WORKSHOPS SESSION 5

Title

Adapting EBM Curriculum to the New Reality: Critical Appraisal of AI responses to Clinical Queries

Primary Category

Curriculum

Presenters

Stephanie London, BS, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Wadim Vodovozov, MD, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Divya Saini, MD, Massachusetts General Hospital, Timothy Kreider, MD, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Abigail Konopasky, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education objectives

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

1. Identify factors that promote responsible AI-assisted EBM practice, including source verification, recognition of unsupported claims, detection of automation bias, and appropriate calibration of clinical recommendations to the strength of evidence

2. Collaboratively develop a "Responsible AI-Assisted Evidence Appraisal Rubric" that can be piloted and adapted within psychiatry training programs and help translate AI-assisted evidence into sound clinical decisions.

3. Apply appraisal rubrics to AI-assisted EBM outputs

Abstract

Psychiatrists must increasingly navigate and synthesize large volumes of clinical and scientific information, which for many now include the use of AI-assisted resources, to make sound clinical decisions. Yet formal training in responsible clinical AI use remains limited, while traditional evidence-based medicine (EBM) curricula do not necessarily teach trainees how to critically integrate AI-generated outputs. For example, EBM curricula do not generally review the risk of automation bias (overconfidence in incorrect AI recommendations without sufficient verification). On top of that, limited representation in training data and inadequate sourcing can lead to less accurate or inappropriate recommendations for underrepresented populations. Emerging psychiatric education literature therefore calls for systematic curricular redesign integrating data-appraisal competencies, hands-on application, and bioethical literacy so that psychiatrists can translate AI outputs into responsible clinical decisions.



We propose embedding responsible AI-assisted evidence appraisal within existing EBM education utilizing a critical appraisal framework. Drawing on traditional EBM's strengths, this moldable and experimental approach includes: constructing an answerable clinical question; critically appraising and verifying retrieved evidence; identifying bias, confounders, uncertain generalizations, and alternative explanations; integrating evidence within patient context; and informing a patient-centered clinical decision.

While EBM practitioners have proposed several approaches to AI-assisted EBM, they are either not yet empirically validated (2,3) or fall short in responsible-use competencies (4). We therefore propose a workshop in which participants develop a pilotable, novel, "Responsible AI-assisted Evidence Appraisal Rubric." Drawing on the literature, we loosely structure this approach around four dimensions: (a) formulation of an answerable clinical question; (b) retrieval, selection, and verification of appropriate underlying evidence; (c) recognition of uncertainty, bias, limitations, and alternative explanations; and (d) translation of evidence into an appropriate, patient-centered treatment decision.

To do this, we will present a curricular model, loosely based on the recently proposed Bloom's Taxonomy-grounded AI-PACE (Psychomotor, Affective, Cognitive, Embedded) framework for longitudinal AI-literacy (5). Participants will be presented a "flawed" case with deliberately imperfect AI-assisted evidence synthesis. Participants will identify observable evidence-to-decision behaviors and translate these observations into critical appraisal rubric domains that will serve as templates to evaluate and teach AI-assisted evidence appraisal. The resulting framework can provide programs with a practical starting point for piloting, evaluating and adapting responsible AI-assisted EBM education within their own curricula.

Practice Gap

Psychiatrists increasingly make clinical decisions informed by complex evidence, predictive models, and artificial intelligence (AI). This requires advanced skills in recognizing bias and confounders, appreciating uncertainty, and critically evaluating the reliability and limitations of emerging technologies. Generative AI is rapidly changing how clinicians retrieve, synthesize, and interpret medical evidence. Although it can make information gathering more efficient, it may also lead to unsupported conclusions, obscure uncertainty, and promote automation bias (i.e., overly trusting AI above contradicting opinions, including one's own).

Meanwhile, traditional evidence-based medicine (EBM) curricula were not designed for an environment in which AI increasingly mediates access to medical knowledge. Moreover, there is no validated instrument for assessing responsible AI-assisted evidence synthesis in EBM practice in psychiatry training, where curricular work remains largely narrative (1). Trainees need support in learning how to critically appraise AI-assisted evidence outputs as they consider its use in patient care.



Agenda

5 minutes: Introductions

10 minutes: Poll audience (i.e. Menti) to assess comfort with AI in clinical decision making and if/how participants have been teaching their trainees about responsible AI use

20 minutes: Didactic reviewing the following topics (a) general principles for teaching EBM in psychiatry training (b) review example of our “critical appraisal worksheet” for experimental studies used in EBM curricula (c) review current literature on frameworks for evaluating AI processes in clinical decision-making

15 minutes: Small Group Activity --> review intentionally flawed AI-assisted evidence generation and application, allow participants to identify problematic areas

10 minutes: Large Group Share

5 minutes: Individual Activity --> brainstorm domains you would include in a responsible AI-assisted evidence appraisal rubric

15 minutes: Small Group activity --> share brainstorms, collaboratively draft an adaptable “rubric” trainees can use to appraise AI-assisted evidence and apply to sample AI-assisted EBM query

10 minutes: Reflections and wrap-up

Scientific Citations

1. Sun, J., Lu, T., Shao, X., Han, Y., Xia, Y., Zheng, Y., Wang, Y., Li, X., Ravindran, A., Fan, L. and Fang, Y., 2025. Practical AI application in psychiatry: historical review and future directions. Molecular psychiatry, 30(9), pp.4399-4408.

2. Jenkins, A., Eisenberg, K. and Ziegelstein, R.C., 2026. Ask–Audit–Apply: A Framework for Clinical Reasoning with Artificial Intelligence. Journal of General Internal Medicine, pp.1-4.

3. Abdulnour, R.E.E., Gin, B. and Boscardin, C.K., 2025. Educational strategies for clinical supervision of artificial intelligence use. New England Journal of Medicine, 393(8), pp.786-797.

4. Wong, A., Sussman, J., Price, N., Makar, M., Li, B., Yang, J. and James, C., 2025. The data-augmented, technology-assisted medical decision making (DATA-MD) curriculum: a machine learning and artificial intelligence curriculum for clinical trainees. Academic Medicine, 100(9), pp.1035-1039.

5. McGrath, S.P., Kim, K.K., Johl, K., Wang, H. and Anderson, N., 2026. AI-PACE: a framework for integrating AI into medical education. npj Digital Medicine.



Title

Calibrating Autonomy and Supervision Across the Training Continuum and Developmental Contexts

Primary Category

Faculty Development

Presenters

Amanda Wallace, MD, New York Presbyterian Hospital - Child and Adolescent Psychiatry, Oliver Stroeh, MD, New York Presbyterian Hospital - Child and Adolescent Psychiatry, Helen Ding, MD, New York Presbyterian Hospital - Child and Adolescent Psychiatry, Tolu Olupona, MD, Interfaith Medical Center

Education objectives

1. Describe factors that should inform the level of autonomy granted to an individual trainee, including demonstrated competence, prior training and experience, clinical context, patient complexity and risk, and stage of the supervisory relationship.

2. Recognize how supervisor assumptions, teaching styles, subjective thresholds, and cognitive biases may contribute to over- or under-supervision of trainees.

3. Identify and apply practical strategies for calibrating and communicating expectations for autonomy through case-based small-group practice.

4. Specifically consider approaches to the supervision of trainees with unique prior experience or expectations for independence that differ from those of the current training environment, including subspecialty fellows, international medical graduates who may be repeating elements of their training, and trainees who previously pursued other careers and/or medical specialties.

