How to Submit a Symposium

Format Description:

- A three-hour session
- Focused on a specific scientific or clinical relevant topic in psychiatry
- Provides a more formal didactic approach than other session types.
- Speakers represent several points of view
- Minimum of one chair, one discussant, and three speakers (can include chair and discussant)
- Maximum of one chair, one co-chair, one discussant, and five speakers.

Checklist for your submission:

- Chair MUST be submitter
- Overall Title of the symposium (maximum of 150 characters, with spaces)
- Participants information
  - Completed Profile by all participants **
- Educational Learning Objectives
  - Minimum of three objectives, maximum of five
  - Maximum 200 characters with spaces per objective
  - Example of learning objective: Please use active words like demonstrate, understand, provide in the statement. At the conclusion of this presentation the participant should be able to: 1) Demonstrate…..2) Provide..................3) Understand...................
- Overall symposium abstract (maximum of 3000 characters, with spaces)
  - The abstract should be a concise description of results, findings, or the importance of presentation. It should provide a strong summary of the presentation(s).
- Select Topic (Track is optional)
- Presenters must be available to present at the Annual Meeting.
- Create agenda for the 3-hour symposium with enough time for substantial interactive and Q &A

The tabs at the top will stay red if you have not completed all items; it will become green after you have completed all steps. After all tabs are green ensure you have FINALIZED your submission. Any submission that is not finalized will NOT be sent to grading.

**All presenters must have completed profiles and financial disclosures for the submission to be considered for review by the Scientific Program Committee. All presenters must register for the meeting prior to the presentation**
Example of Symposium Submission

FRONTAL - SUBCORTICAL NETWORKS AND NEUROPSYCHIATRIC CONCEPTS FOR GENERAL PSYCHIATRISTS

Chairs: Sheldon Benjamin, M.D., David Silbersweig, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Provide several clinical examples of the importance of neuropsychiatry knowledge to general psychiatry practice; 2) Describe what is meant by prefrontal / executive function and prefrontal-limbic-subcortical circuits; 3) List several syndromes seen by psychiatrists in the setting of prefrontal dysfunction, including disorders of motivation, traumatic brain injury, and movement disorders.

SUMMARY:
General psychiatrists are increasingly called upon to evaluate and treat neuropsychiatric disorders. The inclusion of milestones in clinical neuroscience for general psychiatry trainees by the Accreditation Council on Graduate Medical Education (ACGME) is one indicator of the importance of neuropsychiatric education for general psychiatrists. Another indicator is the enhanced role psychiatrists will play in Accountable Care Organizations if they can manage the complex differential diagnosis and treatment of patients with neuropsychiatric disorders, whose care can otherwise be quite costly.

Neuropsychiatric training may be acquired by combined or dual neurology-psychiatry residency training, by fellowship training following general psychiatry or neurology training, or by specialization during general psychiatry or neurology residency. The ACGME clinical neuroscience milestones, implemented in July 2014 as a guide for general psychiatry training, may also serve as a guide to competent neuropsychiatry practice for general psychiatrists. They require demonstration of knowledge, skills, and attitudes in 5 areas: neurodiagnostic testing, neuropsychological testing, neuropsychiatric co-morbidity, neurobiology of psychiatric disorders, and applied social neuroscience.

After presenting a review of prefrontal/executive function and prefrontal-limbic-subcortical circuits, three families of disorders at the interface of psychiatry and neurology that commonly present to psychiatrists will be reviewed: disorders of motivation, traumatic brain injury, and psychiatric comorbidities of extrapyramidal disorders. Each of these families of disorders impacts prefrontal-subcortical circuits of importance to psychiatrists. In all of them, knowledge of the relevant neuroanatomy, pathophysiology, and bedside neuropsychiatric examination leads to better understanding of the patient and increased treatment sophistication. These disorders also embody the aforementioned clinical neuroscience milestones.

NO. 1
INTRODUCTION TO CLINICAL NEUROSCIENCE EDUCATION FOR PSYCHIATRISTS

Speaker: Sheldon Benjamin, M.D.

