PJP

SPECIAL ARTICLE

NEW REQUIREMENTS FOR PSYCHIATRY RESIDENCY TRAINING PROGRAMS (PRTPs) IN THE PHILIPPINES

THE BOARD OF ACCREDITATION OF THE SPECIALTY BOARD OF PHILIPPINE PSYCHIATRY

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INTRODUCTION

It has been more than a decade since the Committee on Standardization and Accreditation of Residency Training was renamed Board of Accreditation of the Specialty Board of Philippine Psychiatry (SBPP). The SBPP is composed of two bodies namely the Boards of Accreditation and Certification. These bodies are mandated to uphold the highest standards of accrediting psychiatry residency training programs (Board of Accreditation) and granting diplomate status to graduates of these programs (Board of Certification). Guided by the biopsychosocial and spiritual model of health, the Board of Accreditation remains steadfast in ensuring that psychiatry residency training programs continue to be relevant to current demands of mental health and psychiatric care in the country. In addition, it sees to it that these programs are in harmony with global standards. As psychiatry faces new challenges in the third millennium, certain innovations and iterations in the manner by which mental illnesses are diagnosed, treated, and prevented must be set in place. Through its Millennium Developmental Goals, the United Nations has declared that the achievement of gender equality is an effective way of combating disease. Mental health problems and psychiatric disorders are closely linked with gender-related issues. Yet, many residency training programs in the Philippines have not formally and systematically integrated gender sensitivity into their curricula. The same can be said of the concepts of religion and spirituality. Numerous researches have established the positive link between religion and spirituality and mental health.

Filipinos take pride in the fact that religion and spirituality occupy a focal point in their mental health. Yet, the relevance of religion and spirituality to mental health and psychiatric care is barely tackled by residency training programs in the country. In this light, the Board of Accreditation recognizes the need for psychiatry residents to apply the principles of gender sensitivity and religion and spirituality to the care of patients with mental health and psychiatric problems. In the same vein, improving the quality of mental health and psychiatric care by residents must be given paramount attention by all training programs. The Board of Accreditation strongly believes that promoting the wellness of psychiatry trainees and arming them with the necessary tools to succeed in their careers are effective and efficient ways to ensure that they are able to provide the highest quality of mental health and psychiatric care for their patients.

Upon the approval of the Board of Directors of the Philippine Psychiatric Association, the Board of Accreditation now requires the inclusion of the following in the psychiatry residency training programs of all accredited institutions.

1. Wellness program for residents
2. Mentoring program for residents
3. Course on gender and psychiatry
4. Course on religion and spirituality and psychiatry

In the spirit of learning outcomes/competency-based/outcome-based education and in consideration of the particular contexts and missions of PRTPs, the Board provides flexibility for the

coordinators of PRTPs to innovate their curriculum on the courses on gender and psychiatry and religion and spirituality and psychiatry. The same flexibility applies to the development and implementation of the wellness and mentoring programs. The PRTPs must design their curricula and programs to suit their own contexts and missions but these must achieve the required minimum set of outcomes. In addition, PRTPs have freedom in curriculum delivery and in specification and deployment of human and physical resources. The PRTPs must show that the alternative route they propose effectively fulfills the program outcomes and satisfies program educational objectives. The program outcomes that the Board prescribes are described in Table 1.

Table 1: **Program Outcomes of Psychiatry Residency Training** (Adapted from 1)

Program Outcomes	Operational Definition of Program Outcomes
1. Demonstrate clinical competence	Competently manage psychiatric conditions in various settings
2. Communicate effectively	Convey information, in written and oral formats, across all types of audiences, venues and media in a manner that can be easily understood
3. Lead and manage health care teams	Initiate planning, organizing, implementation, and evaluation of programs and health facilities Provide clear direction, inspiration, and motivation to the health care team/community
4. Engage in research activities	Utilize current research evidence in decision making as practitioner, educator or researcher Conduct research activities
5. Collaborate within interprofessional teams	Effectively work in teams in managing patients, institutions, projects, and similar situations
6. Utilize systems-based approach to health care	Utilize systems-based approach in actual delivery of care Network with relevant partners in solving general psychiatric problems
7. Engage in continuing personal and professional development	Update oneself through a variety of avenues for personal and professional growth to ensure quality psychiatric care and patient safety
8. Adhere to ethical, professional, and legal standards	Adhere to national and international codes of conduct and legal standards that govern the psychiatric profession
9. Demonstrate nationalism, internationalism, and dedication to service	Demonstrate love for one's national heritage, respect for other cultures, and commitment to service
10. Practice the principles of social accountability	Adhere to the principles of relevance, equity, quality, and cost effectiveness in the delivery of psychiatric care to patients, families, and communities

This paper provides conceptual frameworks on the courses on gender and psychiatry and religion and spirituality and psychiatry and the programs on wellness and mentoring. The general and specific objectives for establishing these courses and programs are described. Furthermore, it also discusses current evidence on the relevance of these courses and programs in psychiatry residency training.

