Workshop Session #1

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

Primary Category
Curriculum

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

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

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

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

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

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

Practice Gap

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

Agenda

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

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

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

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

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

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

Scientific Citations

1,Nolan, I. T., Blasdel, G., Dubin, S. N., Goetz, T. G., Greene, R. E., & Morrison, S. D. (2020). Current State of Transgender Medical Education in the United States and Canada: Update to a Scoping Review. Journal of Medical Education and Curricular Development, 7. https://doi-org.foyer.swmed.edu/10.1177/2382120520934813

2,TRINH, M.-H. et al. Transgender Patients Report Lower Satisfaction with Care Received than Cisgender Patients Receiving Care in an Academic Medical Care System. LGBT health, [s. l.], v. 11, n. 3, p. 202–209, 2024. DOI 10.1089/lgbt.2023.0034. Disponível em: https://research-ebsco-com.foyer.swmed.edu/linkprocessor/plink?id=a0873b09-6d36-360d-be93-3ed8990b2971. Acesso em: 22 ago. 2024.

3. Teti M, Kerr S, Bauerband LA, Koegler E, Graves R. A Qualitative Scoping Review of Transgender and Gender Non-conforming People's Physical Healthcare Experiences and Needs. Front Public Health. 2021 Feb 5;9:598455. doi: 10.3389/fpubh.2021.598455. PMID: 33614579; PMCID: PMC7892585.

4. Polizopoulos-Wilson N, Kindratt TB, Hansoti E, Pagels P, Cano JP, Day P, Gimpel N. A Needs Assessment Among Transgender Patients at an LGBTQ Service Organization in Texas. Transgend Health. 2021 Jun 2;6(3):175-183. doi: 10.1089/trgh.2020.0048. PMID: 34414272; PMCID: PMC8363992.

5. JUAREZ, P. D. et al. Transforming Medical Education to Provide Gender-Affirming Care for Transgender and Gender-Diverse Patients: A Policy Brief. Annals of Family Medicine, [s. l.], v. 21, p. 92–94, 2023. DOI 10.1370/afm.2926. Disponível em: https://research-

ebsco-com.foyer.swmed.edu/linkprocessor/plink?id=63aa5b71-9005-3e25-8894-dc9bd352ad76. Acesso em: 22 ago. 2024.

6. van Heesewijk, J., Kent, A., van de Grift, T.C. et al. Transgender health content in medical education: a theory-guided systematic review of current training practices and implementation barriers & facilitators. Adv in Health Sci Educ 27, 817–846 (2022). https://doi.org/10.1007/s10459-022-10112-y

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

8. Abreu, R. L., Sostre, J. P., Gonzalez, K. A., Lockett, G. M., & Matsuno, E. (2022). “I am afraid for those kids who might find death preferable”: Parental figures’ reactions and coping strategies to bans on gender affirming care for transgender and gender diverse youth. Psychology of Sexual Orientation and Gender Diversity, 9(4), 500–510. https://doi.org/10.1037/sgd0000495

Title
Facilitate the Shift: Crafting Inclusive Spaces through Facilitation Excellence

Primary Category
Faculty Development

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

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

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

Practice Gap

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

Agenda

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

Scientific Citations

Association of American Medical Colleges. (2022). Diversity, Equity, and Inclusion Competencies Across the Learning Continuum.

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

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

Oluo, I. (2019). So you want to talk about race. Seal Press.

Swindall, L. R. (2021). Four Ways to (Re) consider Facilitating Discussions on Race and Social Justice. New Jersey Studies: An Interdisciplinary Journal, 7(1), 373-382.

Warde, B., Kahn, J. M., & Greenberg, J. P. (2022). Conversations about race and racism: a qualitative study of the classroom experiences of recently graduated MSW alumni. Smith College Studies in Social Work, 92(1), 28-47.