SUMMARY:
The ACGME clinical neuroscience milestones, implemented in July 2014 as a guide for general psychiatry training, may also serve as a guide to competent neuropsychiatry practice for general psychiatrists. They require demonstration of knowledge, skills, and attitudes in 5
areas: neurodiagnostic testing, neuropsychological testing, neuropsychiatric co-morbidity, neurobiology of psychiatric disorders, and applied social and emotional neuroscience. The recent development of these milestones combined with the increased value to accountable care organizations of psychiatrists competent to manage complex neuropsychiatric presentations make neuropsychiatric knowledge. This presentation will include an overview of the clinical neuroscience milestones, a review of neuropsychiatry training pathways, and an introduction to the symposium theme.

NO. 2
A USERS GUIDE TO THE FRONTAL LOBES: WHY PREFRONTAL EXECUTIVE FUNCTION MATTERS
Speaker: Sheldon Benjamin, M.D.

SUMMARY:
Psychiatrists have often looked to their neuropsychology colleagues for testing and interpretation of executive deficits. Yet prefrontal and executive functions are major determinants of success in rehabilitation from any psychiatric or neuropsychiatric disorder, so psychiatrists should be expert in this area. After providing simple explanations of prefrontal and executive function and frontal-subcortical circuits, psychiatric and neuropsychiatric disorders that may involve dysfunction in these circuits will be considered. Prefrontal syndromes with predominantly dorsolateral, orbitofrontal, and cingulate dysfunction will be reviewed. Finally, a few easy to use bedside tests of prefrontal/executive function will be presented with an emphasis on real-world behavioral correlates.

NO. 3
FRONTO-LIMBIC-SUBCORTICAL DISORDERS OF MOTIVATION
Speaker: David Silbersweig, M.D.

SUMMARY:
Neuropsychiatric disorders of motivation offer insights ranging from the clinical (e.g. diagnosis, treatment) to the philosophical (e.g. free will). The frontal-limbic-subcortical brain circuitry underlying goal directed behavior will be reviewed. Examples of related disorders and syndromes will be discussed. These include Tourett’s Syndrome, OCD, anhedonia, apathy, akinetic mutism, and impulsivity. These considerations will be integrated into a neuropsychiatric model and approach that transcends neurology-psychiatry distinctions.

NO. 4
NEUROANATOMY AND NEURAL CIRCUITRY OF NEUROBEHAVIORAL CHANGES AFTER TBI
Speaker: Thomas W. McAllister, M.D.

SUMMARY:
Traumatic brain injury (TBI) represents the quintessential neuropsychiatric paradigm: it is difficult to appreciate what an individual with TBI and their family experience without understanding the brain regions impacted by biomechanical trauma, and it is equally critical to understand the effect of injury-related neurobehavioral sequelae on outcome after TBI. The neurobehavioral effects of TBI include changes in cognition, changes in personality, and increased risk of developing a host of psychiatric disorders. These neurobehavioral sequelae follow logically from the typical profile of injury associated with TBI. Several cortical regions including frontal cortex, temporal cortex, and hippocampus are particularly vulnerable to TBI.
Furthermore, sub-cortical white matter, particularly in frontal regions and the corpus callosum, are often damaged. Catecholaminergic, cholinergic, and serotonergic systems are vulnerable to disruption acutely and chronically in TBI. These brain regions and neurotransmitter systems are critical components of key frontal subcortical circuits that modulate complex human emotional expression and behavior. This profile of structural and neurochemical injury plays a direct role in the common neurobehavioral sequelae associated with TBI.

NO. 5
TREATING PARKINSON DISEASE AND OTHER NEUROPSYCHIATRIC DISORDERS: THE ADVANTAGES OF COMBINED TRAINING IN NEUROLOGY AND PSYCHIATRY
Speaker: John F. Sullivan, M.D.

SUMMARY:
One historical distinction between neurologic and psychiatric pathology is the ability of “neurologic” illness to be more clearly localized neuroanatomically. Advances in our understanding of brain function, catalyzed by evolving imaging technology, have demonstrated that psychiatric illnesses and symptoms do have neuroanatomic correlates, but may be better localized to networks rather than to discrete neural structures. Parkinson disease, long considered primarily a movement disorder and purely “neurologic” is now accepted as a neuropsychiatric disorder with hallmark psychiatric and cognitive symptoms that emerge and evolve in parallel with the motor symptoms. Awareness of meso-cortical and meso-limbic dopaminergic pathways, as well as the role of the basal ganglia in multiple frontal-subcortical networks, is helpful to understand, predict, and manage the non-motor symptoms of Parkinson Disease and related disorders. Combined training in neurology and psychiatry is invaluable in treating neuropsychiatric disorders, providing a thorough grounding and familiarity with the natural history, diagnostic tools, and treatments used by clinicians in both fields to assess and care for these patients.