I. Wellness Program

Residency training is a formative and intense period that has its own set of challenges that affect the well-being of trainees. (2, 3)

The COVID-19 pandemic highlighted the complex challenges faced by residents. Mendonça and colleagues found that the COVID-19 pandemic contributed to symptoms of depression, anxiety, and burnout in majority of medical residents. (4) This pandemic may bear a long-lasting impact on residents who may need psychological support for a wide range of personal and professional concerns. (5)

It has been proposed that medical education may select for individuals who are prone to psychological distress because of their high levels of ambition and competition. (6) Medical students bring these stress-inducing qualities with them to residency making them vulnerable to burnout because of disappointment and frustration. In addition, residents may adopt maladaptive perfectionism or develop imposter syndrome. Maladaptive perfectionism involves unreasonable self-expectation, negative reactions to failure, and constant dissatisfaction with one's performance. Maladaptive perfectionism hinders trainees from being aware of their vulnerabilities and limitations. Imposter syndrome is characterized by lack of self-confidence and fear of being discovered as undeserving despite one's achievements. Maladaptive perfectionism and imposter syndrome predispose to psychological distress or pathology. Closely linked with perfectionism and the imposter syndrome is shame. Shame may arise from internal and external factors and it may lead to isolation, distress, or disruption in self-esteem and self-identity. Intrinsic qualities of residents such as the lack of resiliency may not be the sole drivers of diminished well-being. Studies show that multiple factors associated with the training environment contribute to lack or absence of wellness. Experts believe that systemic factors such as organizational pressures and work stressors and not personal resilience contribute to burnout among healthcare professionals. (7)

Although self-directed strategies such as mindfulness practice help reduce stress, anxiety, and burnout, systemic factors that lead to such consequences must also be addressed. Providing interventions geared towards equipping administration and the trainers with the capacity to optimize their roles as educators and role models for residents is an example. This strategy will facilitate a top-down approach aimed at increasing resident wellness. (6)

Alkatan pointed out the phenomenon of "generational gap" that training faculty need to appreciate in order to ensure the success of a wellness program. (8) The current set of trainers belong to the baby boomer and X generations while the current trainees belong to the millennial or Y generation. The latter is characterized by being confident, team-oriented, achievement-oriented, pressured, and conventional. In dealing with this generational difference, trainers are urged to be guided by certain strategies some of which are described in Table 2.

Table 2: Strategies in Dealing with Residents Belonging to the Millennial Generation (Adapted from 8)

1. Clarify the essentials in the training program and methods of evaluation; trainers should not underestimate the millennials' desire for clarity
2. Invite the residents' input on the training program and evaluation systems; this will enhance their collaborative skills and creativity
3. Establish guidelines for a learning structure that allows flexibility and negotiation to give the residents the sense of having choices
4. Satisfy the residents' eagerness for team work by stressing the ideas of team leaders and task-orientation
5. Help the residents overcome stress by decreasing work load while using flexible deadlines and enhancing the training elements using technology
6. Reinforce ethical reflection as a prominent feature of teaching
7. Use powerful resources to demonstrate excellence and facilitate the residents' achievement orientation, self-esteem, and confidence
8. Emphasize intellectual modesty; explain that academic proficiency must be complemented by skills and abilities

The Philippine government has recognized the value of wellness programs thus the Department of Health in cooperation with the World Health Organization and the Australian government, launched The Wellness Movement on 16 January 2023. This is an initiative that aims to improve the mental health and well-being of Filipino healthcare workers. (9, 10)

Literature shows that burnout is prevalent among residents across all specialties. (11, 12, 13) In fact, it is believed to be a growing endemic with at least 60% of residents reporting it. (7). Locally, one study showed an average to moderate degree of burnout among residents of a private tertiary hospital in Metro Manila with single females and those belonging to major or non-surgical departments having higher burnout levels. (13) Another study conducted post-COVID pandemic, showed that a significant number of Internal Medicine residents at a government tertiary hospital were at risk for burnout. (14) There is a dearth of research on stress or burnout among Filipino psychiatry residents. A study conducted at a government tertiary psychiatric facility in Metro Manila measured the occupational stress levels of psy-chiatry residents and showed that burnout was not evident. The number of participants of this study, however, was too small (N=18) to be able to generate substantial conclusions. (15)

As residency training progresses the risk of burnout increases as exhaustion, sleep deprivation, adjustment difficulties, inter-personal conflicts, demanding workload, disen-chantment, detachment, and cynicism increase. Burnout may contribute to the spectrum of stress conditions and/or clinical health issues of trainees such as suicide, depression, and substance use. Burnout has also been associated with physician attrition and poor quality of patient care. On the contrary, physician wellness has been linked with increased patient satisfaction and improved treatment adherence. (3, 16) Traditionally, the Maslach Burnout Inventory is used to diagnose burnout. This scale assesses emotional exhaustion (feeling overworked and losing com-passion), depersonalization (detachment from colleagues and/or patients), and personal accomplishment (feelings of competence and professional satisfaction). (6) Other scales for burnout include the Copenhagen Burnout Inventory and Symptom Checklist 90 (SCL 90). Studying the factors that contribute to burnout is crucial in understanding the factors that ensure patient safety and influence the career trajectory of residents. (6) It was hypothesized that burnout resulted from excessive duty hours. Studies in the US, Canada, and Europe, however, did not show that shortening duty hours improved sleep, work efficiency, or depression. In fact, this strategy potentially lessened the time for residents to learn and compromised patient care. (3) Lu & Ratnapalan conducted a scoping review of resident burnout interventions and found that longitudinal wellness training, physical activities, healthy dietary habits, social activities, formal mentor-ship programs, and health checkups were effective in reducing burnout. (17)