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

Primary Category
Program Administration and Leadership

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

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

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

For many trainees considering the use of paid time off, a critical concern is whether their training will be extended. While ABMS recommends that the 6-week time off should not result in an extension, and ABPN places the responsibility on programs to discuss the impact of the leave with trainees, the final decision rests with the training director and

each program's CCC. They are tasked with determining if the trainee who took the leave has met the training requirements to graduate on time.

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

Practice Gap

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

Agenda

Agenda:
Minutes 0-5: Welcome, introduction and overview
Minutes 5-10: Review current leave policies from ACGME & ABPN
Minutes 10-20: Small breakout groups for general discussion of how policies impact individual programs
Minutes 20-25: Small group report out
Minutes 25-40: Discussion of scenarios from authors' programs and how they were handled
Minutes 40-50: Individual program analysis (create a handout)
Minutes 50-60: Provide support and resources in small groups
Minutes 60-65: Report out
Minutes 65-80: Large group discussion
Minutes 80-90: Workshop evaluation

Scientific Citations

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

American Board of Psychiatry and Neurology. Policies - American Board of Psychiatry and Neurology. [online]. 2023. https://www.abpn.com/wp-content/uploads/2023/04/Policy-Regarding-Training.pdf Accessed on August 30, 2024.

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

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

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

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

Primary Category
Teaching, Supervision, Pedagogy

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

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

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

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

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

Practice Gap

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

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

Agenda

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

Scientific Citations

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

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

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

Piot M-A, Dechartres A, Attoe C, et al. Simulation in psychiatry for medical doctors: A systematic review and meta-analysis. Med Educ. 2020; 54: 696–708. https://doi.org/10.1111/medu.14166

Sawyer, Taylor DO, MEd; Eppich, Walter MD, MEd; Brett-Fleegler, Marisa MD; Grant, Vincent MD; Cheng, Adam MD. More Than One Way to Debrief: A Critical Review of Healthcare Simulation Debriefing Methods. Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare 11(3):p 209-217, June 2016. | DOI: 10.1097/SIH.0000000000000148

Somerville, S. G., Harrison, N. M., & Lewis, S. A. (2023). Twelve tips for the pre-brief to promote psychological safety in simulation-based education. Medical Teacher, 45(12), 1349–1356. https://doi.org/10.1080/0142159X.2023.2214305

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

Primary Category
Recruitment and Selection

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

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

Abstract
INTRODUCTION:

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

METHODS:

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

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

Results

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

Conclusions

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

Practice Gap

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

Agenda

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

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

Scientific Citations

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

2. Bhayani RK, Fick L, Dillman D et al. Twelve Tips for Utilizing Residency Program Social Media Accounts for Modified Residency Recruitment [version 1]. MedEdPublish 2020, 9:178 https://doi.org/10.15694/mep.2020.000178.1

3. Pruett, J. & Deneen, Kristin & Turner, Harrison & Kozar, Thomas & Singh, Nikhi & King, Timothy & Nichols, Michele. (2021). "Social Media Changes in Pediatric Residency Programs During COVID-19 Pandemic". Academic Pediatrics. 21. http://doi.org/10.1016/j.acap.2021.06.004.

4. Kim, Y., Ali, N. S, & Vidal, N. Y. (2021). Social media use in residency recruitment during the COVID-19 pandemic. Dermatology Online Journal, 27(6). http://dx.doi.org/10.5070/D327654053

5. Irwin, T. J., Riesel, J. N., Ortiz, R., Helliwell, L. A., Lin, S. J., & Eberlin, K. R. (2021). The Impact of Social Media on Plastic Surgery Residency Applicants. Annals of plastic surgery, 86(3), 335–339. https://doi.org/10.1097/SAP.0000000000000237

6. Hammoud, M. M., Standiford, T. C., & Carmody, J. B. (2021). The 2020-2021 Residency Application Cycle: Lessons Learned and Lingering Problems. JAMA, 325(22), 2249–2250. https://doi.org/10.1001/jama.2021.5708