Abstract

Progressive autonomy is a central goal of graduate medical education, yet determining how much independence to grant an individual trainee is rarely straightforward. Effective supervision requires faculty to simultaneously promote trainee development, prepare learners for independent practice, and maintain responsibility for safe and appropriate patient care. Decisions about autonomy are influenced not only by trainee competence, but also by patient, supervisor, and contextual factors. The appropriate level of supervision therefore cannot be determined by postgraduate year alone and must be continually calibrated to the individual learner and clinical context. This task is further complicated by the diversity of experiences trainees bring to psychiatric training. A fellow may function independently in areas mastered during residency while requiring greater guidance in a new subspecialty context. An international medical graduate may have previously practiced with substantial clinical independence in another health care system yet be learning unfamiliar institutional expectations and norms. Similarly, trainees pursuing psychiatric training after training in

another specialty or after a career in a non-medical field may have significant experience with autonomous decision-making while simultaneously developing psychiatry-specific competencies. If not explicitly addressed, differences between a trainee's expected and granted level of autonomy can contribute to frustration and supervisory tension and can challenge wellbeing for both supervisee and supervisor.

This interactive workshop will provide psychiatry educators with a practical framework for providing the "just right" level of supervision: enough oversight to support patient safety and clinical development without unnecessarily limiting trainee autonomy and movement towards independence.

Participants will reflect on their own supervisory practices and consider how supervisory style, previous experiences with a learner, subjective thresholds, and cognitive biases may influence decisions about autonomy. Brief didactics will introduce practical strategies for assessing a learner's prior experiences and areas of confidence, establishing expectations at the beginning of supervision, inviting trainees to articulate their clinical reasoning, and determining when to step in or step back. Participants will then work through case-based exercises representing common supervisory challenges. One exercise will specifically examine supervision with trainees who enter a learning environment with substantial prior experience or expectations for greater independence. Such trainees may include fellows in subspecialty training programs, international medical graduates who may be repeating elements of their training, and trainees who previously pursued other careers and/or specialties prior to training in psychiatry. Participants will leave with practical strategies for assessing and recalibrating autonomy across a range of learners and clinical settings and will identify one specific change they can implement within their own supervisory practice or training program.

Determining how much independence to grant an individual trainee is rarely straightforward, and supervisors need practical strategies to assess prior experience and demonstrated competence, establish shared expectations, recognize potential bias, and adjust oversight while maintaining both patient safety and a productive supervisory relationship.

Practice Gap

Although progressive autonomy is a core principle of graduate medical education, determining the appropriate degree of supervision for an individual learner remains challenging. Entrustment decisions are influenced by characteristics of the trainee, supervisor, patient, task, and clinical environment. Variation in supervisory approaches can contribute to both over- and under-supervision, potentially limiting trainee development or compromising patient safety.

These challenges are particularly salient when trainees’ prior experiences do not align neatly with their current level of training, including fellows, international medical graduates, and residents entering psychiatry after training in another specialty. Supervisors need practical strategies to assess prior experience and demonstrated competence, establish shared expectations, recognize potential bias, and adjust oversight while maintaining a productive supervisory relationship. This workshop addresses this gap through brief didactics,

structured self-reflection, and case-based application of strategies for calibrating and communicating trainee autonomy.

Agenda

- Welcome, Introduction, and Self-Reflection (10 min)
- Pair Share on Supervisory Style (5 min)
- Didactic: Calibrating Autonomy and Supervision (15 min)
- Small-Group Case Exercise #1: When Is It Time to Step Back? (15 min)
- Large-Group Debrief and Discussion (10 min)
- Small-Group Case Exercise #2: When Prior Experience and Current Expectations Diverge (20 min)
- Large-Group Debrief and Discussion (15 min)
- Wrap-Up, Takeaways, & Completion of Workshop Evaluation (5 min)

Scientific Citations

1. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). Section 6: Supervision and Accountability, §§6.9–6.11.

2. Carbo AR, Huang GC. Promoting clinical autonomy in medical learners. Clin Teach. 2019;16(5):454-457.

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4. Skelly K, Kim P, Rosenbaum M, Wilbur J. Goldilocks and entrustment: Finding the amount of learner autonomy that's just right. MedEdPORTAL. 2020;16:10987.

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7. Kim SS, Choi HH. Scoping review: Exploring residents' views of supervisor entrustment and its effect on learning and professional development. Korean J Med Educ. 2024;36.

Title

Drugs, Drinks and Deities: Creatively Cultivating Community In Addressing Addiction in Minoritized Populations

Primary Category

Curriculum

Presenters

Brendan Scherer, MD, San Mateo County Behavioral Health and Recovery Services., Anne Ruble, BA, MD, MPH, Johns Hopkins Medical Institutions, Alyson Nakamura, MD, UT Southwestern Medical Center, Theadia Carey, BS, MD, MS, Authority Health/Michigan State, Alfonso Parocua, MD, San Mateo County Behavioral Health and Recovery Services.

Education objectives

1. Recognize gaps in the literature and health disparities in addiction treatment
2. Acquire skills to provide substance use treatment to diverse populations
3. Apply these skills with intersectional awareness to real world cases
4. Develop improved curricula providing more specific treatment
5. Utilize community partnerships to improve substance use treatment

Abstract

Meaningful racial and ethnic differences have been found in drug histories, specific drug use patterns, health consequences of substance use, legal consequences of substance use, medication assisted treatments offered, and the relation of spirituality and acculturation to substance use attitudes. Further, numerous studies demonstrate that important racial and ethnic differences may affect treatment response via pathways to treatment, patterns of treatment engagement and retention, and cultural attitudes about mental health treatment. Together, these differences raise serious concerns regarding a priori assumptions that interventions developed for one ethnic minority group are always applicable and appropriate for another group.

Given that addiction psychiatrists remain underavailable in most settings, it is recommended that all trainees gain an awareness of biases, the intersectional influences on substance use disorders, and health disparities that may influence access to treatment and specific treatments offered. Understanding the evidence base for tailored approaches to addiction treatment in minoritized communities will help promote involvement of community, faith leaders, and family; guide treatment center recommendations; and help psychiatrists co-create treatment plans with patients that leverage strengths and evade unconscious promulgation of disparities.

This interactive workshop, designed for program directors and other educators, will begin with a brief quiz to improve audience engagement and emphasize recommendations and contradictions. Attendees will pair-and-share around effective strategies for addiction treatment. We will provide a brief survey of the literature covering population differences in addiction studies, treatment recommendations, and current research gaps. The didactic component will specifically highlight the role of intersectionality and recognition of health disparities. Specific aspects of care for minoritized communities, including queer, Latine, Black/African American, and Asian communities will be highlighted, including discussions of chemical sex and community influences. The speakers will demonstrate how to modify a broaching curriculum, previously used to help residents introduce racial and ethnic factors into psychotherapy, to substance use treatment with minoritized populations.

Case studies and discussion will help participants gain expertise in treatment guidelines while avoiding biases; these case studies will also serve to equip attendees to teach trainees about addiction treatment in minoritized communities. Case studies will focus on sub-to-standard care of patients with substance use disorders and allow attendees to focus on identifying areas that went wrong or could be improved using evidence based best practices. Attendees will be encouraged to self-aggregate based on regional and structural demographics and collectively co-create changes to their curricula that improve provision of substance use treatment to minoritized populations within their communities without incurring undue risk. Facilitated discussion and brainstorming of next steps will allow attendees to leave with a clear plan of action for themselves and/or their program.

Practice Gap

Population differences in addiction treatment are understudied and undertaught. Health disparities are prominent in both access to treatment and the treatments offered; these disparities reflect underlying biases. Best practices for substance use treatment in diverse populations, where defined, are rarely known and applied, nor are community partners that can assist treatment and retention as understood or incorporated into treatment plans as recommended.