Psychiatry residency training adds another layer of burden that may aggravate stress or lead to burnout. These include vicarious traumatization, patient suicide and violence, and stigma of the profession. International studies showed that 31% to 69% of residents experience patient death by suicide. This results in significant psychosocial stress as residents deal with feelings of helplessness and guilt that may have

lingering effects. (18) The stigma existing within the medical community also poses an additional stressor that has been unaddressed and has a negative impact on the morale of residents. Numerous studies have proven that physician burnout is correlated with consequences beyond the self, such as negative impact on patient care and the health care system. These include medical errors, increased risk of malpractice, and reduced patient satisfaction, quality of care and patient outcomes. (19)

The term “wellness” implies a multidimensional and dynamic state of optimal well-being that may be generally defined as one’s personal recipe for thriving and not just surviving. (20, 21) Specifically, the World Health Organization defines it as “the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically and the fulfillment of [the] individual’s roles in family, workplace and community settings.” (20) The American Medical Association defines it as being composed of six important markers namely, nutrition, fitness, emotional health, preventative care, financial health, and mindset and behavior adaptability. (16, 22) Another model of wellness describes eight dimensions: professional (occupation, vocational), social (family, community), emotional (mental), spiritual (values), intellectual, physical (fitness, nutrition), environmental, and financial. (20)

The individual must strive to achieve wellness because it does not come naturally. Furthermore, its inherent multidimensional nature makes quantitative research challenging. The Gallup-Healthways Well-Being Index Composite Score is one attempt in quantifying wellness. It emphasizes the presence of health rather than the absence of disease. In addition, it describes well-being across the following domains: life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access. (6)

Significant features that contribute to the success of wellness programs for medical students have been identified. (6) These features may also be applicable to residents. These include the presence of a wellness committee that coordinates with administration, consultants, and residents and strategies that are designed to decrease the training burdens of residents.

The wellness committee must conduct a needs assessment among residents which includes quantitative and qualitative evaluations of the degree of resident stress or burnout. This will identify those trainees who may need certain support or intervention. Ultimately, a wellness program must be responsive to the specific needs of the residents. In order to optimize success, the wellness committee must work closely with the mentoring program and training program committees.

Embedding a culture of wellness should be an end goal of every psychiatry residency training program. While working on wellness on an individual level is a given, a systems approach is essential in providing the necessary environment where care for oneself is nurtured and accepted as the norm. In North America, medical education accreditation bodies now consider wellness as a core competency. (7) In the US, the Accreditation Council for Graduate Medical Education (ACGME) mandated residency programs to address trainee wellness within the Common Program Requirements. In 2017, a Resident Wellness Consensus Summit (RWCS) was inaugurated in the US. Part of this summit’s output was a proposal for an evidence-based wellness curriculum that contained seventeen modules that focus on the spectrum of wellness and burnout. A study showed that running small group discussions on these topics significantly increased empowerment and work engagement and decreased rates of burnout, emotional exhaustion, and depersonalization. (21) Table 3 describes these topics. The psychiatry department of McMaster University in Canada launched its well-being program for residents in 2018. This program provided an electronic curriculum on resident resilience, a wellness newsletter, and peer groups as infrastructural supports for residents. (7) Table 4 describes this wellness program.

A wellness program possesses a multidimensional approach that integrates individual needs, institutional and cultural barriers to wellness, and systemic issues that contribute to stress. (2) At an individual level, wellness is achieved when residents practice healthy habits on a daily basis allowing a balance in the physical, emotional, intellectual, social, spiritual, environmental, and occupational aspects of being. Activities and/or interventions throughout the academic year include, but are not limited to, retreats, mental health leaves, recrea-

Table 3: **17-Module Physician Wellness Curriculum** (Adapted from 21)

Topic	Description
Introduction to wellness	Introduction to physician wellness and burnout, the wellness curriculum, and a breakout session for interns on “Transitioning to Residency”
Why wellness matters	Building awareness on burnout, depression and mental health issues in physicians, and that wellness is not the absence of distress
Wellness activities of physicians	A discussion of how physicians stay well through relationships, religion and spirituality, self-care, work, and approach to life
Sleep	Education on sleep hygiene, scheduling, and practical tips for the shift-based physician life
Nutrition	Education on the basics of nutrition and how to eat a healthy, balanced diet, particularly for people with busy lifestyles
Physical fitness	Education on the basics and scientifically proven benefits of physical fitness, as well as how to get started on an exercise program
Financial health	Overview of the basics of budgeting and living within your means; breakout session recommended specifically for graduating senior residents
Mindfulness and reflection	Overview of the concept, scientifically-proven benefits, unwarranted stigma, and practice of mindfulness for the busy resident physician
Building support network	Discussion about the importance of a support network for the resident, especially a mentorship program, in promoting wellness and building resiliency
Physician suicide	Education on risk factors for depression and suicide specific to physicians, and how to recognize them in yourself
“I Need Help”	Education on how to get mental health help for oneself, with a focus on systems that ensure confidentiality
Delivering bad news	Education for resident physicians on how to deliver bad news to patients and their families
Dealing with difficult patients	Education on how to appropriately manage difficult patient encounters with evidence-based recommendations for success
Dealing with difficult consultants and staff	Education on how to appropriately and professionally interact with difficult consultants and staff members
Debriefing traumatic events in the hospital	Education about debriefing techniques following significant events in the hospital to ensure a collective, safe, guided reflection of the event
Wellness in the workplace	Discussion about how individual wellness depends on the supportive workplace wellness culture
Dealing with medical errors and shame	Education on how residents can cope with medical errors in a healthy fashion to minimize feelings of inadequacy, shame, and burnout