7. Oliver, M. G., & Kelly, K. (2022). Student Perceptions and Use of Social Media as Residency Program Information. Family medicine, 54(5), 380–383. https://doi.org/10.22454/FamMed.2022.968351

8. Shayegan Fard, M. J., & Karimi, F. (2023). When is the most effective time to post on Instagram to increase engagement rate?. International Journal of Web Research, 6(2), 43-55. https://10.22133/ijwr.2024.426669.1195

9. Gnade, C. M., Avery, C. C., Yang, Z., Pickett, C. M., & Oshinowo, A. E. (2024). Social media trends in obstetrics and gynecology residency programs on Instagram and X (Twitter). PloS one, 19(5), e0296930. https://doi.org/10.1371/journal.pone.0296930

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

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

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

Primary Category
Teaching, Supervision, Pedagogy

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

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

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

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

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

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

Practice Gap

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

Agenda

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

Scientific Citations

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

Mintz, D (2022). Combining Medications and Psychotherapy. In Gabbard G (Ed.) Textbook of Psychotherapeutic Treatments, American Psychiatric Publishing, Washington DC. 743-760.

Mintz, D., & Bayeva, M. (2023). Supervising Integrated Psychotherapy and Pharmacotherapy. In Kennedy, K., Weldon, R., & Yeomans, F. (Eds.), Supervising Individual Psychotherapy: The Guide to Good Enough, American Psychiatric Publishing, Washington DC. 135-148.

Riba MB, Balon R, Roberts LW, eds. (2018). Competency in Combining Pharmacotherapy and Psychotherapy: Integrated and Split Treatment, Second Edition. American Psychiatric Press, Inc.

Tadmon, D., & Olfson, M. (2022). Trends in outpatient psychotherapy provision by US psychiatrists: 1996–2016. American Journal of Psychiatry, 179(2), 110-121.

White, M., & Koehler, H. (2021). Integrating medication and therapy. In Brenner & Howe-Martin (eds.) Psychotherapy: a practical introduction. Philadelphia (PA): Wolters Kluwer, 343-62.

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

Primary Category
Program Administration and Leadership

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

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

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

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

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

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

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

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

Practice Gap

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

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

Scientific Citations
Leshen, G., Johnston, S., Ries, A. et al. Establishing an Embedded Psychiatry Rotation with Naval Special Warfare: A Win for Both the Education of Military Psychiatry Residents and the Operational Forces. Acad Psychiatry 47, 402–405 (2023). https://doi.org/10.1007/s40596-023-01823-4

Kronsberg, H., Bettencourt, A.F., Vidal, C. et al. Education on the Social Determinants of Mental Health in Child and Adolescent Psychiatry Fellowships. Acad Psychiatry 46, 50–54 (2022). https://doi.org/10.1007/s40596-020-01269-y

Cole R, Rudinsky S, Conley SP, Vojta L, Wook Kwon S, Garrigan AG, Prosek EA, Goolsby C. The Impact of Medical School on Military Physicians' Readiness for their First Deployment. Mil Med. 2022 Jul 1;187(7-8):e995-e1006. doi: 10.1093/milmed/usac049. PMID: 35257164.

Bromage B, Encandela JA, Cranford M, Diaz E, Williamson B, Spell VT, et al. Understanding health disparities through the eyes of community members: a structural competency education intervention. Acad Psychiatry. 2019;43:244–7.

Hansen, H., Braslow, J., & Rohrbaugh, R. M. (2018). From cultural to structural competency—training psychiatry residents to act on social determinants of health and institutional racism. JAMA psychiatry, 75(2), 117-118.

Hansen, H., & Metzl, J. M. (Eds.). (2019). Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health. Springer.

