

Presenters
Raman Marwaha, MD, Case Western Reserve Univ/MetroHealth Medical Center
Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen College of Medicine
Narpinder Malhi, MD, Christiana Care Health System

Educational Objectives
1. Analyze the Increasing Barriers for IMGs in Psychiatry Residency Matching
2. Develop Strategies to Overcome Acculturation Barriers
3. Create Programmatic Solutions for Addressing IMGs' Learning Needs
4. Increase Awareness of Alternative Training and Career Pathways for IMGs

Abstract
International Medical Graduates (IMGs) have always been an integral part of the psychiatric community in the United States. International Medical Graduates (IMG) are a heterogenous group of physicians who are described as having received their medical schooling outside the United States (US). Based on their nationality and citizenship, IMGs can either be non-US IMGs (visa-requiring IMGs) or US IMGs (non-visa requiring IMGs). IMGs represent around one third of Psychiatrists in the US and around one quarter of residents in psychiatry residency programs. IMG psychiatrists play a unique role in the delivery of mental health services in the US to a diverse population of patients especially those who are severely ill, publicly insured, socio-economically disadvantaged, and ethnic minorities.

While psychiatry residency positions continue to increase each year in the National Residency Match Program (NRMP) the match rates for IMGs (both US and non-US) have continued to decrease. IMGs also form a considerable percentage of subspecialists in Psychiatry and this downward trend in matching in psychiatry will have an impact on subspecialty match. While many IMGs note stress related to difficulties with the various aspects of recruitment and NRMP applications and interviews, one-third training directors report that they do not rank IMGs. Once matched many IMGs face further difficulties in residency related to acculturation issues, potential discrimination, mentorship, and job opportunities upon completion.

In this workshop, presenters will provide data about current trends in IMG entry into psychiatry residency and how to mitigate against some of the often implicit bias in selection as well as discrimination that may occur during the training process. Presenters will also guide attendees in recognizing their individual programmatic needs and potential biases with respect to recruitment, acculturation, and mentorship with a focus on addressing IMGs' unique sociocultural and educational needs. There will also be discussion on alternative pathways in training and non GME pathways which have started and will impact GME. Small groups will examine and discuss sample IMG scenarios to understand challenges for both the IMG and training programs and ways to implement systemic changes that can yield the desired successful outcome of producing competent psychiatrists who can provide excellent psychiatric care to diverse populations and also mentor and train future generations of psychiatrists including IMGs.

Practice Gap

IMGs are physicians who have completed their medical education outside the United States. They represent approximately one-third of the US psychiatry workforce and play a critical role in delivering mental health services to diverse patient populations across the country. However, with a growing interest in psychiatry, the number of IMGs matching into psychiatry residency programs has decreased. IMGs face distinct challenges, including potential bias in the residency selection process, the complexities of migration and acculturation, and the need to adapt to new healthcare systems, and social contexts relevant to psychiatric care in the US. In recent years, alternative GME and non-GME pathways have emerged, offering new opportunities for IMGs to contribute to the field of psychiatry. This workshop aims to explore the unique challenges IMGs face during the matching and training processes, as well as to highlight opportunities for their growth and new pathways that can lead to successful practice.

Agenda

Introduction and objectives- 5 minutes
Presentation of recent trends in IMG application and Match data- 10 minutes
Identification of acculturation and training needs and mentorship of IMGs– 10 minutes
Presentation on alternative training and non-training pathways – 10 minutes
Small group discussion of different IMG scenarios about how to help residency applicants as well as training directors regarding developing/assessing applications, interviews, training needs, and potential alternative pathways to help IMGs match into psychiatry or the workforce and achieve successful training/supervision, personal growth, and leadership opportunities- 25 minutes
Large group presentation of small group summary of IMG scenarios- 15 min
Q&A, Summary, take home points, and workshop evaluation - 15 min

Scientific Citations

1.Marwaha, R., Chandraiah, S., Malhi, N. et al. From Training to Practice: Innovative Pathways for International Medical Graduates to Assist with Workforce Shortages. Acad Psychiatry (2024). https://doi.org/10.1007/s40596-024-02041-2

2.The MATCH National Residency Matching Program: Results and Data2024 Main Residency Match https://www.nrmp.org/wp-content/uploads/2024/06/2024-Main-Match-Results-and-Data-Final.pdf. Accessed 9/16/2024

3. Zaidi Z, Dewan M, Norcini J. International medical graduates: promoting equity and belonging. Acid Med. 2020;95:S82-87.

4.Duvivier R, Buckley P, Martin A, Boulet J. International Medical Graduates in the United States Psychiatry Workforce. Academic Psychiatry. 2022; 46:428–434.

5. Accreditation Council for Graduate Medical Education. Advisory Commission on Alternate Licensing Models Hosts Symposium to Discuss Pathways to Licensure for Fully-Trained International Physicians https://www.acgme.org/newsroom/2024/6/advisory-commission-on-alternate-licensing-models-hosts-symposium-to-discuss-pathways-to-licensure-for-fully-trained-international-physicians/#:~:text=The%20Advisory%20Commission%20is%20co,streamlining%20the%20licensure%20of%20international . Accessed 9/16/2024.

Title
Making a List, Checking it Twice: Best Practices and Variations in Rank List Development

Primary Category
Recruitment and Selection

Presenters
Frank Andrew Peters, BS, MD, Prisma Health/University of South Carolina School of Medicine - Columbia
Daniel Gih, MD, University of Nebraska Medical Center College of Medicine
Taylor Preston, MD, University of Alabama at Birmingham
Shawen Ilaria, MD, Rutgers Robert Wood Johnson Medical School
Christine Marchionni, MD, St. Luke's University Health Network – Anderson Campus

Educational Objectives
1. Participants will identify strengths and growth areas in their current NRMP rank list development strategies and assess whether these align with the stated long-term goals for their program.
2. Participants will integrate best practices for developing their NRMP rank list through consideration of content presented in the workshop, as well as discussion with peers in breakout groups.
3. Participants will apply best practices to ensure that strategies for rank list development promote confidentiality, psychological safety, and equity, with a strong emphasis on fostering a diverse and inclusive resident pool.

Abstract
Developing an annual NRMP rank list is one of the key responsibilities for psychiatry residency and fellowship leadership teams across the country. The ranking of applicants and match results have a prolonged impact on the resident milieu for the next several years. It may also have more distant impacts on faculty recruitment and retention of psychiatrists locally. Despite the importance of this task, there is significant variability in the process of rank list development, what factors impact ranking, and who participates in rank list development.

Interviewers new to the ERAS application packet and interview day process may need help prioritizing the various elements in scoring applicants. Significant variability in the format and quality of Medical Student Performance Evaluations (MSPEs) has led to uncertainty around the reliability and utility of this application component. Moreover, the shift in the USMLE Step 1 to pass/fail grading made every remaining element of comparison more important (1). A study of internal medicine residents indicated that strong USMLE scores (now limited to Step 2) are the most predictive of successfully navigating residency (2). However, the unique demands of psychiatric training call for a

holistic review of each applicant, which can lead to significant variability in applicant perception depending on the individual values of selection committee members (3). A desire to recruit a diverse resident pool with a broad array of backgrounds adds further challenges, particularly following recent court rulings around diversity, equity, and inclusion in education (4).

Multiple factors have led to unique recruitment strains within the psychiatry subspecialty fellowships. The current surplus of fellowship training positions relative to fellowship applicants places subspecialty fellowship programs in a significantly more challenging position to fill than general psychiatry programs, creating a need to innovate in fellowship recruitment (5).

In this workshop, we aim to present strategies for ensuring individual program rank strategies align with their stated program goals. We will present a variety of programs' current ranking methods, then utilize program size and type-matched breakout groups to explore current strengths, growth areas, and next steps for attendees. We will conclude with an opportunity for large group discussion and reflection.

Audience: Anyone involved in recruiting applicants to a psychiatry training program will benefit from this workshop. No prior knowledge of recruitment or ranking of applicants is required. New program directors and residents are especially encouraged to attend to learn the behind-the-scenes of several different programs.

Practice Gap

The development of an NRMP rank list is the culmination of dozens of hours of recruitment activities and interviews, and there is an incredible amount of variability in the ranking processes used from program to program. In this workshop, we aim to educate stakeholders on the facts and myths around the NRMP Match, and discuss best practices and pain points in the annual ranking process. We will explore the perspectives of residency programs of varying sizes and resources, as well as those of fellowship programs.

Agenda

- Introduction/Survey of attendees regarding their experience with rank (10 min.)
- Review of data from pubmed, NRMP, AAMC, and AADPRT (10 min.)
- Small group discussion of one main pro/con of the current ranking system for their program (10 min.)
- Formats Used by Presenting Programs (20 min.)
- Application/Breakout Groups "Build a Better Selection Process" (20 min.)
- Large Group Discussion (15 min.)
- Summary/Wrap-Up (5 min.)

Scientific Citations

1. Russo, R. A., Hameed, U., Ibrahim, Y., Joshi, A., Kerlek, A. J., Klapheke, M., ... & Rakofsky, J. J. (2022). Psychiatry residency directors' attitudes toward and uses of the medical student performance evaluation and other potential tools for residency selection. Academic Psychiatry, 46(5), 622-626.

2. Everett, G., Maharam, E. & Yi, F. (2021). National Resident Matching Program Rank Order and Performance in an Internal Medicine Residency. Southern Medical Journal, 114 (10), 657-661. doi: 10.14423/SMJ.0000000000001301.

3. Poremski, D., Tan, G. M. Y., Lau, B. J., Lee, Y. W., & Sim, K. (2020). Selection of new psychiatry residents within a national program: a qualitative study of faculty perspectives on competencies and attributes. Academic Psychiatry, 44, 545-553.