Table 4: Components and Description of the McMaster Well-Being Program

(Adapted from 7)

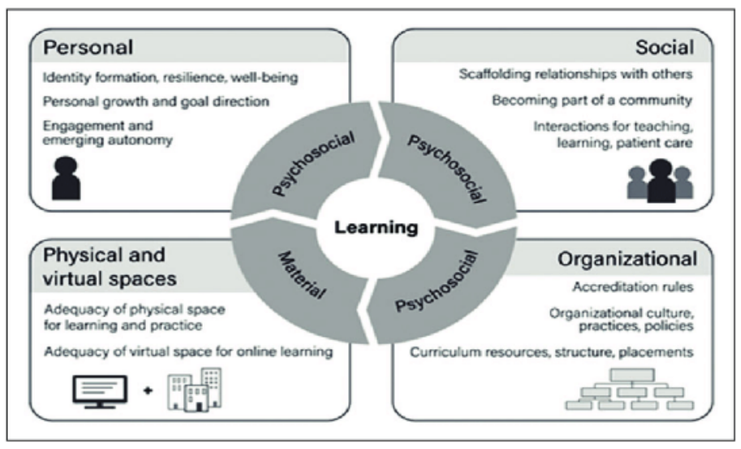
Component	Description
Peer groups	• Offered quarterly in person, voluntary, structured/semi-structured time of 90 minutes • Resident-facilitated and attended to promote confidentiality and security • Integrates aspects of peer-support, debriefing, Balint and Doctor to Heal groups, as well as experiential relaxation exercises • Promotes safe sharing of experiences and processing of emotions related to the ups and downs of residency
Electronic resilience curriculum	• https://respite.machealth.ca • Publicly available, online, voluntary, and can be accessed by trainees during optional teaching times on their own schedules • Founded on two core learning dimensions: *Know Yourself* and *Integrate New Lifestyles*, which respectively teach about burnout, and offer strategies to enhance resilience or combat stress and struggles in medicine • Utilize a case-based approach, skill-building exercises and quizzes to promote reflection and solidify learning
Wellness newsletter	• Distributed quarterly via group ListServe • Designed for residents, but both faculty and residents contribute and receive • Utilizes positive psychology, as well as personal stories and experiences to address stigma and isolation

-tional and leisure activities, exercise, conducive workspaces, retreat zones or quiet spaces, respite spaces with relaxation apps, open air sitting areas, a simple gym area, a snack/hydration station, self-care workshops, and communication and stress management trainings. Avenues for psychosocial support include, but are not limited to, check-ins with mentors or with each other, group peer support (structured group sharing), buddy systems, and therapy sessions. Residents must be made aware of such interventions using multiple channels of communication such as regular emails, fliers posted in work areas, a wellness website, and announcements in team meetings. Ultimately, these programs must be able to reduce the barriers to accessing wellness services. Studies have identified several barriers that include concerns about confidentiality, stigma and stoicism, fears about reporting to credentialing or licensure boards, financial concerns, demanding clinical schedules, and identifying therapists experienced in working with physicians. (5, 16)

Wellness programs should foster a culture that allows open exchange of ideas and flexibility in responding to issues as they emerge. Wellness programs must allow residents to become an integral part of program policy changes and to participate in program improvements. Consequently, wellness programs become more successful and leadership and communication skills are enhanced among residents. The differences in experiences of the learning environment among subgroups of residents does not permit a singular approach to wellness. Understanding such diversity will guide whatever changes to the learning environment are made. (2, 3, 8, 16) The concept of the learning environment (LE) is defined by two main dimensions namely, psychosocial and sociomaterial dimensions. Individual characteristics that contribute to or respond to the LE, interpersonal interactions, and institutional policies, culture, and regulation constitute the layers of the psychosocial dimension. The sociomaterial dimension defines how residents interact with the physical and virtual worlds that they learn in. (20) Incorporating web-based and other digital resources into residency training will contribute to the success of wellness programs because this provides the residents the opportunity to learn at their own pace. (7)

Figure 1 depicts a model of the learning environment. At present, the relationship between wellness and LE is not well understood and needs to be studied using high quality research. (20)

Figure 1: A Model of the Learning Environment (Adapted from 20)



Objectives
General: To develop a program that will enhance the wellbeing of psychiatry residents.