Agenda

- Intro/Kahoot quiz: 10 minutes
- Pair and Share: what factors have helped people you have worked with be successful in recovery (5 minutes)
- Didactics: 15 minutes– Specific populations and the evidence base related to disparities and treatments
- Small Groups (15 minutes)- review cases and discuss what worked, what didn't work and what could have been done better
- Didactics (15 minutes): Broaching curriculum, intersectionality, disparities
- Small Groups (15 minutes): Break into geographical areas/different federal environments, work on improving your own curriculum and treatment connections with community based organizations



- Large group (10 minutes): Report out and brainstorm
- Evaluation: 5 minutes

Scientific Citations

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2. D'Amico EJ, Dickerson DL, Rodriguez A. Virtual Culturally Grounded Interventions for Substance Use in Urban American Indian and Alaska Native Emerging Adults: A Randomized Clinical Trial. JAMA Netw Open Published Online: August 11, 2026 2026;9;(8):e2627878. doi:10.1001/jamanetworkopen.2026.27878

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4. Haeny AM, Oluwoye O, Cruz R, et al. Drug and Alcohol Treatment Utilization and Barriers Among Black, American Indian/Alaskan Native, Latine, Asian/Pacific Islander/Native Hawaiian, and White Adults: Findings From NESARC-III. J Subst Abuse Treat, Epub 2021 Jul 21, 2021 Dec:131:108569. doi: 10.1016/j.jsat.2021.108569.

5. Venner KL, Hernandez-Vallant A, Hirchak KA, Herron JL. A Scoping Review of Cultural Adaptations of Substance Use Disorder Treatments Across Latinx Communities: Guidance for Future Research and Practice. J Subst Abuse Treat, Epub 2022 Jan 11, 2022 Jun:137:108716. doi: 10.1016/j.jsat.2021.108716.

7. Dela Cruz GA, Johnstone S, Kim HS, Castle DJ. Review of Third-Wave Therapies for Substance Use Disorders in People of Color and Collectivist Cultures: Current Evidence and Future Directions. Psychol Addict Behav, Epub 2022 Sep 15, 2023 Aug;37(5):681-694. doi: 10.1037/adb0000883.

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9. Hillyard M, Cockbain B, Drummond C, Rimes K, Roberts E. Barriers and Facilitators to Accessing Addiction Treatment Services for Sexual Minority (LGBQ+) People: Systematic Review. Br J Psychiatry, 2026 Mar 30:1-11. doi: 10.1192/bjp.2026.10589

10. Helminen EC, Cascalheira CJ, Shaw TJ, et al. A Latent Class Analysis of Tailored Substance Use Treatment Programs: Implications for Treating Syndemic Conditions Facing Sexual and Gender Minority Populations. Drug Alcohol Depend, Epub 2022 Jun 30, 2022 Sep 1:238:109550. doi: 10.1016/j.drugalcdep.2022.109550.

Title

Harmony and Humanity: Centering Creativity and Generativity in Education Leadership

Primary Category

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

Presenters

Zheala Qayyum, MD, Boston Children's Hospital/Harvard Medical School, Neha Sharma, DO, Tufts Medical Center Program (Boston), Shireen Cama, BA, MD, Cambridge Health Alliance/Harvard Medical School, Yuri Zoghbi, MD

Education objectives

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

1. Understand how vulnerability and authenticity can be used to teach academic leadership for trainees
2. Develop narrative frameworks to increase self-awareness as they explore values, motivations, and their impact on their team
3. Learn how “pechakucha” can be used to teach professional identity development and career paths.

Abstract

Authentic leadership is a style of leadership that is driven by integrity, accountability, and motivation to better themselves(1). An authentic leader focuses on developing meaningful relationships and experiences as they strive to fulfill an organizational mission, and is a style of leadership that has been shown to have a positive impact on well-being in the work environment (2). A core component of authentic leadership is to be genuine and allow for vulnerability as one connects with others. Psychologist Brene Brown writes about the intense power of vulnerability in leadership, and how vulnerability can help leaders build stronger relationships, take meaningful risks, and forge ahead with confidence during times of uncertainty, which is very relevant currently(3,4).

This interactive workshop will support attendees in exploring their own comfort with vulnerability and how this can be intentionally and purposefully shared and modeled with trainees. First, participants will learn more about the components of authentic leadership and explore their own comfort with vulnerability in their professional spaces. They will learn about potential benefits and pitfalls of showing vulnerability in the workplace, particularly for minoritized groups (5). Leaders will share their own experiences with modeling vulnerability with trainees and colleagues.



Participants will then learn about how the art of story-telling can offer a medium to explore our vulnerabilities in a safe and restorative way. Participants will learn different structured approaches to engaging trainees in exploring their own vulnerability. Attendees will learn how Marshall Ganz's Public Narrative framework (story of "self", story of "us", story of "now") can help trainees explore how their values and life experience can inspire others as leaders and impact meaningful change (6). The pechakucha (chit-chat in Japanese) will be utilized to demonstrate a creative way of storytelling. PechaKucha presentation consists of 20 slides, for 20 seconds each, only with images and no text. It will highlight a tool that trainees and supervisors can use for interactive and engaging presentations, and as a way of narrating and reflection.

Leading authentically can help elevate relationships in the workplace, including within psychiatry training programs. In this workshop, PDs will reflect on their own leadership style and learn practical tools that can help themselves and their trainees embrace vulnerability in the service of connection and authentic, effective leadership.

Practice Gap

Program directors and other training leaders are increasingly expected to lead authentically — to build trust, model reflection, and sustain morale during a period of significant uncertainty in medical education, and in a climate of burnout and moral distress. Yet most have received no formal instruction in authentic leadership, and the element most central to it, vulnerability, is the one they are least prepared to use deliberately.

The result is a skills gap on two levels. PDs lack a framework for calibrating what to share, with whom, and toward what purpose. They also lack structured, reproducible methods for inviting trainees into the same work, relying instead on informal or ad hoc conversation.

Agenda

90 minutes:

- 10 min- Introduction
- 10 min- Interactive activity to explore comfort with sharing one's vulnerability (pair-share, polling)
- 5 min- Exemplify how the worries around sharing vulnerability can be harnessed to teach leadership skills (large group discussion
- 25 min: Interactive description of use public narrative and Pechakucha frameworks
- 10 min: Display of Pechakucha
- 10 min: Small group activity to create story line for audience's to develop a frame for their own PechaKucha or their own public narrative framework
- 15 min: Audience Q&A
- 5 min: Evaluation completion



Scientific Citations

1. Almutairi, M., Timmins, F., Wise, P. Y., Stokes, D., & Alharbi, T. A. F. (2025). Authentic leadership—A concept analysis. Journal of Advanced Nursing, 81(4), 1775–1793. https://doi.org/10.1111/jan.16496

2. Plohr, N. (2025). Mindful leadership: Theoretical foundations, self-leadership and practical implications. Springer. https://doi.org/10.1007/978-3-658-48300-5

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5 Oluic S, Milutinovic S, Gligorevic S, et al. Pecha Kucha in medical education: a narrative literature review. Korean J Med Educ. 2025;37(4):491–502. doi:10.3946/kjme.2025.358

6. Hunt DF. Power of saying "I don't know": psychological safety and participatory strategies for healthcare leaders. BMJ Leader. 2025;9(1):7–10. doi:10.1136/leader-2023-000906

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Title

Harmony in the Storm: Leading Residency Programs Through Crisis

Primary Category

Wellness, Burnout, Resilience

Presenters

Benjamin Li, MD, Baylor College of Medicine, Sindhu Idicula, MD, Baylor College of Medicine, Jeffrey Khan, MD, Baylor College of Medicine, Mauro Garcia-Altieri, MD, Baylor College of Medicine, Sarah Wakefield, BA, MD, Texas Tech University Health Sciences Center

Education objectives

1. Differentiate moral injury, burnout, acute stress reactions and post-traumatic stress disorder as they apply to residency training

2. Compare evidence-informed support models that are effective for residents experiencing individual or collective distress following adverse events

3. Apply a tiered support framework to design a program-level response to a catastrophic or disruptive event

4. Generate practical strategies and resources for a program crisis response toolkit

Abstract

Residency programs are expected to face numerous external and internal challenges that will affect program cohesion and how trainees approach the practice of psychiatry. Such threats have led to moral injury for trainees, or even in some cases, symptoms of acute stress from trauma (1). Within the past decades, these catastrophic events include unforeseen circumstances such as the COVID-19 pandemic, changes within the political climate and immigration laws, practice-shaping medical-legal events and court decisions (e.g.. Clancy, Dobbs), local weather disasters (such as floods, hurricanes, and wildfires), and patient loss (2).