4. Collins, S., & Baker, E. B. (2024). Resident Recruitment in a New Era. International Anesthesiology Clinics, 62(3), 35-46.

5. Williamson, E., Shoemaker, E., Kim, A., Joshi, S., Lewis, A. L., Vandekar, S., ... & Kerlek, A. (2021). Child and adolescent psychiatry fellowship program participation in the national resident matching program match: trends and implications for recruitment. Academic Psychiatry, 1-6.

6. NRMP Charting Outcomes Data, 2024.

7. Kovach, J. G., Batsel-Thomas, S. D., Gih, D., & Thomas, L. (2022). Recruitment in Graduate Medical Education. In Graduate Medical Education in Psychiatry: From Basic Processes to True Innovation (pp. 71-88). Cham: Springer International Publishing.

Title
Navigating Leadership Change: Using Storytelling to Explore Program Director Transitions

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

Presenters
Belinda Bandstra, MA, MD, University of California, Davis
Christine Bertini, BA, University of California, Davis
Rachel Mitchell, MD, Healthy Rural California, Inc. Program
Alan Koike, MD, University of California, Davis
Peter Ureste, MD, University of California, Riverside School of Medicine

Educational Objectives
AIMS: To help participants navigate the challenges of transitioning leadership in residency programs.
Objectives:
1. To utilize storytelling to explore issues regarding transitions into and out of the program director role from outgoing program director, resident, program administrator, and incoming program director perspectives
2. To reflect on how the unique circumstances of specific programs influence the challenges for program directors during times of immense change
3. To collaboratively develop best practices for program directors transitioning into and out of the role

Abstract
In keeping with this year's conference theme of "Leading and Teaching Amidst Change," our workshop will explore issues to consider and strategies for transitions in residency program directors. Despite the mandate from the Accreditation Council for Graduate Medical Education (ACGME) for programs to "demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability" (ACGME, 2022), the rapid turnover of residency program directors is a concerning trend (ACGME, 2021). While the importance of the role of residency program director and the potential impact of turnover of the position is undisputed, we found very little literature on the subject of how to approach program director change. Given the dearth of data and lack of guidance on how to navigate the transition of program directors, a narrative approach will be adopted for this workshop. Narrative pedagogy has become an increasingly popular tool to explore Leadership Education (Armstrong et al., 2021). An approach to thinking about teaching and learning that utilizes the lived

experiences of learners to find and explore meaning, narrative pedagogy utilizes the telling of stories to open the door for eliciting and analyzing issues, interpreting and contextualizing meaning, and reflecting and integrating personal and theoretical knowledge. In this workshop, we explore the experiences of a former psychiatry resident who encountered multiple program director transitions during their training, a program administrator, and both outgoing and incoming program directors through each of the presenters telling their personal story relating to program director transitions. The presenters will discuss their experiences with a relatively long well-planned transition, a more rapid transition and starting a new program. They will compare the issues at a traditional academic institution, an institution relying on various community sites and a rural program. This approach will bring in the perspective of different stakeholders and highlight challenges across different contexts. Attendees will actively participate in live polling during the workshop to reflect on their experience with transitions in program leadership. Participants will also engage in discussions of both themes in the stories they are told as well as resonances with their personal transition experiences. Through the combination of the presenters' narratives and the small group discussions, the workshop hopes to identify common themes and unique challenges across programs, and facilitate the collaborative development of best practices for navigating leadership transitions effectively.

Practice Gap

There is considerable concern regarding the rapid turnover of residency program directors (ACGME, 2022; Brown & Gerkin, 2019). Based on Accreditation Council on Graduate Medical Education data, the median length of tenure of psychiatry program directors is 4.3 years (ACGME, 2021). Transitions into and out of this role are complex, often shaped by each program's unique culture and history (Gisondi et al., 2023). With sparse literature on residency program director transitions, there is little evidence-based guidance to navigate this process. In this workshop, we explore the experiences of outgoing and incoming program directors, using storytelling to highlight challenges and lessons learned across different contexts (Armstrong et al. 2021). Participants will actively engage in small group discussions to explore best practices for navigating leadership transitions effectively.

Agenda

10 minutes - Introduction and interactive poll regarding attendees and their experiences with program director transitions
10 minutes - First story, outgoing program director perspective on program director transition
10 minutes - Small group guided reflection and integration
10 minutes - Second story, resident perspective on program director transition

10 minutes - Small group guided reflection and integration
10 minutes - Third story, program admin perspective on program director transition
10 minutes - Small group guided reflection and integration
10 minutes - Fourth story, three contrasting incoming program director perspectives on program director transition
10 minutes - Small group guided reflection and integration

Scientific Citations

1. The Accreditation Council for Graduate Medical Education (ACGME): Common Program Requirements. Chicago, IL: ACGME, 2022; [accessed 2022 October 27.].?

2. Brown SR, Gerkin R: Family Medicine Program Director Tenure: 2011 Through 2017.?Fam Med.?2019;?51(4): 344–347.?

3. The Accreditation Council for Graduate Medical Education (ACGME): Common Program Requirements. Chicago, IL: ACGME, 2021; [accessed 2022 October 27.].?

4. Gisondi MA, Hopson L, Regan L and Branzetti J. Practical tips for navigating a program director transition. MedEdPublish 2023,?13:3

5. Armstrong, J.P. and McCain, K.D. (2021), Narrative Pedagogy for Leadership Education: Stories of Leadership Efficacy, Self-Identity, and Leadership Development. J Ldrship Studies, 14: 60-70.

Title
No instructor? No problem! Teaching neuroscience when time or teachers are tight.

Primary Category
Curriculum

Presenters
Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa
Mike Travis, MD, Western Psychiatric Hospital
Mayada Akil, MD, Georgetown University Medical Center
David Ross PhD, MD, Yale University School of Medicine

Educational Objectives
By the end of this session, participants will be able to:
1. Comfortably respond to last-minute instruction needs by accessing a library of ready-to-go learning sessions.
2. Utilize at least one neuroscience education resource that incorporates adult learning principles to teach clinical neuroscience.
3. Identify one or more sessions (or the entire curriculum) in their program's neuroscience teaching that could be enhanced by experiential learning exercises.

Abstract
Neuroscientific knowledge about mental illness is exploding. While many psychiatrists recognize the importance of neuroscience to the field of mental health, and regulatory bodies now require resident instruction and competence in this area, many programs still lack resources for delivering high-quality, engaging neuroscience classroom content. Instructors and even program directors, many of whom may not have received robust neuroscience training themselves, may not feel comfortable discussion neuroscientific concepts with trainees. When a neuroscience instructor cancels (or leaves the program altogether!) programs may be left with little to no time to prepare material to fill the classroom time, further widening the divide. To bridge this gap, we have developed a toolbox of interactive sessions based on principles of adult learning that can be run off-the-shelf with little to no preparation time. This workshop will provide participants the ability to quickly access content that can be used either with trainees or faculty, as well as practice facilitating different types of learning modules. Participants will be equipped with tools to implement both single sessions, as well as an entire neuroscience curriculum.

Practice Gap
Despite rapid advances in medical literature related to psychiatric neuroscience over the last decade, most psychiatrists still have relatively minimal knowledge of neuroscience as

it relates to their day-to-day clinical activities. Many clinical faculty may not feel comfortable discussing these topics with trainees and patients, limiting the pool of instructors available to teach neuroscience. This issue is compounded by inevitable last-minute instructor cancellations, which leave curriculum directors scrambling to fill classroom time. Series coordinators would benefit from access to and comfort using high-quality, ready-to-implement resources for single sessions or entire series of neuroscience education.

Agenda
10min – introduction and brief didactic
30min – large/small group activity and practice teaching #1 (demonstration and discussion)
20min – small group activity and practice teaching #2 (participants lead their groups)
10min – small group activity and practice teaching #3 (each participant has opportunity to demonstrate)
5min – brief didactic (whole curriculum and other resources)
15min – large group reflection on using available neuroscience resources at home institutions, Q&A

Scientific Citations
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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Psychodynamic Formulations 2.0: An updated tool for the modern psychiatrist

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Sindhu Idicula, MD, Baylor College of Medicine
Alyson Gorun, BA, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Randon Welton, MD, Northeast Ohio Medical University
Andrew Hunt, MD, Case Western Reserve University/University Hospitals of Cleveland Program
James Burden, MD, Baylor College of Medicine

Educational Objectives
By the end of this session attendees will be able to:
1. Describe the diagnostic and therapeutic uses of psychodynamic formulations
2. Create and use “working psychodynamic formulations” in a variety of clinical settings
3. Compare different methods for teaching and creating psychodynamic formulations
4. Incorporate “working formulations” into their own clinical practice

Abstract
Psychodynamic formulations have long been a foundational tool for psychodynamic psychotherapy. They were used to create a tentative hypothesis incorporating biological, intrapsychic, interpersonal, developmental, social, and situational factors. They would include considerations of early childhood trauma as well as family, social, and cultural factors. Despite their usefulness in long-term psychodynamic psychotherapy, they rarely crossed into general psychiatric practice. Several misconceptions created this barrier. The belief that they are useful only for psychodynamic psychotherapy ignores the fact that the success of any treatment may depend on understanding, supporting, or modifying aspects of a patient’s personality. They also tended to be extremely elaborate and time-consuming making them impractical for anything except for the protracted opportunities created by long-term therapy approaches. The amount of time spent creating the psychodynamic formulation tended to render them fixed and unflexible, and diminished their helpfulness. While the comprehensive in-depth psychodynamic formulation taught to so many generations of psychiatrists still serve a useful purpose, many psychiatry training programs are creating newer, more flexible variations.