Specific: The wellness program must aim to

1. Increase the awareness of psychiatry residents of the factors and resources that contribute to well-being.
2. Provide information, activities, and services designed to support healthy lifestyle choices among psychiatry residents.
3. Encourage habits of wellness among psychiatry residents.
4. Empower psychiatry residents to take responsibility for their own health.
5. Address the physical, emotional, intellectual, social, spiritual, environmental, and occupational needs of psychiatry residents.
6. Improve the quality of life of psychiatry residents.
7. Promote the resiliency of psychiatry residents.
8. Recognize the early signs of psychological distress among psychiatry residents.
9. Prevent burnout and other psychiatric sequelae of residency training.
10. Facilitate access to medical and psychosocial services to trainees with health concerns.
11. Combat stigma to encourage residents to share their experiences with chronic stress and burnout.
12. Engage residents in program policy making.
13. Evaluate its effectiveness.
14. Produce and/or publish research outputs about wellness of psychiatry residents.

Bibliography of Recommended Resource Materials for Wellness Programs

1.AMA STEPS Forward

https://edhub.ama-assn.org/steps-forward/module/2702511

2. APA Toolkit for Well-Being Ambassadors: A Manual

(https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/well-being-resources#:~:text=Download%20the-,Toolkit%20for%20Well%2Dbeing%20Ambassadors,-Download%20the%C2%A0)

3. Nasirzadeh Y., Chertkow L., Smith S. et al. (2021). What do residents want from wellness? A needs assessment of Psychiatry residents to inform a residency wellness strategy. Academic Psychiatry.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8782672/pdf/40596_2021_Article_1578.pdf

4. Resident Wellness Toolkit (John Hopkins Medicine)

https://christianacare.org/documents/medical-dental%20staff/ResidencyWellnessToolkit-Prototype-Dec17.pdf

5. Resilience in the Era of Sustainable Physicians: An International Training Endeavour

https://respite.machealth.ca

In summary, the following steps in developing a wellness program for psychiatry residents are recommended by the Board. First, a wellness committee must be formed. Second, the committee conducts a baseline needs assessment and burnout inventory profile of the residents. Although not validated locally, the Maslach Burnout Inventory may be used as this is considered the gold standard. Alternatively, the Copenhagen Burnout Inventory and screening scales for depression and/or anxiety may also be utilized. Third, the committee creates a module (see Table 3 for an example) to introduce stress, burnout and wellness. These topics are introduced not as a formal lecture but embedded in various activities (small group dis-

-cussion or sharing) or in spaces within the wellness program structure. Flexibility, creativity and resourcefulness is important in this area. Fourth, review existing wellness resources within the workplace and improve when able and necessary. These include safe/quiet spaces such as residents' quarters or working spaces, hydration stations, access to healthcare, among others. Fifth, the wellness committee must work closely with the training and mentoring committees. This will address the stressors that come from the learning environment. Simple examples of these may be honoring protected time or schedules that have been set beforehand and improving avenues of communication to allow open exchange of ideas.

In conclusion, data on burnout among psychiatry residents in the Philippines is scanty. This must not hinder initiatives to introduce wellness programs among the training centers. Worldwide data shows an upward trend in burnout and depression and anxiety in the medical profession. In order to generate baseline data, the accredited training centers of PPA must collaborate to develop a working system that is relevant, dynamic, and adaptable.

II. Mentoring Program

A study of 229 Psychiatry chief residents participating in the American Psychiatric Association National Chief Residents Leadership Program in 2004 and 2005 showed that half of them reported a lack of clearly defined career development mentors. These trainees believed that they were less prepared to practice psychiatry after graduation. This showed the need for psychiatric residency training programs to clarify and implement effective mentorship programs. (23)

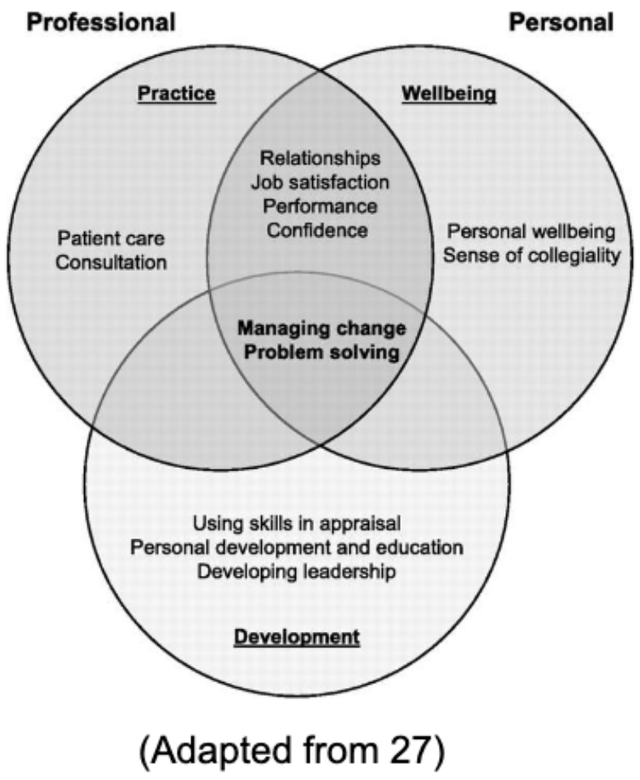
The Standing Committee on Postgraduate Medical and Dental Education (24), defined mentoring as, "guiding another individual in the development and re-examination of their own ideas, learning and personal and professional development." Since the transitions in the journey from medical student to consultant can be complicated, mentoring can help residents cope and adjust to the challenges.