This workshop examines how the impact of unique and unpredictable crises can be mitigated through formal and informal support structures embedded within residency training. This may include, but is not limited to, conferences related to morbidity and mortality, resident-led support meetings, patient memorial seminars, narrative medicine, process groups, and medical improv.(3,4,5)

However, for more unpredictable, larger scale, or unique disasters, responses may require more creativity and a deeper understanding of the concerns of the resident body to carefully craft a more effective intervention to promote emotional stability and safety. While resource limitations (such as time, financial, faculty/resident

availability, etc) should be acknowledged, utilizing the strengths of a program and the collective problem-solving of residents/faculty can build resilience (6) .

Participants will engage in a simulation-based exercise in which small groups are assigned realistic residency program crisis scenarios. Drawing upon a structured framework, participants will identify immediate, short-term, and longitudinal interventions to support residents and faculty, improve psychological safety, and maintain educational continuity. Groups will share their approaches and compare strategies across diverse scenarios. The workshop will conclude with assembly of a practical crisis-response toolkit that participants can adapt to the needs and resources of their own program. This workshop emphasizes practical leadership skills that help programs preserve psychological safety, maintain community cohesion, and foster humanity and connection during times of crisis.

Practice Gap

Residency programs increasingly face disruptive events that affect trainee well-being, professional identity formation, and program functioning. These events may be large-scale and external, such as pandemics, natural disasters, socio-political changes, or medico-legal developments, or local events such as patient suicide, unexpected deaths, or institutional crises.

While considerable attention has focused on resident burnout, less guidance exists regarding how residency programs can proactively prepare for and respond to sudden events that generate collective distress, moral injury, or trauma-related symptoms. Training programs would benefit from practical frameworks that combine structured wellness programming with adaptable crisis-response strategies that can be tailored to local circumstances while fostering resilience, trust, and community.

Agenda

Total duration 90 minutes

- 0-5 minutes: Why residency programs need crisis-response frameworks and crisis leadership
- 5-10 minutes: ACGME expectations and institutional responsibilities
- 10-20 minutes: Understanding resident distress during times of disruption
- 20-35 minutes: Evidence-informed approaches to supporting residents and faculty
- 35-45 minutes: Case studies: Responding to major program-wide stressors
- 45-75 minutes: Small Group Exercise: “Pick Your Own Disaster”
    - Identify immediate, short-term and longitudinal responses
    - Consider available resources, stakeholders, communication strategies and trainee needs
    - Complete a structured crisis-response worksheet
    - Develop a practical action plan focused on preserving community and educational functioning
    - Large group debrief and cross-program learning
- 75-85 minutes: Building the toolkit: Key takeaways and next steps



- 85-90 minutes: Questions and Evaluation

Scientific Citations

1. Cohen GH, Wang R, Sampson L, Lowe SR, Ettman CK, Abdalla SM, Wellenius GA, Cabral H, Ruggiero K, Galea S. Depression and PTSD among Houston Residents who Experienced Hurricane Harvey and COVID-19: Implications for Urban Areas Affected by Multiple Disasters. J Urban Health. 2023 Aug;100(4):860-869. doi: 10.1007/s11524-023-00767-2. Epub 2023 Aug 7. PMID: 37550501; PMCID: PMC10447846.

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Title

Helping the Neurodivergent Trainee

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Ayame Takahashi, MD, Southern Illinois University School of Medicine, Sammie Wong, MD, Children's Hospital of Philadelphia, Pascale Chrisphonte, MD, MS, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Krishna Taneja, MD, Indiana University School of Medicine, Abigail Buckholz, MD, Rochester Regional Health Program

Education objectives

1. Recognize the unique strengths neurodivergent graduates bring to the workplace, alongside the barriers they may experience.

2. Develop an understanding of how to support graduates in requesting and implementing reasonable adjustments that enable them to succeed at work.

3. Identify appropriate sources of further advice, advocacy, and support for neurodivergent graduates.

4. Promote neurodiversity-affirming practice by addressing gaps in training and improving diagnostic and support pathways.

5. Explore available data comparing employment outcomes for neurodivergent graduates, including employment rates, job retention, and length of time in work.

6. Understand the challenges neurodivergent graduates may encounter during recruitment, workplace screening, and integration into predominantly neurotypical workplaces, including explicit and implicit employer discrimination.

Abstract

The number of students who identify as neurodivergent (ie carrying a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD) is increasing due to increased societal awareness and acceptance, resulting in reduced stigma (1). In graduate medical education, neurodivergent trainees may face executive-functioning challenges, including time management, task prioritization, clinical documentation, and communication. Social and emotional difficulties may also arise, such as conflict with peers or staff, misinterpreting social cues, verbal impulsivity, and difficulty maintaining appropriate boundaries with patients. Neurodivergent graduates have a greater chance of encountering difficulties in recruitment and other forms of job screening, including overt or tacit forms of employer discrimination and difficulties integrating

into neurotypical workplaces (2). These experiences can affect both trainee wellbeing and workplace performance. Trainees with neurodivergence are more likely to experience anxiety, depression, and have a higher risk of developing substance use disorders. Individuals diagnosed with autism spectrum disorder are more likely to experience mental health conditions, such as depression and anxiety, across the lifespan (3). Masking autistic traits may be both triggered by and contribute to anxiety, and sustained masking has been associated with burnout, depression, substance use, and suicidality (4). Likewise, Rejection Sensitive Dysphoria (RSD) is an emotional condition characterized by extreme emotional pain in response to perceived or actual rejection, often linked to ADHD (5).

These issues highlight the importance of neurodiversity-affirming educational environments that recognise individual strengths, reduce unnecessary barriers, and provide timely, appropriate support for neurodivergent medical trainees. Thus, we aim to collaboratively develop practical interventions to support neurodivergent learners. These interventions address common areas of need, including executive functioning, navigating professional settings, building effective relationships with colleagues and staff, self-advocacy and disclosure, and in integrating neurodivergent identity into therapeutic practice, while contributing to advocacy and wider systemic change.

Practice Gap

Greater public awareness and acceptance of neurodivergence have helped reduce stigma, encouraging more students to identify as neurodivergent. As a result, more self-identified neurodivergent students are attending and graduating from colleges and universities and are matriculating into professional schools, specifically medical school. There is little information in the Graduate Medical Education (GME) literature on how to accommodate neurodiverse students who will surely be entering graduate medical education. As learners in GME become more diverse and neurodiversity is increasingly discussed, such as ADHD and ASD, GME educators must learn best educational practices to support these learners. Having increased neurodiversity in the medical field will ultimately help neurodiverse patients through enhanced understanding and representation in healthcare.