The main purpose of the psychodynamic formulation is to create a structured hypothesis that explains the conscious and unconscious aspects of a patient’ presentation. It needs

to include considerations of how unconscious thoughts and feelings might affect a patient's problems and how those unconscious thoughts and feelings may have developed. It will include an understanding of what has happened in patients' lives and how it happened. We will lead a discussion with attendees about the basic components of a useful psychodynamic formulation and how they can be obtained in a relatively efficient manner in a variety of clinical of settings including inpatient psychiatric units, consultation and liaison teams, emergency departments, and busy medical management settings as well as therapy clinic.

The workshop will describe basic psychodynamic realities that can be observed, documented, and used in a jargon-free fashion. These include 1) What people say and do has meaning, 2) We don't always understand ourselves (active unconscious), 3) The past helps to shape the present, 4) We tend to form recurring patterns of behavior and relationships, and 5) The doctor-patient relationship has both diagnostic and therapeutic potential. We will discuss how these can shape a psychiatrist's understanding and response to patients. We will have scenarios where participants will observe and summarize psychodynamic components. We will describe methods used by a variety of training programs in training psychiatry residents to create and use these "working formulations". Some tools to be discussed will include worksheets, scripts, role-plays, group discussion strategies, and the use of artificial intelligence to help create materials. Participants will have an opportunity to consider their own patients using some of these approaches.

Practice Gap

Academic psychiatry is faced with a culture where biological treatments are prioritized over psychodynamic approaches to a patient. However, the use of psychotherapeutic skills in all clinical care allows for care to be more comprehensive and treat more complex cases. The skill of crafting psychodynamic formulations may be seen as intimidating or a heavy lift, as it requires the ability to reflect on multiple perspectives as well as to be acting in the here-and-now while simultaneously reflecting on the clinical process as it unfolds. In addition to learners finding the process daunting, faculty with limited exposure or experience with formulations may shy away from teaching these clinically due to unfamiliarity with the process. This workshop explores some strategies to make formulations more accessible and allows them to be seen as "working formulations" that are dynamic and allow for planning next steps in intervention.

Agenda

1. Introduction – 5 minutes (Didactic)
2. Review of purpose of formulation – 5 mins (Didactic)
3. Components of a Psychodynamic Formulation – 10 mins (Large Group Discussion)

4. Working Formulation – Example – 10 mins (Didactic)
5. Clinical examples from attendees – 15 mins (Small Group Discussion)
6. Discussion of training methods for teaching formulations – 20 mins (Didactic)
7. Comparing various methods for teaching formulations – 15 mins (Small group discussion)
8. Conclusions Discussion – 10 mins (Large Group Discussion)

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Title
The Art of Running an Outpatient Resident Clinic: Diverse Solutions to the Challenges of Billing, Panel Management, and Resident Efficiency

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Judith Lewis, MD, University of Vermont Medical Center
Anna Costakis, MBA, MD, Hofstra Northwell-Staten Island University Hospital
Brian Evans, DO, University of Cincinnati
Michael Sean Stanley, MD, Oregon Health Sciences University
Kevin Winders, MD, Gateway Behavioral Health CSB

Educational Objectives
At the end of this workshop, participants will be able to
1) Name five challenges in the administration of their outpatient resident clinics
2) Identify two innovative solutions to bring home to their institution
3) Access resources from five outpatient clinics to enhance their own clinic infrastructure

Abstract
The ACGME Program Requirements for Psychiatry state, “each resident must have a significant experience treating outpatients longitudinally for at least one year” and further specifies that the experience should include psychotherapy, multiple treatment modalities, and psychosocial rehabilitation techniques1. Embedded in this requirement are three clear values: that an immersive learning experience in outpatient practice is important, that conducting longitudinal treatments2 under supervision is important, and that optimal training involves exposure to a variety of treatment modalities. In today’s specialty world, clinic directors face the complex task of how to meet these laudable aims within the constraints of current institutional economic pressures and models of care.

Across the country at each residency program, clinic directors struggle with the same challenges, such as how to orient residents, manage caseloads, allow for graded autonomy, provide supervision, manage turnover, balance diversity of patients, balance and determine treatment modalities (including the use of televideo3), determine length of visits4, bill for resident services, and design a treatment model5. While there are common challenges, there are also many differences between training clinics and therefore many diverse solutions. This workshop aims to discuss 3 specific areas of challenge and “crowdsource” a diversity of solutions from the collective wisdom of the group. In this workshop, we will elicit the top five challenges each participant faces, compare them to a master list compiled last year, and then cover the following topics in

depth: 1) optimal billing for resident services 2) the art of patient panel management, and 3) strategies to improve resident efficiency (including the pros/cons of AI in documentation).

Practice Gap

Outpatient resident clinic directors have few shared resources or forums to inform the design and administration of their training clinics despite the unique challenges they face. In addition, there is the literature is scant and there are few educator workshops to guide them. Our AADPRT workshop last year on this topic was very successful with around 50 participants and excellent reviews. Participants were eager to continue the conversation. This workshop aims to fill this need by reviewing the common challenges we face and offering diverse solutions to three selected challenges—specifically, those that were identified as "pain points" by last year's participants-- via a panel format and audience engagement. The policies and procedures repository we started last year, from five geographically and structurally diverse programs, was well-received and we aim to grow that resource.

Agenda

1) Introduction and overview (10 min, moderator)
2) Small group share: what are your current most pressing challenges? (5 min)
3) Large group report out (5 min)
4) Panel and group discussion of 3 common challenges (15 min per topic; 60 min total)
-Description of challenge (1min, moderator)
-Panelist prepared comments (10 min)
-Small group share and report out of novel solutions (8 min)
-Resource listings for that topic (1 min, moderator)
5) Wrap up and course evaluation (10 min)

Scientific Citations

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
When Technology and Psychiatry Collide: Creating Space for Innovation Using Longitudinal, Simulation-Based Learning Residency Curricula

Primary Category
Curriculum

Presenters
Samuel Dotson, BS, MD, Northeast Georgia Medical Center Program
Ahmad Hameed, MD, Penn State University, Hershey Medical Center
Kalpana Prasad, MD, Northeast Georgia Medical Center Program

Educational Objectives
Through participating in this workshop, attendees will be able to:
1. Explain the existing state of the education literature on technology integration into the psychiatric classroom and apply this knowledge to identify learning scenarios which may be well suited to this approach
2. Identify existing opportunities in their own programs for technological-innovation and analyze the potential challenges that their institutional culture and structure could present to implementing these strategies
3. Create a longitudinal technology-based curriculum for residents incorporating simulation-based learning, artificial intelligence, virtual reality, and co-teaching opportunities, as well evaluate the success of their curriculum from both a learner and program perspective

Abstract
Although the incorporation of technology into medical curricula has been steadily increasing for years, psychiatrists have historically been late adapters in this field. A variety of unique challenges in psychiatric education have contributed to a reliance on historical pedagogical methods and a resistance to innovation. Some of these concerns are valid, while others are based on false assumptions, so determining what topics are appropriate for the use of virtual reality, artificial intelligence, and simulation-based learning is a challenge with limited available guidance in the literature. This workshop will lead learners through a series of interactive sessions designed to promote self-reflection and a transformation in perspective on the potential value and pitfalls of using technology in residency programs. Learners will be exposed to the existing pedagogical research on the appropriate use of these methods, as well as arguments in the psychiatric literature for and against the use of technology in the classroom. Exercises will focus on identifying ideal topics for innovation, designing longitudinal curricula incorporating technology, and the value of technology in differentiating content according to post-graduate year in programs with limited teaching resources and grouped classrooms.

Practice Gap
From virtual reality to artificial intelligence, the list of technologies available to educators is rapidly expanding. Simulation-based learning is a pedagogical approach that can offer teachers a dedicated space for innovation in their curricula. Many programs, however, struggle to leverage this unique educational approach in psychiatry, and psychiatric educators lag behind other fields in the use of technology in their training programs. This workshop will help educators evaluate their own institutional resources and training needs with the goal of identifying opportunities for innovation and novel approaches to teaching.

Agenda
Introduction (25 Minutes)
-5 Minutes: Introduce speakers, learning objectives, and conduct a KWL needs assessment (PollEverywhere)
-10 Minutes: Minididactic reviewing the literature on technology use in psychiatric education with an emphasis on unique opportunities and challenges
-10 Minutes: Exercise 1 – "Good Tech Use, Bad Tech Use: Identifying Appropriate Topics" (think-pair-share)
Technology-Based Curriculum Mapping, Differentiating, and Practical Consideration (25 Minutes)
-10 Minutes: Review of example use scenarios. a longitudinal model curriculum example, and needed tools and resources for implementation
-15 Minutes: Exercise 2 – "We Don't Do that Here: Barriers to Implementation" (break-out groups)
Evaluation and Assessment Methods (25 Minutes)
-10 Minutes: Review data-drive approaches to evaluating simulation success and methods of providing feedback to residents across PGY
-15 Minutes: Exercise 3 – "How Many Evaluations Do I Have to Complete?! Selecting Appropriate Evaluation Metrics" (break-out groups)
Conclusion (15 Minutes)
-15 Minutes: Q&A and Evaluations

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1. Amsalem D, Martin A, Mosheva M, Soul O, Korotkin L, Ziv A, Gothelf D, Gross R. Delivering difficult news: simulation-enhanced training improves psychiatry residents' clinical communication skills. Frontiers in Psychiatry. 2021;12:649090. https://doi.org/10.3389/fpsyt.2021.649090

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Workshop Session #6

Title
A Necessary Challenge: Identifying and addressing racial enactments in Psychiatry residency training

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Daniel Knoepflmacher, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Nia Harris, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Alyson Gorun, BA, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Norman Greenberg, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Stephanie Cherestal, PhD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives
Upon completion of this workshop, participants will be able to:
1. Identify how racial enactments, which are ubiquitous and often go unaddressed, impact psychiatry residency training.
2. Analyze common dynamics between trainees, supervisors, and patients to understand how and when racial enactments arise.
3. Develop a tailored approach for educating psychiatry residents and attendings about racial enactments in residency training.