Many graduate medical education programs internationally have mandated the inclusion of mentoring in postgraduate training.

Citing the importance of mentorship in the continuum of academic medicine, the Office for Diversity Inclusion and Community Partnership of the Harvard Medical School, for instance, offers mentoring for junior faculty, trainees and students. They offer varied mentor trainings and provide online resources for mentors and mentees in order to ensure the quality of the program. (25) A study of successful physicians showed that medical career success was determined by the acquisition during training of core competencies such as patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. (26) Mentoring programs should therefore be designed in line with the core competencies set by training or accrediting bodies in the specialty.

The perceived benefits of mentoring may cross the personal-professional interface and may override organizational differences. (27) The diagram below highlights the complex relationships which exist between the three areas of professional practice, personal well-being, and personal and professional development. This can be a guide for the mentoring process for both mentors and mentees.

Figure 2. The Personal-Professional Overlap: Areas of Benefit and Underlying Processes



(Adapted from 27)

Mentors can provide support and encouragement for a resident's personal development, usually with a professional focus, that also factors in work-life balance (22). Mentoring involves the long-term development of residents who are helped to manage their training and improve their skills. In addition, mentoring provides a venue for the residents to discuss their personal issues in confidence and a

way of achieving both individual and organizational goals. (28)

Mentoring programs during residency training can increase the satisfaction, well-being, positive work, and career attitudes of trainees. It can help them realize their full potential in Psychiatry and achieve the results they value by allowing them to take charge of their own development. (29) Additionally, the benefits of mentoring apply not only to residents but to the wider system they are in. Since their personal and professional developments are enhanced, these may lead to increased trainee retention in training programs, enhanced team relationships, improve competence in patient care and elevate over-all improvement in the quality of mental healthcare services. (30)

De Souza asserts that mentoring must not be confused with direct work-related supervision and therapy or counseling. (31) Hameed and colleagues point out that mentoring can mean different things to different people and there may be a confusion between mentoring and other formal structures of support such as supervision, coaching, consultation, befriending, and even counseling. (32) Mentoring is none of the above but at the same time a combination of them. Mentoring may overlap with coaching, which is viewed as building particular skills and focusing on a narrowly defined task or goal. The difference is that mentors, who have more experience in the profession, convey and instill the standards, norms and values of the profession with a holistic broader view (33).

Since there will be investment in time, effort, and resources for mentoring programs, this demands evaluation that may include any of the following: mentee empowerment and training, mentor training, aligning expectations, mentor self-reflection, and mentee evaluation of mentor. It is also important in the long run to evaluate the sustainability of the program. (34) Mentoring relationships last for varying lengths of time but they can continue after the training stages in order to include guidance in the early stages of practice. (24) It is a formative and developmental relationship that can significantly impact the personal and professional life of an individual.

What is the state of mentoring in Psychiatry training in the Philippines at present?

Informal mentoring between consultants (mentor) and residents (mentee) is being conducted in some training programs. These programs, however, must be formalized, structured, and standardized in order to ensure the quality and consistency of its benefits. Mentoring programs must be embedded in all Psychiatry residency training programs in the Philippines and must essentially be part of the evaluation of training programs for accreditation.

Training on how to design, run, and evaluate a mentoring program is a significant activity that ensures the success of the mentoring endeavor. Collaboration among the different training institutions is highly encouraged and supported by the Board because this will guarantee that the program outcomes are uniformly aspired for and achieved.

Objectives

General: The mentoring program must empower and support Psychiatry residents in their training and future career development in order to increase their professional satisfaction, well-being, positive work experiences, and career attitudes.

Specific: The mentoring program must:

1. Provide resources and support to ensure that mentors and mentees have productive, fulfilling, and sustainable interactions.
2. Help the trainees realize their full potential by helping them take charge of their own development.
3. Provide a nurturing learning environment where networking between mentors and mentees are facilitated.
4. Provide mentors with opportunities to develop their skills, knowledge, and attitudes related to their mentoring roles.
5. Provide mentors with opportunities to share their wisdom and experience to mentees.
6. Support and guide mentees in order to ensure trainee retention, enhanced team relationships, and improvement in the quality of mental healthcare services.
7. Evaluate its effectiveness.
8. Produce and/or publish research outputs on mentorship of psychiatry residents.

Proposed Methodologies

A. Training of mentors

B. Matching/selection of mentees/mentors

C. Orientation sessions
D. Mentorship sessions
E. Collaboration among the training institutions in developing mentoring programs

III. Gender Sensitivity

Gender and gender role orientation increasingly assume salient functions in mental health and illness both on the individual and community levels. A study of young adolescents showed that perceived gender role influences one's expression of empathy. (35) Another study showed that adolescents who possessed both positive masculine and feminine qualities in their self-concept had optimal levels of school-related well-being. (36) The rapid increase in transgender and gender diverse people seeking medical help has created a transgender healthcare system that is evolving into an interdisciplinary field. (37) Gender may be a factor that contributes to poor mental health because of stigma, social inequality, and discrimination. For instance, mental health conditions such as anxiety, depression, and low levels of well-being are more common among women. (38). Gender and gender roles may also influence the prevalence, symptom profile, age of onset, comorbidities, functional impairment, and prognosis of mental disorders. Furthermore, gender-related factors have important implications to treatment response. (39) The major systems of classification of mental disorders, namely DSM 5 and ICD 11, contain stand-alone chapters for gender-related mental disorders. (40, 41, 42).