Agenda

- Introduction and Background
- Provide a brief overview of neurodiversity in medical and/or higher education and the purpose of the session.
- Interactive Discussion: Think–Pair–Share Format
    - Participants will reflect individually, discuss ideas in pairs, and share key insights with the wider group.
- Clinical Vignettes and Group Brainstorming
    - Use case-based scenarios to explore common challenges experienced by neurodivergent learners and identify practical, supportive interventions.



- Developing a Practical Support Toolbox:
- Conclude by collating strategies, resources, and useful tips into a shared “toolbox,” which may include a worksheet for future reference.

Scientific Citations

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3. Chapman, L., Rose, K., Hull, L., & Mandy, W. (2022). “I want to fit in… but I don’t want to change myself fundamentally”: A qualitative exploration of the relationship between masking and mental health for autistic teenagers. Research in Autism Spectrum Disorders, 99, 102069.

4. Cremone, I. M., Carpita, B., Nardi, B., Casagrande, D., Stagnari, R., Amatori, G., & Dell’Osso, L. (2023). Measuring social camouflaging in individuals with high-functioning autism: A literature review. Brain Sciences, 13(3), 469.

5. Dahlstrom, C. (2024). Understanding neurodiversity and executive dysfunction to discover more effective accommodations and create a more inclusive workforce for neurodivergent individuals.

Title

Might your program be nutritionally deficient? Cooking up an ACGME-Aligned Nutrition Curriculum

Primary Category

Curriculum

Presenters

Melissa Buboltz, BA, MD, Oregon Health Sciences University, Jennifer Ferrer, MD, Kaiser Permanente Southern California Program, Jo Everett, BS, MD, Kaiser Permanente Southern California Program, Dhana Ramasamy, MBBS, MD, Lehigh Valley Health Network, Zehra Aftab, MD, University of Chicago

Education objectives

1. Describe and contextualize new ACGME nutrition initiatives and requirements

2. Identify specific areas in which your program is not already meeting requirements

3. Develop a plan for curriculum development to promote progression along nutrition milestones and ensure ACGME-required experiences and competencies are met

4. In alignment with the conference theme, participants will consider innovative experiences they may incorporate into the curriculum that generate joyfulness and connection.

Abstract

This workshop offers participants a guided opportunity to think creatively and strategically about how nutrition and its influence can be further incorporated into their training program, translating emerging expectations into a more systematic curriculum. After being provided with updates regarding the latest guidance, participants will perform a gap analysis for their own program. Specifically, they will consider curriculum subject matter including Dietary Guidelines, Public Health Nutrition & Social Determinants of Health regarding Food Access, Nutrient Deficiencies & Psychiatric Manifestations, Screening for Food Insecurity, Behavior Change Counseling, and Community Resources & Referral Pathways. Teaching methods may include lectures, case-based learning, simulation, interdisciplinary teaching with dieticians, and community engagement activities. Facilitators will share practical strategies and evidence-based educational resources that can be adapted to any program size, including didactic material, screening tools, counseling scripts, case vignettes, and learning resources (recommended readings, toolkits). The curriculum plan will include consideration of how to integrate the required experiences across the years of training. A variety of evaluation tools such as simulations, direct observation, chart reviews, examinations, and reflective essays will be reviewed. Participants will leave the workshop with an action plan for a structured approach to nutrition education that outlines immediate opportunities for improvement alongside longer-term initiatives. In connection with the conference theme, participants will consider more innovative and experiential curricula elements, such as culinary medicine

sessions or cultural food storytelling, identifying activities that promote joyfulness and community connection while reinforcing the nutrition competencies.

Practice Gap

Nutrition plays a critical role in health outcomes, disease prevention, and overall well-being. Despite evidence to support nutritional interventions in those with psychiatric illness, most psychiatry residents receive limited structured training and lack competency in screening, counseling, and addressing nutrition-related contributors to mental health (4). The ACGME convened a national Summit on Medical Education in Nutrition in 2023 and subsequently advanced psychiatry-specific nutrition program requirements with a proposed effective date of July 1st, 2027 (2). In addition, a JAMA consensus statement outlined 36 nutrition competencies for UME/GME (5). In the context of national calls to action and more specific guidance, psychiatry residency programs are now positioned to develop more robust nutrition training that is aligned with these standards. Psychiatry training programs need an organized curriculum and clear implementation strategies to equip residents with the knowledge and skills to incorporate nutrition into comprehensive patient care.

Agenda

- Background and greater context of nutrition initiatives (5 Min)
- Review of guidance available from ACGME (10 minutes)
- Pair-Share exercise: Share the current state of nutrition education in your training program. Perform a comparison with the latest guidance and identify areas in which to strengthen training (15 minutes)
- Facilitators share nutrition educational content and resources (20 minutes)
- Small group work: Develop a tailored strategy for enhancing nutrition training, including identifying prospective program nutrition champions and outlining both immediate opportunities for improvement and long term initiatives. (20 minutes)
- Large group discussion: With consideration of conference theme, brainstorm potential creative and community-building elements that might be incorporated into a new curriculum. (5 minutes)
- Q&A (10 min)
- Workshop evaluation (5 min)

Scientific Citations

1. Agusala, B., Broad Leib, E., & Albin, J. (2024). The time is ripe: The case for nutrition in graduate medical education in the United States. Journal of Medical Education and Curricular Development, 11, 23821205241228651. https://doi.org/10.1177/23821205241228651

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3. Accreditation Council for Graduate Medical Education. (n.d.). Patient Care X: Nutrition to optimize health (Nutrition supplemental guide). https://www.acgme.org/globalassets/pdfs/standalonedocuments/nutrition-supplemental-guide.pdf

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Title

Navigating Accommodations in Psychiatric Training: Balancing Legal Mandates, Core Competencies, and Trainee Support

Primary Category

Program Administration and Leadership

Presenters

Jonathan Heldt, MD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA, Sabrina Reed, MD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA, Melvin Rico, MD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA, Xiaoyi Sherry Yao, MD, New York Presbyterian Hospital - Child and Adolescent Psychiatry, Sarah Nguyen, MD, UCLA Geffen School of Medicine/UCLA Medical Center Program/VA Greater LA

Education objectives

1. Identify the legal and regulatory frameworks (ADA, ACGME, ABPN, collective bargaining agreements, etc.) governing accommodations.

2. Differentiate essential vs. non-essential training functions under ACGME and ABPN frameworks to evaluate accommodation feasibility.

3. Oversee an objective, standardized interactive process in partnership with institutional GME/disability offices while maintaining trainee psychological safety and privacy.

4. Apply practical scheduling, coverage, and remediation models to complex accommodation vignettes without compromising core educational milestones or clinical equity.

5. Maintain an empathic and humanistic outlook during operational challenges in resource-limited environments.

Abstract

With increasing trainee self-disclosure and evolving ACGME/ABPN mandates, psychiatry training directors face mounting pressure to balance disability civil rights with patient safety, educational equivalence, and peer equity. This 90-minute interactive workshop equips program leaders with the legal, regulatory, and operational frameworks to replace precarious, ad-hoc workarounds with legally sound, standardized interactive processes that focus on upholding educational integrity.

(5 min) Introductions: The workshop will start by introducing the presenters, reviewing workshop objectives, and establishing community expectations.