Abstract
To meet the mental health care demands of a richly multicultural U.S. population, psychiatry residency training programs must forge ahead (in the spirit of Magpadayon!) with collective efforts to diversify the psychiatric workforce of the future. With many residency programs successfully recruiting residents from more diverse backgrounds, more attention should be given to the challenges that complicate efforts to foster inclusivity and belonging within residency communities. Complex yet inevitable race-related dynamics arise, often adding additional emotional burden for BIPOC residents.

Our workshop will delve into these challenges, by focusing on racial enactments—a term describing how internalized ideas related to race and racism play out unconsciously in group and interpersonal processes. These dynamics are often left unaddressed, but they

negatively impact the learning environment. They are multidirectional and ubiquitous, occurring during residency training in clinical, educational, and social contexts. By training residents and faculty to understand and address racial enactments, a program can nurture a more inclusive culture for all residents, improve the ability to broach these difficult but important conversations with colleagues and patients, and help trainees become culturally sensitive psychiatrists.

Participants attending our workshop will hear from trainees and training directors. One member of our panel will describe the psychodynamic principles underlying the concept of racial enactments. We will present examples of racial enactments, including a case of challenging dynamics in a supervisory context. In describing this case, participants will hear from a trainee, two training directors, and the psychiatry department's Director of Health Justice. All will share their individual experiences and lessons learned. After, workshop attendees will participate in a small group exercise designed to help participants identify racial enactments in their respective settings and consider ways to address them.

The second half of the workshop will focus on educational efforts taken to address racial enactments in training, using examples from our residency program. A former resident, who led these efforts within our program, will describe didactics on racial enactments that have been incorporated into the residency curriculum. A current resident will share his experience of how these formal didactics and less formal peer supervision helped him navigate challenging clinical dynamics. The workshop will end with a group discussion designed to help attendees think about adopting similar didactics at their own programs and answering any questions from the audience.

Practice Gap

As residencies seek to diversify their programs and incorporate DEIB principles into education, there have been increasing efforts to foster inclusivity in the learning environment. Achieving this goal requires skillful management of the inevitable challenges that arise within changing cultures. Racial enactments—conflicted dynamics related to race and racism that unconsciously play out in group and interpersonal processes—are a common area of challenge in programs with diverse populations of residents. Despite the ubiquity of racial enactments in training, they are not regularly discussed in educational settings, either informally or formally. With more understanding of the nature and impact of racial enactments, psychiatry residency programs can bridge the gap by increasing awareness of how these dynamics impact the experiences of learners, supervisors, and patients. While this requires continuous learning and humility, it can help foster a sense of belonging that supports trainee development within a diverse community of residents.

Agenda

- 0-10m: Introduction: Speaker introductions, poll everywhere for audience identification
- 10-15m: Defining and identifying racial enactments
- 15-35m: Case presentation of a racial enactment in training:
  - Trainee perspective
  - PD and APD perspectives
  - Director of Health Justice perspective
- 35-50m: Small group discussion
- 50-60m: Model didactic on racial enactments
- 60-65m: Resident perspective on the implementation of racial enactment education
- 65-85m: Large group discussion on incorporating enactment didactics into curricula and Q&A
- 85-90m: Q&A and closing/survey

Scientific Citations

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Destigmatizing language and beyond: Brief educational interventions to reduce substance use stigma

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Jeremy Weleff, DO, Yale University School of Medicine
Michael Dawes, MD, Boston University Medical Center
Alena Balasanova, MD, University of Nebraska Medical Center College of Medicine
Jacob Givens, BS, MD, University of Nebraska Medical Center College of Medicine
Sandra DeJong, MSc, MD, Cambridge Health Alliance/Harvard Medical School

Educational Objectives
At the end of this session, the learner will be able to:
1) Distinguish different aspects of stigma (public-, self-, and structural), and apply these aspects of stigma to other social determinants.
2) Distinguish between stigmatizing and non-stigmatizing language around substance use.
3) Identify ways in which our clinical learning environments may unintentionally contribute to stigma and integrate substance use stigma into our learners' professional identity formation.
4) Apply brief educational interventions designed to reduce stigma in clinical care and harm reduction settings.
5) Mobilize strategies and approaches to educate trainees about stigma, challenge stigma in their professional practice, and advocate for systemic change.

Abstract
Stigma towards those who use substances or have substance use disorders is rooted in the long history of moral superiority and "othering" that permeates many cultures towards marginalized sectors of the population. The language that has been used to describe substance use reflects this history: Words like "dirty" and "clean" have permeated our description of people who use substances not yet in treatment, associated paraphernalia, and even the individuals who are in treatment and relapse. These biases are reflected in key legislation produced by biased US congressional legislators who had stigmatizing views of persons who used substances and SUD treatment. At the beginning of the 1900s, the Harrison Narcotics Act and Volstead Act established abstinence and prohibition as the standard approaches to substance use. Throughout the mid-20th century, other legislation regarding opioid use disorder treatment including methadone treatment, further reinforced and entrenched these

biased and stigmatizing views in SUD treatment in the US. To this day, our language, health care system, and medical education for trainees on substance use treatment are often biased and stigmatizing towards persons with SUD. Understanding how these stigmatizing factors manifest and persist is critical if psychiatric educators are to effectively address stigma and treatment gaps for this population.

Despite advances in understanding SUDs as chronic medical conditions, individual developmental and historical factors, intersecting with societal and institutional biases, continue to influence perceptions, behaviors, and policies. Clinicians are often hesitant to address the treatment of substance use disorders, and thus, trainees (and currently practicing physicians) have inherited these biased and toxic beliefs from society and their mentors. Explicitly considering how these beliefs contribute to the Professional identify Formation of our trainees is critical.

After defining and describing the various aspects of stigma (public-, self-, and structural), and their relationships to other social determinants, we will present a menu of creative educational interventions to address stigma, ranging across fields from journalism to neuroscience. While each approach has its own merits, each has faced appropriate criticisms and has its own shortcomings. By examining practically relevant conceptualizations of internalized and externalized stigma, this workshop aims to provide participants with actionable insights to combat stigma effectively. Through this, we hope as a result, to cultivate a more compassionate and scientifically informed approach to the treatment of substance use disorders, ultimately leading to better education for our learners and improved outcomes for our patients.

Practice Gap

The persistence of substance use stigma creates significant barriers to effective treatment and harm reduction, for both patients seeking help and clinicians providing care. Despite advances in understanding substance use disorders (SUDs) as chronic medical conditions, individual developmental and historical factors intersecting with societal and institutional biases continue to influence perceptions, behaviors, and policies. Stigma is deeply rooted in society and history. And clinicians often hesitate to treat persons with SUDs due to their own stigmatizing perspectives, biased professional identities, and lack of training, while patients often avoid seeking care due to shame or fear of discrimination. To close these educational gaps, we must enhance or training methods to reduce stigma. We will explore aspects of stigma, stigma's manifestations in the clinical learning environment, and present practical strategies for psychiatric educators to mitigate stigma, with the goal of improving care and harm reduction strategies.

Agenda

Part 1: Using art and photographs to recognize stigma in a self-reflection activity (5 mins – Sandra DeJong)
Part 2: Stigma: Types, etiology, developmental trajectories, and historical roots (10 mins – Michael Dawes)
Part 3: The language of stigma and teaching best practices (10 mins – Alëna Balasanova)
Part 4: The use of neuroscience and other creative interventions to mitigate stigma (10 mins – Jeremy Weleff)
Part 5: A resident's perspective on professional identity formation around stigma (10 mins – Jacob Givens)
Part 6: Synthesis and Integration: Small group discussion and large-group talk-back about program-based interventions, mini educational interventions, and experiences in substance use disorder training (20-30 mins – Sandra DeJong / Team)
Q&A and Evaluation (10 mins)

Scientific Citations

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Title
Forging Bridges Across Generations: Addressing Intergenerational Gaps in Academic Psychiatry Learning and Leadership

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

Presenters
Ailyn Diaz, MD, Penn State University, Hershey Medical Center
Sebastian Acevedo, MPH,
Monica Arora, MD, Creighton University Psychiatry Residency Program (Omaha)
Peter Ureste, MD, University of California, Riverside School of Medicine

Educational Objectives
Upon completion of the workshop, attendees will be able to:
1. Describe three instances where intergenerational gaps arise between faculty and residents in in academic psychiatry practice through guided group discussion.
2. Assess the influence of intergenerational gaps on learner outcomes in academic clinical psychiatry practice through the application of a case vignette.
3. Apply the use of connectivism as an example of a learning paradigm to bridge intergenerational gaps in academic psychiatry through the interaction with a simulated social media platform.
4. Explore how intergenerational gaps impact leadership and collaboration, providing actionable insights in fostering a more inclusive academic environment through a concentric circle collaborative activity between senior faculty in leadership roles, junior faculty, and learners.

Abstract
This workshop addresses the unique challenge of managing intergenerational gaps in academic psychiatry, a field where five different generations—Silent Generation, Baby Boomers, Generation X, Millennials, and Generation Z—work and learn side by side (1). These generational differences can lead to variations in attitudes, learning, and work styles, potentially resulting in misunderstandings and gaps in teaching and learning (3). For example, while the Silent Generation may prefer traditional, structured learning methods, Generation Z gravitates towards technology-enhanced, network-based learning. This workshop aims to explore these gaps, providing a historical, social, and political context to how they occur, and offering practical strategies to bridge them, particularly focusing on the learning paradigm of connectivism.