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

Primary Category
Research and Scholarship

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

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

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

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

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

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

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

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

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

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

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

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

Primary Category
Curriculum

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

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

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

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

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

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

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

Practice Gap

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

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

Agenda

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

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

Scientific Citations

1. Wisner KL, Sit DK, McShea MC, et al. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. JAMA Psychiatry 2013;70(5):490-8 doi: 10.1001/jamapsychiatry.2013.87[published Online First: Epub Date]|.

2. Koire A, Suleiman M, Teslyar P, Liu CH. Prevalence of Community Perinatal Psychiatrists in the US. JAMA Netw Open 2024;7(8):e2426465 doi: 10.1001/jamanetworkopen.2024.26465[published Online First: Epub Date]|.

3. Nagle-Yang S, Lebin LG, Standeven LR, Howard M, Toscano M. Reproductive psychiatry training: A critical component of access to perinatal mental health treatment. Semin Perinatol 2024;48(6):151949 doi: 10.1016/j.semperi.2024.151949[published Online First: Epub Date]|.

4. Osborne LM, JV; Barzilay, EM; Meltzer-Brody, S; Miller, L; Yang, SN. . Reproductive psychiatry residency training: a survey of psychiatric residency training directors. Acad Psychiatry 2018;42(2):197-201

5. Trost SB, J; Njie, F; et al. Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 36 US States, 2017-2019. In: Prevention CfDCa, ed., 2022.

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

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

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

Title
What Stories can Teach us

Primary Category
Teaching, Supervision, Pedagogy

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

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

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

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

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

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

Practice Gap

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

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

Agenda

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

Scientific Citations

1. Narrative medicine as a medical education tool: a systematic review MM Milota, GJMW van Thiel, JJM van Delden - Medical teacher, 2019 - Taylor & Francis https://www.tandfonline.com/doi/abs/10.1080/0142159X.2019.1584274

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

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

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

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

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

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

Primary Category
Teaching, Supervision, Pedagogy

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

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

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

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

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

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

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

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

Practice Gap

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

Agenda

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

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

Scientific Citations

1. Pescosolido BA, Halpern-Manners A, Luo L, Perry B. Trends in Public Stigma of Mental Illness in the US, 1996-2018. JAMA Netw Open. 2021;4(12):e2140202. doi:10.1001/jamanetworkopen.2021.40202

2. Deng M, Zhai S, Ouyang X, Liu Z, Ross B. Factors influencing medication adherence among patients with severe mental disorders from the perspective of mental health professionals. BMC Psychiatry. 2022;22(1):22. doi:10.1186/s12888-021-03681-6

3. Tham SS, Solomon P. Family Involvement in Routine Services for Individuals With Severe Mental Illness: Scoping Review of Barriers and Strategies. Psychiatr Serv. Published online June 28, 2024:appi.ps.20230452. doi:10.1176/appi.ps.20230452

4. Chow HHE, Chew QH, Sim K. Spirituality and religion in residents and inter-relationships with clinical practice and residency training: a scoping review. BMJ Open. 2021;11(5):e044321. doi:10.1136/bmjopen-2020-044321

5. Zalpuri I, Domakonda M, Wrzosek M, DeJong S. Trainees on Technological Terrain: a Video Vignette-Based Tool to Teach E-Professionalism. Acad Psychiatry. 2021;45(2):224-230. doi:10.1007/s40596-020-01325-7

6. Weingarten K. Witnessing, Wonder, and Hope*. Fam Process. 2000;39(4):389-402. doi:10.1111/j.1545-5300.2000.39401.x

7. Griffith JL, Gaby L. Brief Psychotherapy at the Bedside: Countering Demoralization From Medical Illness. Psychosomatics. 2005;46(2):109-116. doi:10.1176/appi.psy.46.2.109

8. Peteet JR, Amonoo HL. Spirituality in the care of patients with cancer: What is the psychiatrist's role? Palliat Support Care. 2023;21(1):173-175. doi:10.1017/S1478951521001930