Example of Symposium Submission

UPDATES IN WOMEN’S HEALTH
Chairs: Linda L. M. Worley, M.D., Christina L. Wichman, D.O.
Discussant: Michelle Riba, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List the consequences of intimate partner violence; 2) Describe the psychological impact infertility and pregnancy loss can have on a patient and her partner; 3) Describe the risks of psychotropic medication use to the fetus and breast-feeding infant; 4) Compare risk and benefits of methadone versus buprenorphine in pregnancy; 5) Describe common sexual difficulties associated with sexual trauma, infertility and fetal loss.

SUMMARY:
Working in the field of women's mental health is both challenging and extremely rewarding. The rapid influx of literature addressing whether a medication is safe to prescribe in pregnancy and lactation creates great angst for the clinician in the field. Staying abreast of state of the art perinatal pharmacotherapy is critically important. It is also essential to recognize the prevalence of trauma in the lives of the women who seek relief from ongoing pain and suffering. Psychosomatic medicine physicians treating women throughout their reproductive
years encounter many women who continue to struggle with complex presentations including tobacco, alcohol and illicit substance use along with co-morbid medical and psychiatric conditions. This symposium will focus on the practical treatment of these women.

We will begin by reviewing the scope of the problem of trauma and violence in the lives of women and how it is often associated with co-morbid medical, psychiatric and substance use disorders. Psychosomatic medicine experts in women's health will discuss the psychological impact of infertility and pregnancy loss, and strategies in working with these women and their partners. Psychopharmacological management for pregnant and breast-feeding women who suffer with depression, anxiety, PTSD, bipolar and psychotic disorders, and substance use disorders (including tobacco, alcohol and opioids) will be reviewed in detail. Examples of clinical documentation will be provided. Participants will be armed with the tools to critically analyze future publications. Lastly, addressing the sexual well-being of these patients will be discussed. Throughout the symposium, clinical cases will be interwoven demonstrating the implementation of evidence-based practices in a clinical setting.

NO. 1
INTIMATE PARTNER VIOLENCE AND PSYCHOSOMATIC MEDICINE
Speaker: Donna Stewart, M.D.

SUMMARY:
Intimate partner violence (IPV) is a global human rights and public health issue that disproportionately affects women. Physical and mental health disorders are common sequelae of IPV and both have relevance to general psychiatrists and psychosomatic medicine specialists. In addition to signs of acute trauma (e.g., fractures, contusions, lacerations etc.), less obvious physical symptoms (chronic pain, musculoskeletal complaints, chronic fatigue, irritable bowl and medically unexplained symptoms) may be seen by psychiatrists, often without the patient disclosing IPV. Psychological disorders which may follow IPV include depression, anxiety, PTSD, sexual disorders and insomnia, again without IPV disclosure.

This presentation will review the epidemiology, risk factors, physical and mental health sequelae of IPV and how to inquire about, and respond to, IPV by mental health professionals.

NO. 2
MANAGEMENT AND ASSESSMENT OF ALCOHOL, TOBACCO AND OPIOID USE DISORDERS DURING PREGNANCY
Speaker: Leena Mittal, M.D.

SUMMARY:
Substance use disorders in women can present differently than in men, often with a distinct natural history, and their persistence during pregnancy raises unique concerns for treaters. While pregnancy is a time of great motivation to improve health-related behaviors resulting in decreases in use of tobacco, alcohol and other addictive substances, there is a subset of women who are unable to stop use of substances during pregnancy. These patients represent a more refractory subpopulation of substance use disorders requiring a collaborative approach informed by principles of perinatal psychiatry and a knowledge of their obstetrical needs. In this presentation, assessment and management of alcohol, tobacco and opioid use disorders during pregnancy will be discussed.
NO. 3
INFERTILITY AND PERINATAL LOSS: WHEN THE BOUGH BREAKS
Speaker: Nancy Byatt, D.O., M.B.A.