Participants will engage in group discussions to identify the impact of these gaps on learner outcomes and interact with a simulated social media platform to experience

connectivism firsthand. By examining these intergenerational differences, attendees will leave with practical insights into how to bridge the intergenerational gap in their own institutions, enhancing both teaching and learning experiences in academic psychiatry.

Practice Gap

Intergenerational gaps in academic psychiatry practice reflect the varying attitudes, learning styles, and expectations of different generations working together. With psychiatry being the third oldest specialty in the United States (1), these gaps are particularly pertinent as older generations may prefer structured, constructivist learning methods, whereas younger generations, like Generation Z, thrive on connectivism—a learning approach centered on networking and technology (2). Bridging these gaps is essential to optimize learner outcomes, enhance leadership dynamics, and ensure effective knowledge sharing across generations. This workshop will provide an overview of these gaps, focusing on strategies to bridge them through the application of connectivism and collaborative intergenerational communication activities between learners, faculty, and leadership.

Agenda

Minutes 0-3: Introduction of topic and speakers.
Minutes 3-15: Didactic Presentation. Define intergenerational gaps and explore how these gaps form in academic psychiatric practice from historical, political, and social contexts.
Minutes 15-30: Small Group Breakout: Vignette-based discussion where participants identify three instances of intergenerational gaps in academic settings and assess potential outcomes.
Minutes 30-40: Simulation Exercise. Attendees will interact with a simulated social media platform to experience the digital learning landscape of the newer generation.
Minutes 40-65: Concentric Circle Exercise. Think, pair, and share in a concentric circle between senior faculty in leadership positions, junior faculty, and learners, followed by a discussion with the larger group, exploring how intergenerational gaps affect leadership and collaboration.
Minutes 65-85: Q&A and Conclusion. Open floor for questions, summarizing key takeaways, and reflecting on strategies to bridge the generational gap in academic psychiatry.

Scientific Citations

1. 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.

2. D'souza F, Shah S, Oki O, Scrivens L, Guckian J. Social media: medical education's double-edged sword. Future healthcare journal. 2021 Jul 1;8(2):e307-10.

3. Josephine J, Jones L. Understanding the Impact of Generation Gap on Teaching and Learning in Medical Education: A Phenomenological Study. Adv Med Educ Pract. 2022;13:1071-1079. Published 2022 Sep 16. doi:10.2147/AMEP.S370304

Title
How to Create a Psychologically Safe Environment During Residency

Primary Category
Program Administration and Leadership

Presenters
Anju Hurria, MD, MPH, University of California, Irvine Medical Center
Kalyn Reddy, MD, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)
Corina Vasquez, MD

Educational Objectives
1. Define “psychological safety” and its relevance within a residency training program.
2. Develop skills to create and implement a psychological safety survey tailored to their residency program.
3. Evaluate different interventions designed to improve psychological safety and exchange ideas for implementation across various programs.

Abstract
Dr. Amy Edmondson described the concept of psychological safety, namely: beliefs around the safety of interpersonal risk taking, such as speaking up with ideas and concerns or admitting mistakes1. Psychological safety can be conceptualized on an individual, group, and organizational level and can have implications for healthcare outcomes and employee learning, and burn-out2,3. Our institution faced concerns after receiving low scores on the annual Accreditation Council for Graduate Medical Education (ACGME) survey regarding fear of retaliation within our psychiatry residency program. Despite efforts by leadership to address these concerns with residents directly, the sensitive nature of the topic often led to hesitation in providing candid feedback, preventing effective resolution.. To address this, we drew inspiration from existing research on psychological safety and from Dr. Iram Ahmad, an ENT surgeon from Stanford, who conducted a comprehensive evaluation of psychological safety among faculty in her department and implemented targeted interventions4. We adapted Dr. Ahmad’s psychological safety evaluation to create a survey specifically for our psychiatry residency program.

We distributed the adapted survey to all trainees, ensuring anonymity to encourage honest and open feedback without fear of retaliation. The survey included both quantitative data and qualitative free-response sections, which provided specific, detailed insights into specific issues such as biases, communication gaps, and challenging dynamics between attendings and residents. This approach enabled us to identify

recurring themes and develop targeted interventions, including department-wide presentations, faculty workshops, and opportunities for individual coaching.

Preliminary results from these interventions have been positive, with faculty expressing a strong interest in personal feedback for self-growth and residents reporting improvements in program culture. We plan to substantiate the impact of these changes using future ACGME survey results and a follow-up psychological safety survey. If the data is supportive, this intervention could be used on a recurring basis to continue to identify areas of growth, promote program development, enhance resident well-being, and foster a culture of openness and psychological safety.

This interactive workshop will guide participants through our methods and findings, followed by small group activities in which participants will develop the skills to conduct and evaluate a similar intervention at their own programs. The goal of this workshop is to equip program directors and psychiatric educators with practical tools for creating a psychologically safe training environment.

Practice Gap

The ACGME survey is distributed annually for all trainees. It covers a range of topics including evaluations, diversity and inclusion, and teamwork5. It provides valuable quantitative data, but does not offer space for free response. It offers a snapshot of program satisfaction but does not provide qualitative insights necessary to fully understand the factors affecting culture.

A psychological safety survey can bridge this gap by providing trainees with a safe, anonymous platform to offer detailed feedback. This approach allows for a more comprehensive understanding of the program's culture and identifies areas for improvement that may not be evident through quantitative data alone. Program leadership can use the psychological safety survey results to impart meaningful changes to their program that will address areas of concern identified on the ACGME survey effectively. In addition, regular evaluations of psychological safety may provide an approach for training directors to evaluate effectiveness of prior interventions.

Agenda

- Minutes 0 - 5: Introduction and completion of a psychological safety survey by participants.
- Minutes 5 - 30: Overview of psychological safety, literature review, and the rationale for the survey's implementation
- Minutes 30 - 40: Small Group Discussion #1: Participants discuss aspects of psychological safety. Each small group will have an area for discussion such as gender

bias, racial bias, boundaries and transference, generational gaps, and promoting a culture of openness.
● Minutes 40 - 50: Large Group Discussion: Summarization of small group findings
● Minutes 50 - 63: Small Group Discussion #2: Participants share thoughts on survey questions and discuss strategies for implementing changes within their programs based on survey feedback.
● Minutes 63 - 75: Large Group Discussion: Exploration of factors that contribute to a positive training culture, effective change implementation and leadership support
● Minutes 75 - 90: Closing discussion and workshop evaluation

Scientific Citations

Mohamed, I., Hom, G. L., Jiang, S., Nayate, A., Faraji, N., Wien, M., & Ramaiya, N. (2023). Psychological Safety as a New ACGME Requirement: A Comprehensive All-in-One Guide to Radiology Residency Programs. Academic Radiology, 30(12), 3137–3146. https://doi.org/10.1016/j.acra.2023.08.032

Edmondson, A. C., & Bransby, D. P. (2023). Psychological Safety Comes of Age: Observed Themes in an Established Literature. Annual Review of Organizational Psychology and Organizational Behavior, 10(Volume 10, 2023), 55–78. https://doi.org/10.1146/annurev-orgpsych-120920-055217

Grailey, K. E., Murray, E., Reader, T., & Brett, S. J. (2021). The presence and potential impact of psychological safety in the healthcare setting: An evidence synthesis. BMC Health Services Research, 21(1), 773. https://doi.org/10.1186/s129

Torralba, K. D., Jose, D., & Byrne, J. (2020). Psychological safety, the hidden curriculum, and ambiguity in medicine. Clinical Rheumatology, 39(3), 667–671. https://doi.org/10.1007/s10067-019-04889-4

O'Donovan, R., & McAuliffe, E. (2020). A systematic review exploring the content and outcomes of interventions to improve psychological safety, speaking up and voice behaviour. BMC Health Services Research, 20(1), 101. https://doi.org/10.1186/s12913-020-4931-2

Title
"How to financially support mentoring and well-being programs".

Primary Category
Program Administration and Leadership

Presenters
Silvina Tonarelli, MD, Texas Tech University Health Sciences Center, El Paso
Arden D Dingle, MD, University of Nevada-Reno
Alma Liliana Monroy Tijerina, MD, Texas Tech University Health Sciences Center, El Paso
Ruby Lekwauwa, BS, MD, Yale University School of Medicine

Educational Objectives
1. During the workshop the participants will learn about possible and potential sources of funding within and outside their institutions
2. Participants will explore the most frequent allies and potential partnerships
3. Participants will brainstorm useful rationales for funding and reasonable goals and outcomes to justify financial support

Abstract
ACGME states that to achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program. ACGME requires that programs, in partnership with their Sponsoring Institutions address well-being as an essential aspect of resident competence. Unfortunately, there are no accompanying mandates for financial support of these activities. In the recent editorial of Academic Psychiatry, Brennan et al (3) highlighted the importance to continue addressing the wellness and stress in medical education. Managing a successful mentoring or wellbeing program in medical education can be costly, and many programs struggle with limited funding, especially for activities that are not direct patient care. This workshop aims to identify potential sources of financial support within and outside institutions for wellness and mentorship programming with the exploration of strategic partnerships. Presenters will discuss the rationale for funding, goals and outcomes to justify grant applications/ provision of funds and offer practical steps for securing financial resources. Despite extensive analysis of mentoring programs, recent studies, including Joe et al. (2023) and Dennis et al. (2023), do not addressed financial limitations as a common barrier. By highlighting these aspects,

the workshop seeks to enhance understanding and provide actionable resources to support and grow mentoring and well-being programs.