(15 min) Overview: The workshop will provide context on the rising frequency of accommodation requests in GME and conduct a comprehensive review of legal and regulatory mandates (including the ADA, ACGME, and ABPN). We will then shift focus to the unique residency and fellowship structural challenges such as overnight call coverage, shift lengths, and continuity of care, highlighting strategies for balancing institutional legal duties with ACGME core competency thresholds and ABPN credentialing standards through the utilization of operational frameworks and institutional support systems including GME leadership and disability specialists.

(30 min) Small-Group Cases: Participants will divide into small groups and engage in problem-based learning, with each group focusing on a different vignette reflecting both common and complex accommodation scenarios, including:

- Call exemptions (e.g., no overnight call) and managing cross-coverage
- Visual impairment
- Increased allowances for sick days and intermittent leave
- Modified shift lengths
- Reassignment to a different training site

Each small group will be asked to draft actionable, objective accommodation plans while explicitly identifying essential versus non-essential training tasks. Focus will also be placed on addressing hidden systemic friction points, including preventing co-resident burnout from cross-coverage, avoiding retaliatory culture, and decoupling disability accommodations from academic remediation/probation.

(25 min) Large-Group Reflection: All participants will regroup to share how they decided to respond to each type of accommodation request. The presenters will provide feedback and highlight best practices based on available literature.

(15 min) Q&A and Session Evaluation: We will conclude with a Q&A. The final 5 minutes will be dedicated to completing the official session evaluation form. To help guide participants in managing future program-level requests, a structured "Accommodation Navigation Toolkit" will be distributed, containing:

- A sample Essential Functions Worksheet tailored to psychiatry clinical settings.
- Step-by-step Interactive Process Flowcharts coordinating the program, GME office, and Title IX/Disability Resource Center.
- Template language for Formal Accommodation Agreements (MOUs) and fair-share coverage policies.

Through this structure, we hope that participants will acquire concrete tools to transition from ad-hoc, informal program adjustments to standardized, objective interactive processes. Throughout the workshop, we will maintain a focus on safeguarding trainee privacy and psychological well-being while ensuring the attainment of core educational milestones, clinical standards, and peer equity.



Practice Gap

Higher education is currently experiencing a significant rise in accommodation requests, and GME is no exception. The Americans with Disabilities Act (ADA) mandates the provision of "reasonable accommodations," while the ACGME and ABPN maintain core competency thresholds and credentialing requirements. Balancing these competing demands presents a critical challenge for program leadership, requiring a sophisticated balance between supporting trainee wellbeing, working within institutional constraints, and mitigating impact on other trainees. This workshop provides concrete and actionable tools to navigate these complex situations. This session moves beyond basic regulatory compliance and aims to foster humanity by prioritizing trainee psychological safety, privacy, and empathy while also seeking harmony through the implementation of standardized, collaborative processes, and creative scheduling solutions.

Agenda

0:00–0:05 (5 min) | Introductions

Welcome, review of workshop objectives, and establishing community ground rules for discussing sensitive administrative dilemmas.

0:05–0:20 (15 min) | Regulatory & Operational Overview

Examining ADA, ACGME, and ABPN mandates; navigating structural residency friction points (overnight call, shift lengths); and leveraging institutional partnerships.

0:20–0:50 (30 min) | Small-Group Problem-Based Cases

Analyzing clinical vignettes (call exemptions, intermittent leave, visual impairment, site reassignments) to differentiate essential functions and mitigate co-resident cross-coverage burnout.

0:50–1:15 (25 min) | Large-Group Reflection & Debrief

Group report-outs, presenter feedback, contrasting informal workarounds with defensible structural plans, and reviewing evidence-based best practices.

1:15–1:30 (15 min) | Q&A, Toolkit Distribution & Evaluation

Open participant discussion, distribution of the Accommodation Navigation Toolkit (worksheets, SOP flowcharts, MOU templates), and session evaluations.

Scientific Citations

1. Green E, Volpe KA. From Policy to Practice: Building the Disability Inclusion Infrastructure in Graduate Medical Education. Acad Med. 2025 Oct 1;100(10S Suppl 1):S184-S187. doi: 10.1097/ACM.0000000000006127. Epub 2025 Jun 16. PMID: 40526790.



2. Pereira-Lima K, Meeks LM, Ross KET, Marcelin JR, Smeltz L, Frank E, Sen S. Barriers to Disclosure of Disability and Request for Accommodations Among First-Year Resident Physicians in the US. JAMA Netw Open. 2023 May 1;6(5):e239981. doi: 10.1001/jamanetworkopen.2023.9981. PMID: 37166801; PMCID: PMC10176117.

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Title

Teaching 16-Minute Psychotherapy: Integrating Psychotherapy Skills into Routine Medication-Focused Visits

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Samuel Dotson, BS, MD, Northeast Georgia Medical Center Program, David Mintz, MD, Austen Riggs Center - NOT ACCREDITED, Donna Sudak, BS, MD, Tower Health -- Phoenixville Hospital General Psychiatry

Education objectives

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

1. Describe how brief, intentional psychotherapy interventions during routine medication-focused visits can strengthen the therapeutic alliance, widen the range of symptoms treated and improve patient outcomes across diverse practice settings.

2. Apply principles from teaching traditional 45-minute supportive, psychodynamic, and cognitive-behavioral therapy to short follow-up visits.

3. Develop curricular and supervisory strategies that integrate abbreviated psychotherapy training into existing outpatient workflows to support education and financial sustainability.

Abstract

Despite evidence that medical students, residents, faculty and patients continue to value psychotherapy as central to psychiatric identity, studies have documented a sustained decline in the percentage of community psychiatrists practicing traditional psychotherapy after graduation. Prior workshops and scholarly papers have appropriately defended the 45-50 minute therapeutic hour as an essential part of psychiatric training. There are no studies, however, of the length of sessions required to achieve meaningful change. At the same time, residency programs must also prepare graduates for the realities of contemporary outpatient practice, where many psychiatrists provide care in shorter medication-focused visits. If psychotherapy training is to remain clinically meaningful and financially sustainable, then educators must help residents translate core psychotherapy principles into every encounter.

This workshop addresses this gap by offering a thoughtful pedagogical approach to teaching psychotherapy skills within short medication-focused visits. We will briefly review the practical landscape of psychotherapy integrated with medication management, including the 90833 psychotherapy add-on code (16-37 minutes of therapy delivered with medications) and evidence that psychiatrists may not be abandoning psychotherapy so much as shifting how they practice it. In fact, studies now indicate that the 90833 code is the most common



therapy code submitted for Medicare reimbursement and the third most common billing code used by psychiatrists overall. This opening section will include a brief needs assessment designed to help attendees reflect on how their own programs currently teach and supervise this work.

The workshop will then proceed through three case-based modules organized around the Y-model of psychotherapy. These modules will illustrate how supportive psychotherapy, psychodynamic psychotherapy, and cognitive-behavioral therapy can each inform brief clinical encounters, while also highlighting the strengths and limitations of adapting each modality to shorter visits. A specialist in each modality will lead participants through small-group discussion of a fictitious patient and resident supervision case, emphasizing how faculty can teach residents to use psychotherapy-informed interventions in routine outpatient care. The final portion of the workshop will discuss practical barriers to implementation, including supervision models, clinic structure, documentation, billing and reimbursement, and faculty development.

Throughout the workshop, participants will actively engage with the material through question-and-answer discussion, self-reflection, case-based vignettes, and small-group exercises. The ultimate goal of the workshop is to help educators teach psychotherapy as a skill set present in every psychiatric encounter. When residents learn to use brief psychotherapy-informed interventions during medication-focused visits, they can improve patient care by strengthening the therapeutic alliance, increasing engagement in treatment, identifying behavioral and relational barriers, better assessing the root causes of treatment resistance, and making their care more collaborative and humane. In doing so, the workshop aligns psychotherapy education with the needs of all learners, including those who may not plan to practice traditional long-form therapy but will still need relational, humane, and financially viable approaches to psychiatric care.