It is imperative that psychiatrists possess a firm and thorough understanding of the concepts of gender and gender role orientation because this has serious implications on the diagnosis and management of mental disorders and the establishment of a therapeutic relationship and the quality of patient care. (43) The Philippine Psychiatric Association, through the Board of Accreditation of the Specialty Board of Philippine Psychiatry therefore require the incorporation of learning activities on gender sensitivity in all psychiatric residency training programs in the country.

Objectives
General: At the end of the course, the psychiatric resident must be able to integrate the principles of gender sensitivity to clinical practice.

Specific: At the end of the course, the psychiatric resident must be able to

1. Illustrate how the theoretical foundations of gender and gender role orientation are applied in medicine and psychiatry.
2. Compose biopsychosocial formulations of patients that integrate gender and gender role concepts.
3. Design and implement gender sensitive interventions for patients and their families.
4. Propose and/or researches on gender and gender role orientations.

Proposed Methodologies

1. Didactics
2. Seminars
3. Workshops
4. Focus group discussions
5. Case conferences
6. Clinical supervision

Ideally, this learning exercise should be accomplished during the resident's second year of residency training.

Proposed Topics

Learning activities include, but are not limited to, the following topics.

1. Key concepts on gender
2. Sex and gender differences in health
3. Guidelines on anti-sexual harassment
4. Gender sensitive healthcare
5. Gender sensitive language
6. Gender sensitive clinical practice
7. Gender aspects in psychiatry, psychodynamics, and psychotherapy

IV. Religion and Spirituality (R/S) and Psychiatry

In recent time, the relevance of R/S to health issues has been increasingly studied. Literature abounds with empirical researches that demonstrate the relationship between R/S and health. The concepts of religion and spirituality (R/S) have been used synonymously because of the lack of a universally agreed definition. (44) At present, religion and spirituality are viewed as distinct yet overlapping concepts. Spirituality is a broad concept that involves a dimension of subjective, embodied, and emotional experiences of closeness and connection with the sacred or transcendent or to ultimate reality.

Spirituality is intimately linked with values, meaning and purpose and it develops individually or in communities and traditions. In contrast, religion is the institutional aspect of spirituality. It involves a search for importance in the context of adhering to established and organized beliefs, behaviors, and practices that are part of a particular faith tradition, community, or social group. (44, 45, 46, 47, 48) Spirituality is more popular than religion because it is self-defined and inclusive. Religion, on the other hand, may be unpopular because of its potential to be divisive.

The growing interest in the role of R/S in health care in general and in mental health care in particular has led to studies that show that patients want their R/S concerns addressed by health care providers. (44) In fact, the World Health Organization considers R/S as an essential quality of life element (49). A meta-analysis of 48 longitudinal studies showed evidence for a positive effect of R/S on mental health (50). The association of R/S with mental health has an even greater implication for global public health because more than 84% of the world's population has some religious affiliation. (51). Specifically, attendance in religious services has been significantly asso-ciated with greater longevity, less depression, less suicide, less smoking, less substance abuse, better cancer and cardiovascular disease sur-vival, less divorce, greater social support, greater meaning and purpose in life, greater life satisfaction, greater wellbeing, more charitable giving, more volunteering, and greater civic engagement (44, 52, 53). King and Bushwick found that 94% of patients believed spiritual health was as important as physical wellbeing. Although 77% of the patients wanted spiritual matters to be considered in their care, only 10-20% had conversations with their physician on the topic. (54)

R/S has significant implications on the prevalence, diagnosis, outcomes, and prevention of mental disorders (44). Fitchett and colleagues reported that 80% of psychiatric patients expressed the need for prayer and 65% of them needed a visit from a chaplain to pray with them. (55) Studies also suggest that R/S is related to greater subjective well-being, life satisfaction, and marital satisfaction, as well as to decreases in mental health problems such as depression, suicide, delinquency, and alcohol and drug use. (56).

On the other hand, R/S may be associated with negative health outcomes, such as depression, obesity, poor compliance to treatment and even oppression and violence (57). Religious crises may lead to distress or be symptoms of psychopathology (e.g., delusions or hallucinations). Religion may also become a problem when it is used to avoid making changes in attitude or behavior or when religious teachings are rigidly and inflexibly applied. (52) The integration of R/S in psychotherapy has been shown to result in greater improvement in psychological and spiritual functioning compared with no treatment and non-R/S psychotherapies. R/S-adapted psychotherapy influences treatment through case formulation, treatment goals, interventions, and interpersonal processes. (47) Despite this evidence, most psychotherapists receive little or no training in R/S issues. One possible explanation to this problem is the absence of an agreed-upon R/S competencies or training guidelines. (48)

R/S contributes to the psychological wellbeing of residents which, in turn, is associated with greater sense of work accomplishment, overall self-rated health, lesser burnout and depressive symptoms, and better therapeutic relationship. These redound to better treatment adherence and coping among patients. (46)