Practice Gap

The financial limitation in the creation of a successful mentoring and well-being programs is not frequently reported in the literature. A recent publication by Joe and et al. (1) showed the results of analysis of more than 50 studies about mentoring programs in residency and fellowship in United Stated and Canada. The authors summarized all potential barriers and facilitators for success of the programs however "financial support" is not identified as a common barrier. Dennis and co-authors in 2023 (2) provide a set of guiding principles for promoting wellness during residency, however financial resources are not discussed. In practice, obtaining adequate funding for mentorship and wellness programming often is a major challenge for training programs. In addition to the direct costs of wellness and mentorship activities, faculty, learner and staff time and effort must be paid for.

Agenda

The workshop will be highly interactive incorporating both didactic and practical components:

- Welcome and Introductions (5 min, 5 min total)
- Brief didactics to introduce concepts and possible approaches/ strategies (10 min, 15 min total)
- Small Breakout Groups 1 (25 min, 40 min total): Participants will discuss potential funding sources, a template for discussion will be provided.
- Presentation of Action Plan examples (10 min, 50 min total) Examples of successful funding strategies will be shared.
- Leg stretch/water break (5 min, 55 min total)
- Small Breakout Groups 2 (25 min, 80 min total): Groups will brainstorm partnership ideas and funding strategies.
- Questions, feedback, fill out survey (10 min, 90 min total) Participants will provide feedback and complete a survey."

Scientific Citations

1) Joe MB, Cusano A, Leckie J, Czuczman N, Exner K, Yong H, Ruzycki S, Lithgow K. Mentorship Programs in Residency: A Scoping Review. J Grad Med Educ. 2023 Apr;15(2):190-200. doi: 10.4300/JGME-D-22-00415.1. Epub 2023 Apr 17. PMID: 37139208; PMCID: PMC10150829.

2) Dennis AA, Colton L, Tewari P, Slavin S. Promoting Well-Being in Graduate Medical Education: Embracing Principles Rather Than "Recipe". Acad Psychiatry. 2024

Aug;48(4):378-383. doi: 10.1007/s40596-023-01827-0. Epub 2023 Aug 8. PMID: 37552402.

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Title
Integrating Collaborative Psychiatric Care into Residency & Fellowship Training: Strategies for Forging Ahead

Primary Category
Curriculum

Presenters
Caitlin Engelhard, PhD, MD, McGaw Medical Center, Northwestern University
Ramanpreet Toor, MD, University of Washington Program
Shireen Cama, BA,MD, Cambridge Health Alliance/Harvard Medical School
Rachel Weir, MD, University of Utah School of Medicine
Richard Ly, MD, Samaritan Health Services Psychiatry Residency Program

Educational Objectives
1) Describe how integrated care improves population mental health including access to care and equity.
2) Name three approaches to incorporate integrated care education into residency and fellowship curriculum.
3) Describe Kotter's "8 Steps for Leading Change" as a model to effectively promote change within an organization.
4) Develop an action plan to take the next step in improving integrated care education in their program.

Abstract
As the healthcare landscape evolves, implementing integrated psychiatric care into medical education is crucial for advancing equity and serving diverse populations, as well as providing a critical access point and expanding the reach of psychiatry. The American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP) have recommended greater use of integrated care models in clinical practice, particularly in light of the widening gap between population mental health needs and the available psychiatric resources. Workforce development is critical to promote expansion of integrated care, including the education of psychiatric residents and fellows (1). Several models for integrated care curricula have been developed (2-4) but implementation is often challenging due to practical and institutional barriers (5), and many psychiatry residency and fellowship programs have limited or no integrated care education.

This workshop will support attendees to develop a blueprint for incorporating integrated mental health care models into psychiatric training programs, guided by Dr. John Kotter's model "8 Steps for Leading Change" (6). Participants will learn to advocate for integrated care models within their institutions, utilizing Kotter's eight-step process to create

urgency, build coalitions, and develop and implement a strategic vision. The session will cover a spectrum of essential educational initiatives, such as didactics and integrated care rotations, which can equip trainees to navigate the changing medical landscape. The workshop will share currently available resources, discuss strategies for securing stakeholder support, share how collaborative educational programs have been successfully developed at different institutions, and explore potential future directions.

Interactive breakout groups will focus on applying Kotter's model “8 Steps for Leading Change” to implement these educational programs and changes in attendees' organizations. By the end of the session, participants will be equipped to lead the integration of integrated care into graduate medical education, fostering a future of psychiatric practice that is equitable, accessible, interdisciplinary, and patient-centered.

Practice Gap

Integrated mental health care models are a key strategy to address the population’s psychiatric needs, expand access to care, and improve equity. However, many psychiatry residency and fellowship programs provide limited training in integrated care, which means trainees are less prepared to work in these settings after graduation. Incorporating integrated care into graduate medical education can be challenging due to lack of time, funding, faculty expertise, available clinical experiences, and institutional barriers. This workshop will teach participants how to incorporate integrated care education in a wide variety of residency/fellowship settings as well as practical strategies to navigate barriers and promote change within their programs.

Agenda

1) Making the case for inclusion of integrated care in psychiatry residency and fellowship education: a review of integrated care models and how they improve access to quality mental health treatment (10 minutes)
2) Review a range of integrated care education approaches from five different programs at different stages on the integrated care education continuum. Provide tips on curriculum development and present resources from the AADPRT Integrated Care Caucus. (20 minutes)
3) Introduce Kotter’s model “8 Steps for Leading Change” (10 minutes)
4) Break out groups. Participants will break up into small groups based on where their program is along the integrated care education continuum, so that participants are grouped with others facing similar challenges. Participants will use Kotter’s “8 Steps for Leading Change” to identify feasible strategies to promote integrated care education in their programs. (30 minutes)
5) Wrap up and discussion (20 minutes)

Scientific Citations

1) Sunderji N, Ion A, Huynh D, Benassi P, Ghavam-Rassoul A, Carvalhal A. Advancing Integrated Care through Psychiatric Workforce Development: A Systematic Review of Educational Interventions to Train Psychiatrists in Integrated Care. Can J Psychiatry. 2018 Aug;63(8):513-525.

2) Burruss, N.C., Murray, C., Li, W. et al. Integrated Care Education for General Psychiatry Residents in the US: a Review of the Literature. Acad Psychiatry 47, 390–401 (2023).

3) Dobscha, S.K., Dandois, M., Rynerson, A. et al. Development and Evaluation of a Novel Collaborative Care Rotation for Psychiatry Residents. Acad Psychiatry 46, 491–494 (2022).

4) Ratzliff ADH, Toor R, Erickson JM, Bauer AM, Duncan MH, Chang D, Chwastiak L, Raue PJ, Unutzer J. Development and Implementation of an Integrated Care Fellowship. J Acad Consult Liaison Psychiatry. 2022 May-Jun;63(3):280-289.

5) Reardon CL, Bentman A, Cowley DS, Dunaway K, Forstein M, Girgis C, Han J, Hung E, Jones J, Keeble T, McCarron RM, Varley CK. General and Child and Adolescent Psychiatry Resident Training in Integrated Care: a Survey of Program Directors. Acad Psychiatry. 2015 Aug;39(4):442-7

6) Kotter, J. P. (1995) Leading Change: Why Transformation Efforts Fail. Harvard Business Review, 73, 59-67.

Title
Steering through Rough Waters: Strategies for Successful Change Management

Primary Category
Program Administration and Leadership

Presenters
Kari Wolf, MD, SIU School of Medicine
Steven Scheinthal, DO
Mauricio Tohen, MD

Educational Objectives
Explain key principles of change management Assess barriers to change and generate strategies to overcome these barriers Develop strategies to drive change in your areas of responsibility

Abstract
Medicine is becoming increasingly complex. Market pressures have forced traditional academic medical centers to shift from institutions primarily focused on research and education to thriving healthcare businesses. Increasingly, successful private healthcare organizations are entering the field of residency education. To be successful in this rapidly evolving landscape, psychiatric educational leaders need to learn to successfully navigate the changing environment and implement changes to enhance the educational programs they lead. Traditional physician education does not prepare psychiatric educators to navigate this ever-changing environment. As a result, decisions affecting everything from clinical service design to budgeting and finances to educational programs are being made (or strongly influenced) by non-physicians. One opportunity for skill development of psychiatric educators involves learning how to successfully navigate and lead change. Using a combination of brief didactics, facilitated small group exercises, and questions & answers, this workshop will provide an overview of key theories of change management, exploring concepts developed in both business and healthcare industries. Participants will identify barriers to successful change initiatives and develop strategies to overcome these challenges. By the end of the workshop, participants will understand key principles to drive successful change and have created a change management plan that they can implement in their home institution. This workshop will be led by chairs from three academic departments across the country. Their experiences span traditional academic school settings, private healthcare settings, a community-based medical school, state-wide systems of care, and allopathic as well as osteopathic schools. They will highlight strategies that have resulted in successful change initiatives as well as common pitfalls that will derail even the best ideas.

Practice Gap
As the Greek philosopher Heraclitus said, “There is nothing permanent except change.” The healthcare environment is changing. As academic medicine transitions from institutions of research and higher education to healthcare businesses being forced to adapt to the ever-changing healthcare environment, many physicians—especially clinician educators—are left at a loss for how to navigate the changing clinical environments in which residency learning occurs. Being in an ever-changing healthcare landscape offers opportunities for physicians to influence and lead change. However, many physicians lack the skills and expertise to successfully drive change to improve their areas of responsibility.

