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

Mathias C, Sandoval J, Noble S. Reflections on Piloting a Health Policy and Advocacy Curriculum for Psychiatry Residents. Academic Psychiatry. 2023 Apr; 47(6): 667-671. PMID: 37052781.

Scott M, McQueen S, Richardson L. Teaching Health Advocacy: A Systematic Review of Educational Interventions for Postgraduate Medical Trainees. Academic Medicine. Apr 2020; 95(4): 644-656. PMID: 31702691.

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Vance M, Kennedy K. Developing an Advocacy Curriculum: Lessons Learned from a National Survey of Psychiatric Residency Programs. Academic Psychiatry. 2020 Jan; 44(3): 283-288. PMID: 31950369.

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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

2. van Helden, D. L., den Dulk, L., Steijn, B., & Vernooij, M. W. (2023). Gender, networks and academic leadership: A systematic review. Educational Management Administration & Leadership, 51(5), 1049-1066. https://doi.org/10.1177/17411432211034172

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4. Wilkins KM, Goldenberg MN, Cyrus KD. ERASE-ing Patient Mistreatment of Trainees: Faculty Workshop. MedEdPORTAL. 2019 Dec 27;15:10865. doi: 10.15766/mep_2374-8265.10865. PMID: 32051848; PMCID: PMC7012314.

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

Friedman K, Lester J, Young JQ. Clinician-Educator Tracks for Trainees in Graduate Medical Education: A Scoping Review. Acad Med. 2019 Oct;94(10):1599-1609. doi: 10.1097/ACM.0000000000002814. PMID: 31169537.

Keil MA, Westbrook C, Stephens JJ, Spada M, Hafeman D, Jacobson SL, Travis MJ, Gopalan P. Longitudinal Outcomes of a Resident Academic Administrator, Clinician Educator Track. Acad Psychiatry. 2024 Jul 1. doi: 10.1007/s40596-024-02004-7. Epub ahead of print. PMID: 38954159.

Jibson MD, Hilty DM, Arlinghaus K, Ball VL, McCarthy T, Seritan AL, Servis ME. Clinician-educator tracks for residents: three pilot programs. Acad Psychiatry. 2010 Jul-Aug;34(4):269-76. doi: 10.1176/appi.ap.34.4.269. PMID: 20576984.

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Wasser T, Ross DA. Another Step Forward: A Novel Approach to the Clinician-Educator Track for Residents. Acad Psychiatry. 2016 Dec;40(6):937-943. doi: 10.1007/s40596-016-0599-7. Epub 2016 Aug 24. PMID: 27558628.

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
- Balasanova, A.A., Kennedy K.G. What is the Value of the Psychiatrist in Resident Psychotherapy Supervision? Academic Psychiatry 2024; 48 (2): 183-187.

- Gorun A., Welton R.S., Katz-Bearnot, S.P. Why Supervise Psychotherapy? Academic Psychiatry 2023; 47: 561-562.

- Miller C.W.T., Hodzic V., Ross D.R., Ehrenreich M.J. Annotated Bibliography for Supervising Psychiatry Residents in Psychodynamic Psychotherapy. Academic Psychiatry 2019; 43: 417-424.

- Watkins C.E. The Psychotherapy Supervisor as an Agent of Transformation: To Anchor and Educate, Facilitate and Emancipate. American Journal of Psychotherapy 2020; 73: 57-62.

- Welton R., Nelson S., Cowan A., Correll T. Supporting and Training Psychotherapy Supervisors. Academic Psychiatry 2019; 43: 464-465.

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

1. Amari N. Self-formulation in counselling psychology: The Power Threat Meaning Framework. Journal of Humanistic Psychology. 2023:00221678231154292. https://doi.org/10.1097/ACM.0000000000004562

2. Calhoun A, Genao I, Martin A, Windish D. Moving beyond implicit bias in antiracist academic medicine initiatives. Academic Medicine. 2022;97(6):790-792.

3. Cavanagh A, Vanstone M, Ritz S. Problems of problem-based learning: Towards transformative critical pedagogy in medical education. Perspectives on Medical Education. 2019;8:38-42. https://doi.org/10.1007/s40037-018-0489-7

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11. Göregen MS, Cornelissen E. Dealing with controversial topics and peacebuilding in the classroom: The case of democratic dialogue examined by the principles of conflict resolution programs in education. In EDULEARN20 Proceedings 2020 (pp. 8283-8292). IATED. https://doi.org/10.21125/edulearn.2020.2048

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)

Scientific Citations

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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, Icahn School of Medicine at Mount Sinai (Morningside/West)
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.

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AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

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

Scientific Citations
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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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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
Anusuiya Nagar, 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

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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

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