In the Philippines, the Philippine Council for Mental Health (created through Republic Act 11036) calls for a reorientation of the concept of mental health. It advocates for the integration of the spiritual dimension of health in the extant biopsychosocial model of health. This movement is also being pursued in government sectors apart from the health sector. (58) In other parts of the world, psychiatrists – regardless of their religious, spiritual, or philosophical orientations – are urged to include R/S in the evaluation and management of patients. Studies show, however, that mental health professionals fail to integrate R/S in clinical practice because of several reasons. A major impediment is the lack of formal training. Many psychiatry residency training coordinators and faculty have an insufficient knowledge of the subject and a lack of time to include it in training. In addition, they are apprehensive about proselytizing or introducing an unscientific approach and adding another topic to an already full curriculum. (57) There are few psychiatry training programs that integrate R/S

in research and clinical practice.

The World Psychiatric Association (WPA) and national psychiatric organizations from Brazil, India, South Africa, UK, and USA created organizational sections on R/S. In addition, WPA has included R/S in the core training curriculum for psychiatry. (44, 57) Courses in psychiatry residency programs in North America are being developed to address this important aspect of life. The American Accreditation Council for Graduate Medical Education and the American Psychiatric Association (APA) emphasize the importance of addressing spiritual issues in psychiatry training. The APA has started to establish R/S competencies for psychiatrists. In addition, the American Association of Medical Colleges and the Joint Commission on the Accreditation of Healthcare Organizations in the US, require the incorporation of R/S in patient care. (47) In Canada, psychiatric residency training programs are increasingly mandating training in R/S (59, 60). De Oliveira and colleagues developed a comprehensive R/S curriculum based on a review of prevalent strategies of training and recommendations from psychiatric associations. This curriculum consists of a 12-hour course for psychiatry residents that is easily implementable even if the faculty does not have expertise in R/S and there is little time to learn it. (57)

R/S is woven into the fabric of the core beliefs, values, and experiences of many Filipinos. These constructs should therefore play a central role in academic, clinical, and investigative psychiatry in the Philippines. At present, the Philippine Council for Health Research and Development is working on identifying aspects of R/S that are relevant to mental health research in the country. (61) In the Philippines, most psychiatry residency training programs do not incorporate formal and systematic courses on R/S. The Board of Accreditation therefore requires inclusion of this course in psychiatry residency training because of its benefit to resident trainees and, ultimately, patients.

Objectives

General: At the end of the course, the psychiatry resident must be able to apply the concepts and principles of R/S in mental health care.

Specific: At the end of the course, the psychiatry resident must be able to:

1. Conceptualize R/S as an important aspect of human diversity along with factors such as race, ethnicity, sexual orientation, socioeconomic status, disability, gender, and age.
2. Discuss how R/S are distinct yet overlapping constructs.
3. Compare the diverse forms of R/S.
4. Discuss the positive and negative ways by which R/S affects mental health.
5. Discuss how patients' R/S develops and changes over the lifespan.
6. Construct a complete R/S history as a routine part of psychiatric practice.
7. Integrate the bio-psycho-socio-spiritual elements of a case in the diagnostic process and the treatment plan.
8. Demonstrate the psychodynamic aspects involving R/S issues in psychotherapy (e.g., transference, countertransference).
9. Disseminate information about the relationship of R/S and mental health to the wider community as a way of helping promote the health and wellbeing of individuals.
10. Formulate ways by which his/her patients may access their R/S strengths and resources.
11. Apply evidence-based strategies or interventions in addressing the mental health issues and mental disorders of patients with diverse R/S backgrounds.
12. Contrast the experiences of patients that are consistent with their R/S and those that are part of psychopathological processes.
13. Examine legal and ethical issues related to R/S that may arise when working with patients.
14. Demonstrate empathy, respect, and appreciation for patients from diverse spiritual, religious, or secular backgrounds and affiliations.
15. Examine how his/her own R/S background and beliefs influence his/her clinical practice and his/her attitudes, perceptions, and assumptions about the nature of mental processes.
16. Assess his/her R/S competence continuously.
17. Demonstrate the willingness to collaborate with leaders or members of faith communities, chaplains, pastoral workers, clergy, and other qualified individuals and groups in support of the wellbeing of their patients.

18. Analyze current research on the relationship of R/S to clinical practice.
19. Propose and/or publish researches on the relationship between R/S and physical and mental health.

Proposed Pedagogical Strategies

1. Blended and hybrid learning
2. Didactics
3. Seminars
4. Workshops
5. Focus Group Discussions
6. Case conferences
7. Supervision
8. Feedback
9. Reflective practice
10. Faculty and peer support

This course is recommended during second year of residency training. In developing this course, the training program committee must be cognizant of the following caveats: (1) R/S is not more important than other core areas of mental health; (2) residents are not required to gain in-depth knowledge of theologies or R/S concepts and traditions around the world; and (3) R/S does not apply only when working with highly religious or spiritual patients. The residency training program committee must be able to identify hindrances to R/S-related training and assess the outcomes of R/S-related curriculum including how they affect the wellbeing of patients and residents through time. (46)

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