Agenda
Introduction to change (5 minutes)
Small group activity to Identify changes affecting your area (1-2-group – 8 minutes)
Principles of change management (17 minutes)
Small group activity to identify barriers to change and develop solutions (Triz Exercise – 40 minutes)
Best Practices in change management (10 minutes)
Wrap-up (large group discussion, Q&A – 10 minutes)

Scientific Citations
Michael Beer (2021) Reflections: Towards a Normative and Actionable
Theory of Planned Organizational Change and Development, Journal of Change Management,
21:1, 14-29, DOI: 10.1080/14697017.2021.1861699

Errida, A., & Lotfi, B. (2021). The determinants of Organizational Change Management Success: Literature Review and Case Study. International Journal of Engineering Business Management, 13. https://doi.org/10.1177/18479790211016273

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Title
The ERAS Tour: recruitment trends and strategies for tortured residency and fellowship program directors

Primary Category
Recruitment and Selection

Presenters
Denise Baughn, MD, University of Texas Medical Branch, Galveston
Simone Bernstein, MD, National Capital Consortium Program
Carrie Ernst, MD, Icahn School of Medicine at Mount Sinai
Jessica Sandoval, MD, BA, MS, University of Texas Health Sciences Center at San Antonio
Daniel Gih, MD, University of Nebraska Medical Center College of Medicine

Educational Objectives
1. Summarize the newest psychiatry application data and related residency matching and fellowship results.
2. Describe the effects of ERAS program signaling and conversion to residency program interviews.
3. Define available tools and resources for recruitment for applicants and programs.
4. Describe how to collaborate with other stakeholders in recruitment.
5. Outline new challenges to residency and fellowship recruitment and recruitment.
6. Apply past recruitment season results to target future success in recruitment.

Abstract
Medical student interest and applications to psychiatry residency programs have been growing for the last decade. Competition for residency slots has similarly increased, reflected by significant numbers of unmatched applicants to psychiatry. Since 2022, substantial changes in the residency application system have been made, incorporating new elements like program signaling and geographic preferences.

The increase in competitiveness of psychiatry has not yet translated into an increase in competition for fellowship slots. The overall psychiatry workforce shortage has affected all of the psychiatric subspecialties and up to 50% of subspecialty fellowship positions go unfilled each year. Barriers to subspecialty recruitment include financial burden, better alternative career opportunities, prolonged training period, and residency burnout. Many recent efforts have been made to improve the fellowship application and recruitment process.

In light of these challenges, program directors want the latest and most relevant information to gauge the level of applicant competitiveness and interest and determine a

plan to recruit the best trainees. Residency and fellowship applicants get information about programs from numerous and varied sources. Knowing where applicants get their information – primarily program websites – can help training directors plan the best strategies for recruitment. (7) Recent data notes that applicants desire transparency about exam score requirements, geography and the information about the racial/ethnic backgrounds of program faculty and current residents when choosing a residency. (6)

Various stakeholders, including DIOs, medical school deans, UME psychiatry colleagues, and training directors from other departments have additional goals in recruitment. Understanding the roles of these stakeholders is vital to training directors in navigating the recruitment season.

This workshop is geared towards program directors and all attendees involved in the residency/fellowship application process. Endorsed by the AADPRT Recruitment Committee and Subspecialty Caucus, it will present updated lessons and data from the most recent residency and fellowship matches and the latest ERAS application format. Recruitment challenges faced will be explored through small group breakout session cases and a large group discussion. Presenters will provide practical tips for successful recruitment and session participants will be encouraged to share their own best practices. The session will conclude with an interactive question and answer session.

Practice Gap

Matching into a psychiatry residency program has become increasingly challenging due to the growing competitiveness of psychiatry and the ever-changing Electronic Residency Application Service (ERAS) application. Subspecialty recruitment has a different set of recruitment challenges. Programs need to stay updated with the latest information and data to determine a strategy to recruit trainees. In this workshop, we will present lessons learned from the 2024 Match and the latest ERAS format to provide ways to enhance knowledge and skills for a successful outcome in a residency or fellowship match.

Agenda

5 Minutes Introductions
5 Minutes Poll to gauge audience experiences in recent recruitment cycles (including audience identification questions)
10 Minutes Didactic presentation: Current ERAS application, 2024-2025 match data (including fellowship data), trends, data on signals from AAMC
20 minutes Small groups of 4-6 participants will discuss provided cases of challenging situations faced during the recruitment season, with approximately 10 minutes per case. Case discussions will allow participants to learn about what other programs do to develop new strategies for recruitment.

20 Minutes Large group discussion: Small groups will join to present the cases discussed, share the challenges presented by the case, and discuss their strategies to approach the situation with a goal of successful recruitment.
10 minutes Summary of findings and potential best practices in recruitment
15 minutes Q&A Discussion to ask audience about best practices in recruitment
5 Minutes Designated time for evaluation and Feedback

Scientific Citations

1. Thomas, L.A., Schatte, D., Briscoe, G., et al. What Should Faculty Advisors Know Before Advising Students Applying to Psychiatry Residency. Acad Psychiatry, 45, 506–510 (2021). https://doi.org/10.1007/s40596-021-01438-77??

2. Moran, Mark. Number of Students Matching Into Psychiatry Increases for 13th Year. Psychiatric News, PN, 59, no. 05 (May 2024). doi:10.1176/appi.pn.2024.05.5.36.??

3. NRMP. Results and Data: 2024 Main Residency Match. https://www.nrmp.org/match-data/2024/06/results-and-data-2024-main-residency-match/. Accessed 07/30/2024?

4. AAMC. What You Need to Know About the 2025 ERAS® Application Season. https://students-residents.aamc.org/applying-residencies-eras/what-you-need-know-about-2025-eras-application-season. Accessed 07/30/2024?

5. AAMC. Impactful Experiences.? https://students-residents.aamc.org/applying-residencies-eras/publication-chapters/impactful-experiences. Accessed 07/30/2024?

6. Ulin L, Bernstein SA, Nunes JC, Gu A, Hammoud MM, Gold JA, Mirza KM. Improving Transparency in the Residency Application Process: Survey Study. JMIR Form Res. 2023 Dec 25;7:e45919. doi: 10.2196/45919. PMID: 38145482; PMCID: PMC10775039.

7. Bernstein SA, Hodgins GE, Abu-Hamad S, Gih DE, Gold JA. Understanding the Use of Program Resources During Virtual Recruitment by Psychiatry Residency Applicants. Acad Psychiatry. 2023 Aug;47(4):380-384. doi: 10.1007/s40596-023-01804-7. Epub 2023 May 26. PMID: 37237083; PMCID: PMC10218770.

8. Akhtar RR, Rana MJ, Joychan S, Malik S. Assessing the Factors Affecting Recruitment to Child and Adolescent Psychiatry Fellowship Programs. Acad Psychiatry. Published online July 9, 2024. doi:10.1007/s40596-024-02007-4

9. Becker MA, Bradley MV, Montalvo C, et al. Factors Affecting Psychiatry Resident Decision to Pursue Consultation-Liaison Psychiatry or Other Subspecialty Fellowship Training. J Acad Consult Liaison Psychiatry. 2021;62(1):38-45. doi:10.1016/j.psym.2020.05.009

10. Gupta DR, Candilis PJ, Choi O, et al. Attitudes of Forensic Fellowship Psychiatry Directors towards an Applicant Match. J Am Acad Psychiatry Law. Published online July 25, 2024. doi:10.29158/JAAPL.240053-24

AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
The power of collaboration: Strategies for creating wellness initiatives

Primary Category
Curriculum

Presenters
Anetta Raysin, DO, Maimonides Medical Center
Sophia Mikityanskiy, DO, Maimonides Medical Center
Jinal Patel, MD, Maimonides Medical Center
Angela Liu, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program
Dustin Brinker, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program

Educational Objectives
At the conclusion of this workshop, participants should be able to:
1. Describe the unique stressors that contribute to burnout for psychiatry residents
2. Discuss current evidence-based strategies to promote wellness and target burnout in psychiatry residents
3. Design curricular innovations to support residents while in training and promote life-long wellness strategies

Abstract
Background: Psychiatry residents experience significant amounts of stress, leading to increased rates of burnout, depression, and other mental health challenges (Chan et al., 2019; Tipa et al. 2019). The contributors to this issue are multifaceted; however, one strategy for addressing this need is the creation and integration of wellness curricula (Nasirzadeh et al., 2022). This workshop aims to highlight such curricular efforts. Through examples from two psychiatry training programs in New York City, we hope to provide a framework for other institutions to reflect upon their wellness endeavors and develop integrative wellness initiatives to combat the demands of psychiatry residency and facilitate retention to practice.

Methods: The wellness initiatives at both institutions were co-led by program faculty and residents. These initiatives were both curricular and co-curricular. Curricular components incorporated members from wellness and anti-racism committees to develop didactics and workshops available to all residents in the respective programs. In addition to general education on burnout and wellness (e.g., moral injury, imposter syndrome, resiliency building, self-care), the didactics highlighted personal challenges that residents may face during training (e.g., bereavement, illness, immigration issues) and provided resources and strategies to cope with these challenges. We conducted debriefs before

and after these sessions to evaluate their content and effectiveness. Co-curricular initiatives included the creation of support groups, and resident “sibling/family” matches, as well as amendments to policy, budgets, and benefits. In doing so, we sought to address the individual, interpersonal, and structural influences on wellness.

Feedback from program directors, faculty, and residents suggested the initiatives contributed to increased awareness of potential challenges residents may face during training, and equipped residents with the tools, resources, and information they may need during periods of stress, adverse life events, and burnout.

Results: The results of these initiatives highlight the power of inviting residents in the co-creation of educational innovations. We have implemented a two pronged approach to address wellness for residents, focusing on wellness curricula that are supported by practical efforts to prioritize wellness. Our approach utilized a combination of lectures and group discussions to improve awareness of key policies, benefits, and external resources for support, working closely with the resident union, and creating initiatives to improve peer support and community in residency.