Practice Gap

Psychiatrists use psychotherapy skills within short, medication-focused visits, including encounters in which insurers may reimburse psychotherapy services as brief as 16 minutes through billing codes such as 90833. In fact, studies now indicate that the 90833 code is the most common therapy code submitted for Medicare reimbursement and the third most common billing code used by psychiatrists overall. However, curricula rarely recognize these combined, abbreviated sessions as a distinct skill set. Residents are therefore seldom provided with a thoughtful approach for translating psychotherapy skills into routine psychopharmacology practice in ways that humanize care, strengthen alliance, improve patient outcomes and support sustainable clinical models. Psychotherapy educators need practical pedagogical tools and approaches in this area.

Agenda

- Introduction (15 Minutes)
    - 5 Minutes: Introduce speakers and review objectives
    - 5 Minutes: Brief needs assessment on current approaches to teaching psychotherapy within medication-focused visits



    - 5 Minutes: Mini-didactic on abbreviated psychotherapy, 90833, and the “16-minute hour” concept
- Brief Supportive Psychotherapy (20 Minutes)
    - 5 Minutes: Review of basic supportive therapy distinctives, strengths, and weaknesses for abbreviation
    - 15 Minutes: Small-group case discussion focused on teaching the use supportive common factors in shorter visits
- Psychodynamic Psychopharmacology (20 Minutes)
    - 5 Minutes: Review of basic psychodynamic therapy distinctives, strengths, and weaknesses for abbreviation
    - 15 Minutes: Small-group case discussion focused on teaching attendance to alliance, meaning, and medication-related dynamics
- Abbreviated CBT (20 Minutes)
    - 5 Minutes: Review of basic CBT distinctives, strengths, and weaknesses for abbreviation
    - 15 Minutes: Small-group case discussion focused on teaching structured, short CBT-informed interventions
- Implementation and Wrap-Up (15 Minutes)
    - 10 Minutes: Discuss supervision models, clinic structure, documentation, billing/reimbursement, and barriers
    - 5 Minutes: Evaluations

Scientific Citations

1. Dotson S, Markowitz JC, Mintz D, Thase ME. The 16-minute hour: combining abbreviated psychotherapy with medication visits. Part 1: introduction. Journal of Psychiatric Practice®. 2025 Mar 1;31(2):89-94.

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5. Kennedy K, Balasanova A, Gilbert C, Welton R, Crocker E, Sudak D, Ruble A. The Future of Psychotherapy Training Requirements: A Call to Action. Academic psychiatry. 2026 Jun 8:1-6.

6. Sudak DM, Brenner AM. The future of psychotherapy training. Academic Psychiatry. 2024 Oct;48(5):511-5.

7. Murray A, Sudak D, Topor DR, Ruble AE, Frank A. Where Have All the Supervisors Gone? Practical Tips for Recruiting Psychotherapy Supervisors. American journal of psychotherapy. 2026 Mar 1;79(1):32-6.

8. Markowitz JC. Brief supportive psychotherapy: a treatment manual and clinical approach. Oxford University Press; 2022 Aug 2.

9. Mintz D. Psychodynamic psychopharmacology: Caring for the treatment-resistant patient. American Psychiatric Pub; 2022 Feb 10.

10. Sudak DM, Royter E. Supervision of Cognitive-Behavioral Therapy. Supervising Individual Psychotherapy: The Guide to" Good Enough". 2023 Apr 28:251.

Title

The Next Generation of ACGME Requirements: Navigating Tensions Shaping the Future of Training in Psychiatry

Primary Category

Program Administration and Leadership

Presenters

Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute, Omair Abbasi, MD, Memorial Regional Hospital, Anna Kerlek, MD, The Ohio State University College of Medicine, Rebecca Lundquist, MD, TriHealth GME (Non-accredited), Paul Rosenfield, MD, Icahn School of Medicine at Mount Sinai (Morningside/West)

Education objectives

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

1. Describe key findings from the AADPRT national survey from March 2026 and task force recommendations regarding potential revisions to psychiatry residency training requirements.

2. Analyze common tensions between educational priorities and the practical realities of implementing curricular change.

3. Identify strategies for actualizing innovations in residency education that balance educational value with feasibility.

Abstract

Psychiatry general residency education is at an inflection point. Workforce shortages, evolving models of care, advances in treatment, and growing interest in competency-based education have generated calls to modernize training. While there is broad agreement that residency education should evolve, programs face finite curricular time, faculty expertise, and institutional resources. The challenge is no longer whether change is needed, but how to implement meaningful change in ways that are educationally sound, feasible, and sustainable. To inform potential revisions to the Accreditation Council for Graduate Medical Education (ACGME) psychiatry residency training requirements, the Association of Directors of Psychiatric Residency Training (AADPRT) convened a task force in 2025 to review current requirements, survey program directors nationally, and develop recommendations.

This interactive workshop will engage participants in the same implementation challenges encountered by the task force. Using national survey findings as a foundation, participants will work in small groups to analyze real-world educational dilemmas reflecting tensions between educational priorities and implementation

realities, including workforce preparation, competency-based education, psychotherapy training, and emerging areas of psychiatric practice. Participants will focus on how shared educational goals can be translated into achievable, sustainable approaches within real-world residency programs as the landscape of residency training continues to evolve.

Practice Gap

The upcoming revision of ACGME psychiatry general residency requirements offers an opportunity for AADPRT to examine which requirements are working well, which create unintended burden, and which no longer reflect contemporary practice. It also allows the field to identify where programs need greater clarity, flexibility, or support and which emerging areas of psychiatric practice warrant greater emphasis. Recommendations must balance national expectations with the realities of programs that vary in their institutional resources, faculty expertise, and patient populations. Just as importantly, the process should consider implementation: how programs can incorporate new expectations within finite time and resources, and how AADPRT can support programs in translating revised requirements into feasible, meaningful educational practices that prepare residents for the evolving practice of psychiatry.

Agenda

10 min: Overview and "big questions" facing psychiatry training

20 min: Small-group case discussions

20 min: Report out from groups

20 min: Presentation of survey findings and task force recommendations

10 min: Discussion of implementation strategies and national collaborations

10 min: Q&A

Scientific Citations

1. Aggarwal R, Balon R, Morreale MK, Guerrero APS, Beresin EV, Louie AK, Coverdale J, Brenner AM. Is It Time to Rethink Psychiatry Residency Training? Part I: Overview. Acad Psychiatry. 2023 Apr;47(2):117-119.

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Title

The Secret Mission: Financial Literacy, Career Planning, and Transition to Practice

Primary Category

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

Presenters

Dimal Shah, MD, Virginia Commonwealth University Health System Program, Taiwo Babatope, MBA, MD, MPH, McGovern Medical School at UTHealth, Martin Huynh, BS, MD, McGovern Medical School at UTHealth, Mary Burris, MD, University of Utah School of Medicine, Lauren Kaczka-Weiss, DO, Hackensack Meridian Health- Jersey Shore University Medical Center

Education objectives

1. Recognize the importance of TTP education and career development as an essential component of professional development, career satisfaction, and overall well-being.

2. Identify gaps and barriers within their current training programs related to career preparation, financial literacy, employment planning, board/MOC preparation, and graduation readiness, and recognize opportunities to integrate these topics into individualized learning plans.

3. Identify and leverage institutional, professional, alumni, and external resources to support TTP programming and create a practical resource toolkit addressing financial planning, career development, mentoring, billing, contracts, employment models, and other aspects of the transition to independent practice.