Conclusion: Integrating wellness didactics and practical initiatives that are, co-created and co-led by resident and faculty staff, into psychiatry residency training is a promising approach to mitigate the negative impact of stress, adverse life events, and burnout on resident physicians. By openly exploring the unique challenges and stressors faced by psychiatric residents, highlighted by examples of sensitive and emotionally demanding situations, these sessions can equip them with essential tools, and resources to navigate the rigors of training while fostering a culture of self-care, awareness, and support. We hope that such efforts lead to the development of resilient psychiatric providers and training programs, and maintain residents retention in programs. Simultaneously, this helps directors better understand the needs of trainees, and resources for support, while simultaneously adhering to the policies and expectations of training programs.

Practice Gap

Despite the growing need for mental health providers in the United States, the psychiatric workforce continues to fall short (Aggarwal et al., 2022). Our field has prioritized the recruitment and retention of trainees as one means of filling this gap, for example through concerted efforts to integrate international medical graduates into both residency and independent practice (Marwaha et al., 2024). Nonetheless, the retention of trainees and graduates remains a concern, due in part to the general demands of graduate medical education but also to the unique challenges of psychiatry residency (Brenner et al., 2024).

Agenda
0-10 min: Introductions, didactic overview of the literature on resident wellness in psychiatry training
10-20 min: Small group discussion on challenges residents face at respective institutions
20-30 min: Large-group share out
30-45 min: Narrative presentation of wellness initiatives at two programs
45-60 min: Individual activity guided by handout for programs to outline potential initiatives at their own institutions
60-75 min: Large group share out of individual activity
75-90 min: Large group debrief, Q&A, and wrap up

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Title
To Supplement, Not Supplant: An Interactive Workshop on Harnessing AI in Psychiatric Training

Primary Category
Curriculum

Presenters
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Educational Objectives
Objectives
- Define Artificial Intelligence (AI) and key concepts such as large language models (LLMs), natural language processing, and deep learning.
- Discuss current positions on AI by the APA and AADPRT, as well as the ethical implications of using AI in psychiatric education.
- Describe a rotation started at Hackensack Meridian Health (HMH) in Digital Psychiatry for PGY1 Psychiatry Residents.
- Explore strategies for integrating AI into psychiatry training programs to assist with improving medical knowledge and supplementing training.
- Demonstrate the steps needed to create a custom voice-driven AI tailored to psychiatric education.

Abstract
Artificial Intelligence (AI) is rapidly reshaping the medical landscape, including psychiatric practice, and its influence on residency training is no longer a question of if but when. Whether or not we actively teach AI, our trainees—and increasingly, our patients—will be utilizing AI tools in clinical and personal settings. This workshop will explore how AI is poised to enhance psychiatric education and why now is the time for training programs to engage with this technology.

The session will provide participants with an interactive introduction to AI in education, starting with a comprehensive overview of foundational AI concepts, such as large language models (LLMs), natural language processing (NLP), and deep learning, ensuring

all participants have a baseline understanding. We will discuss the role of AI in bolstering key initiatives such as Justice, Equity, Diversity, and Inclusion (JEDI); Competency-Based Medical Education (CBME); leadership development; cultural competency training; and well-being and burnout prevention.

We will then introduce a new Digital Psychiatry rotation being piloted at Hackensack Meridian Health (HMH), which is designed to prepare residents for the future. This rotation reflects the growing need for psychiatrists to not only understand digital therapeutics but to actively teach its applications and limitations.

The core of the workshop will be a hands-on demonstration. Participants will collaboratively create a customized AI tool tailored to their residency program's specific needs using ChatGPT's Custom GPT feature. No programming skills are required—attendees will define behaviors, guidelines, and training criteria to develop the AI model. Following this, we will showcase AI's voice recognition and speech simulation capabilities through an interactive demonstration, allowing participants to experience AI as a simulated patient in real-time, potentially providing a valuable supplement to training.

Additionally, the workshop will address the potential challenges of integrating AI into psychiatric training, including the risks of residents becoming overly reliant on AI, the importance of developing critical clinical judgment, and the necessity of understanding the technology's limitations. We will also discuss practical strategies to protect patient confidentiality and ensure responsible AI use in training programs.

By the end of the session, participants will leave with a clear understanding of how AI can be effectively incorporated into their residency programs in a way that enhances educational outcomes without compromising patient care or ethical standards. They will also gain the skills and confidence to begin developing and utilizing AI tools tailored to their own educational environments.

Practice Gap
Practice gaps to be addressed include:

1) Understanding of AI Concepts and Their Relevance to Psychiatric Training Programs

2) Guidance on the Ethical Implications and Official Stances on AI from Professional Bodies Regarding the Role of AI in Medical Education

3) Lack of Structured Approaches to Integrating AI into Psychiatry Training Programs

4) Understanding of Customizing AI for Residency Training Programs

Agenda

0:00 – Introduction

-Overview of AI in psychiatry: Definitions, key concepts, and how models like ChatGPT function.

-Presentation of current APA and AADPRT statements on AI and its emerging role in psychiatry.

0:10 – Audience Poll & Discussion

0:15 – Presentation: AI in Healthcare

-Exploration of AI's current role in JEDI, CBME, leadership development, and burnout prevention in healthcare.

0:20 – Overview of Digital Psychiatry Rotation at Hackensack Meridian Health

0:30 – Interactive Demonstration #1: Guided Creation and Utilization of a Custom AI

0:50 – Interactive Demonstration #2: Use of Newly Created AI

-Interactive use of the AI for simulating resident-patient interactions, curriculum planning, and faculty development exercises.

1:05 – Breakout Group: Planning AI Integration in Residency Training

-Participants will discuss in break-out groups how AI can be integrated into residency training.

1:20 – Closing Remarks

-Summary of AI best practices in psychiatric education.

-Strategies to prevent over-reliance on AI, while maintaining clinical judgment and safeguarding patient care.

1:25 – Q&A Session

1:35 – Evaluations

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Title
Using the Annual ACGME Reporting System to Your (Web) AD-vantage

Primary Category
Program Administration and Leadership

Presenters
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Russ Kolarik, MD, Prisma Health/University of South Carolina School of Medicine - Greenville
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Educational Objectives
• Understand the process for completing the ACGME annual reporting (WebADS) process
• Identify the content included in the ACGME annual report
• Discover strategies and tools for leveraging the WebADS process to highlight the strengths of and to respond to challenges within their program
• Generate an action plan to effectively manage and to leverage the ACGME annual reporting (WebADS) process to help support post-graduate psychiatry training

Abstract
The Accreditation Council for Graduate Medical Education (ACGME) requests annual reports through the Accreditation Data System (ADS), informally referred to as "WebADS." The psychiatric training director is responsible for the submission of these reports each year, and this process can be daunting, particularly for new training directors, or programs who have gone through many recent changes. There are many important topics that are included in the annual reports such as an accounting of trainee and faculty scholarly activity, clinical schedule information (ie. block diagrams), program overview information including inclusion and diversity initiatives, program major changes, and responses to citations. Information presented in WebADS is an opportunity for training directors to highlight the strengths of their program and to directly address areas of concern that are seen on the ACGME survey results or citations. Preparation of the content in WebADS can be time-consuming, daunting, and is a high-stakes responsibility held by the training director.

The presenters of this workshop are comprised of current training directors and a designated institutional officer (DIO). During this session, the presenters will break down

the elements of the WebADS annual report in an effort to provide tips and strategies for using the WebADS process in an effective way. The presentation will review the limited available literature associated with the ACGME survey and then will introduce a "WebADS toolkit," that includes tools for creating internal Annual Performance Evaluations (APEs), structured Program Evaluation Committee (PEC) meetings, internal surveys, and block diagrams. The toolkit will help training directors collect data throughout the year to be better prepared for the WebADS yearly report, thereby decreasing the burden of this important duty. The presenters will review cases where the WebADS process has been used as a tool to assist responding to an unfavorable ACGME survey into receiving ACGME continued accreditation with commendation, all within one academic year.

The participants will then divide into breakout groups to share strategies that they have incorporated to help them with their own WebADS reports as well as ways that they have used the annual reporting system to help support their programs. In a subsequent breakout group, participants will work together to create an action plan around which strategies they would like to incorporate for managing and organizing their future WebADS reports in their home institutions. Finally, participants will share their strategies to the larger group and will leave the session empowered to leverage the annual WebADS reporting system to their program's AD-vantage.

Practice Gap

Psychiatric training directors (TDs) are faced with the daunting task of submitting an annual report to the Accreditation Council for Graduate Medical Education (ACGME) through the Accreditation Data System (ADS), informally referred to as "WebADS." This report includes a program overview, diversity and inclusion efforts, faculty/trainee scholarly activity, major program changes, and responses to previous citations or areas of concern. This report, along with the yearly ACGME Program Survey, is one of the main tools that the ACGME uses to determine program status and to identify areas of program non-compliance. Despite the importance of this report, many TDs lack strategies for completing this annual report outside of what is available in the ACGME online resources. There is currently no literature that outlines strategies for WebADS completion, and our workshop hopes to bridge this gap to empower TDs to use WebADS to best reflect their training program.

Agenda

0-5 minutes – Introduction and Learning Objectives
5-10 minutes – Presentation of the ACGME annual report/WebADS process and limited literature
10-15 minutes – Detailed breakdown of each WebADS category

15-30 minutes – Presentation of case examples, success stories, and proposed tools/strategies that can be used throughout the year to generate content and data in preparation for the annual WebADS report
30-40 – Breakout groups: participants will identify and discuss strategies that they have incorporated to help them with their own WebADS reports as well as ways that they have used the annual reporting system to help support their programs
40-55 – Breakout groups: participants will work together to create an action plan around which strategies that they would like to incorporate for managing and organizing their future WebADS reports in their home institutions
55-65 – Breakout groups share back to the large group.
65-75 – Question, answer, and wrap-up session

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