4. Receive practical resources for implementation of Transition To Practice curriculum in your own institution

Abstract

Transition from residency to independent practice is a critical stage of professional development as trainees move from structured graduate medical education to independent clinical practice, yet many residency programs lack a structured, longitudinal approach to preparing them for this transition. The literature identifies a paucity of guidance for residency programs seeking to develop and implement local Transition-to-Practice (TTP) curriculum, with variation in the content and priorities identified across programs.(1) TTP extends beyond job searching to include career development, professional identity, practice management, financial literacy, and physician well-being. The American Psychiatric Association has identified many of these areas as important components of career and transition planning, while emerging data demonstrate significant interest among psychiatry residents in formal financial education.(2-7)

Research examining psychiatry residents' perceptions of TTP competencies similarly highlights the importance of practice management, business aspects of practice, and career preparation.(8) While it has been identified that perceptions of TTP curriculum are important from a national organization and trainee perspective, there is no literature regarding outcomes amongst psychiatry residents. Results of a transition to practice curriculum in an Emergency Medicine residency found aspects of the curriculum could be implemented immediately, and it was also noted to improve their confidence to reduce anxiety during the transition.(9) McColl, T., et.al, surveyed Canadian Emergency Medicine program directors and held focus groups with recent residency graduates which led to the creation of fourteen consensus recommendations for a national transition to practice curriculum that encompassed residency training programs and departmental leadership. US psychiatry training programs can follow these models to develop consensus guidelines to integrate into future versions of milestones. Our workshop is aimed at the first step of this process.

This workshop will explore practical approaches to incorporating TTP education into psychiatry residency curricula in a structured and sustainable manner. We will explore our personal and program challenges and lessons learned to help the next generation of physicians. Part of this process will include a needs assessment activity to help residency programs assess their current resources, identify gaps, prioritize areas for improvement, and develop sustainable strategies to strengthen early-career preparation within existing education structures. The workshop will also introduce tools and resources that can support programs in the development of TTP curriculum.

Practice Gap

Transition from structured graduate medical education to independent clinical practice is a critical period of professional development for residents. Many residency training programs lack a longitudinal framework to transition-to-practice (TTP) education, leaving residents ill-prepared for this transition. Literature identifies a paucity of guidance for residency programs seeking to establish a TTP curriculum within their programs.(1) Given the current workforce shortages, TTP must extend beyond seeking first employment to include career development, professional identity, practice management, financial literacy, and physician well-being in order to retain psychiatrists in this field. The American Psychiatric Association has identified many of these areas as important components of career and transition planning, while emerging data demonstrate significant interest among psychiatry residents in formal financial education.(2-7) Psychiatry residents' perceptions of TTP competencies similarly highlights the importance of practice management, business skills, and career preparation.(8)

Agenda

- Introduction/Poll (5 min): Assess current practices around Transition to Practice curriculum
- Didactic 1 - The Practice Gap (10 min): Review literature on shortages in educational debt counseling, retirement planning, and career preparation; discuss employment trends and use of Individualized Learning Plans, general supervision, and semi-annual reviews to reduce burnout into attendinghood

- Didactic 2 -Analyzing Your Program (10 min): Framework for assessing program type (clinician-educator vs. research; rural vs. suburban vs. urban), existing resources, and institutional/alumni support
- Group Work 1 (20 min): Apply framework to participants' programs; group discussion
- Didactic 3 - Overcoming Barriers (15 min): Real-world solutions across curriculum design, billing and coding education, employment-type exposure, financial planning, contract review, and success measures
- Group Work 2 (15 min): Identify barriers and next steps worksheet
- Wrap-up & Q&A (15 min): Closing remarks, discussion, evaluation, and takeaway toolbox of transition to practice resources

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Title

Unscripted: Teaching the Art of Psychotherapy Through Improv

Primary Category

Teaching, Supervision, Pedagogy

Presenters

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Education objectives

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

1. Define medical improv and its core pedagogical principles.

2. Describe how medical improv can strengthen foundational psychotherapy skills, including curiosity, close listening, emotional attunement, tolerance of uncertainty, and responsiveness in the moment.

3. Apply improv theory and techniques to create engaging, experiential psychotherapy skills training for residents.

4. Utilize a take-home toolkit of adaptable exercises, foundational literature, training opportunities, and national resources to incorporate medical improv into psychotherapy education within their own programs.

Abstract

Psychotherapy asks clinicians to do something deceptively difficult: listen closely while remaining curious, emotionally attuned, and responsive to an interaction whose direction cannot be predicted. Improv asks its participants to practice many of these same skills. The relevance of improv to therapy and as therapy has previously been acknowledged [3]. Like psychodynamic psychotherapy and many other therapy modalities, improv prioritizes curiosity, empathy, attunement to affect, and responsiveness to the unexpected. Rather than planning what comes next, improvisers learn to notice what is happening between people, accept what their partner offers, and build from it in real time. In improv, this includes asking "what is the about about?"—closely paralleling the psychodynamic task of listening beyond explicit content to recognize underlying meaning and respond thoughtfully in the moment [4].

Medical improv has been applied across undergraduate and graduate medical education to promote skills including clinical communication and empathy, digital communication and advocacy, and wellbeing [5-9]. Within

psychotherapy skills training, it has been used to strengthen internal medicine residents' motivational interviewing skills; however, it remains underutilized in psychiatry residency training [10]. Improv offers an opportunity to transform concepts that can be difficult to teach didactically—such as presence, curiosity, attunement, flexibility, and tolerating uncertainty—into skills residents can actively practice. It also introduces playfulness, experimentation, and spontaneity into psychotherapy education, which has declined in recent decades for multiple reasons, including time constraints and limited access to supervision [11].

This interactive workshop will move quickly from learning about medical improv to experiencing it. Participants will engage in a progressive sequence of low-stakes, playful exercises designed to make core psychotherapy skills visible and practicable

Practice Gap

Some of the most important skills in psychotherapy are among the hardest to teach: remain curious when the path forward is uncertain, listen for what is not being said, notice shifts in affect, and respond authentically in the moment. Nancy McWilliams has described psychodynamic practice as grounded in "curiosity and awe, a respect for complexity, the disposition to identify empathically, the valuing of subjectivity and affect" [1]. While these capacities exist in abundance among psychiatry residents, developing the confidence and flexibility to use them during complex, unpredictable therapeutic interactions requires practice.

Medical improv—the application of improvisational theatre principles to enhance clinical communication, collaboration, and thinking in the moment—offers a uniquely experiential way to provide this practice [2]. This interactive workshop invites participants to experience medical improv firsthand and leave with a practical toolkit of exercises and resources readily adaptable to psychotherapy training.

Agenda

Introduction (15 min)

Introduction to medical improv and parallels with psychotherapeutic practice, including deep listening, curiosity, building on another's "offer," and remaining present with uncertainty.

Experiencing Medical Improv (40 min)

Participants work in small groups through a warm-up and two core exercises targeting listening, emotional attunement, responsiveness to unexpected contributions, and flexibility when interactions change direction. Facilitators connect each exercise to psychotherapy skills including affect recognition, therapeutic use of self, managing uncertainty, and responding rather than reacting.

Debrief (10 min)

Participants reflect on moments of connection, discomfort, surprise, and spontaneity and translate these experiences to psychotherapy teaching.

Toolkit & Next Steps (10 min)

Participants receive foundational literature, best practices, training opportunities, and resources for introducing medical improv within their programs and pursuing further training.

Q&A and Open Discussion (10 min)

Participants explore applications across learners, settings, and curricula.

Closing Evaluation (5 min)

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