SUMMARY:
A substantial number of women and their partners suffer from perinatal loss and infertility. Approximately half of stillbirths occur in seemingly uncomplicated pregnancies. Despite evaluative efforts, in half of all stillbirths, no cause for fetal demise is ever found. Women suffering from a stillbirth may experience sadness, guilt, or anxiety symptoms, including symptoms consistent with PTSD. Evidence is controversial regarding how to best handle perinatal loss, especially regarding delivery and contact with the infant. Additionally, up to 10% of couples suffer from infertility. Women who suffer from infertility have higher rates of depression and anxiety and these rates may increase as fertility treatment progresses. The presentation will provide the knowledge base that providers need when evaluating and treating women with infertility and/or perinatal loss. The presentation will describe: 1) the psychological effects of infertility and perinatal loss; 2) how to best support and treat women and their partners who are suffering from infertility and/or a perinatal loss; and, 3) how to collaborate with other providers (reproductive medicine, OB/GYN, and maternal-fetal medicine) to provide the best care.

NO. 4
PSYCHOTROPIC MEDICATION MANAGEMENT IN PREGNANCY AND POSTPARTUM FOR DEPRESSION AND ANXIETY.
Speaker: Madeleine Becker, M.D.

SUMMARY:
Depression and anxiety are common in pregnancy and in the postpartum period. Untreated psychiatric illness during and after pregnancy has been associated with adverse effects on the mother and the baby. Despite this, many women are either undertreated, or untreated, as doctors may be hesitant to recommend medications to pregnant or lactating mothers. Subsequently, women may not be well informed of the risks and benefits associated with the use of taking medications during pregnancy. This presentation will:
1. Discuss the impact of untreated depression and anxiety disorders in pregnancy and postpartum;
2. Discuss treatment decision-making, both to help guide the practitioner and to help educate the patient;
3. Summarize the current data on the safety of antidepressant/anxiolytic medication use in pregnancy;
4. Provide an overview of the safety of antidepressants and anxiolytics in lactation.

NO. 5
PSYCHOPHARMACOLOGIC APPROACHES IN THE PERINATAL PERIOD: MOOD STABILIZERS AND ANTIPSYCHOTICS
Speaker: Christina L. Wichman, D.O.

SUMMARY:
Psychiatric disorders during pregnancy and the postpartum period are very common and as such, psychiatrists are often asked to evaluate and treat pregnant and postpartum women. Unfortunately, psychiatrists often do not feel well-equipped to manage treatment of perinatal
patients, especially with the use of mood stabilizers and antipsychotics; this is in part due to the concerns about the potential impact of medications on the fetus, pregnancy and delivery itself, and/or lactation. Trying to navigate the literature on the safety of these medications during pregnancy and lactation can also be confusing and frustrating due to conflicting and controversial evidence. We will provide an overview of the current evidence for the using mood stabilizers and antipsychotics during pregnancy and lactation. Additionally, information as to how to document these conversations with patients will be provided.

NO. 6
PROMOTING SEXUAL HEALTH AND WELL-BEING
Speaker: Linda L. M. Worley, M.D.

SUMMARY:
Sexual difficulties (e.g. decreased desire, discomfort, dissatisfaction and difficulty achieving orgasm) are highly common in the lives of the women we treat, yet limited curricula exist within medical school or psychiatric training devoted to achieving competence in this area. This brief presentation will address 1) What our patients need from us when they have sexual complaints; 2) How to ask about sexual health; and 3) What to recommend to help achieve overall sexual health and wellbeing. Clinical examples will be provided.

ONE DREAM, THREE PERSPECTIVES: THE PLACE OF THE DREAM AND DREAMING IN CLINICAL PRACTICE AND TRAINING
Chairs: Mark D. Smaller, L.C.S.W., Ph.D., Harriet L. Wolfe, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the controversy over the place of the dream in clinical practice; 2) Differentiate between three theoretical views of dreams: Freudian, British School and Jungian; 3) Recognize opportunities for dream interpretation within a clinical hour.

SUMMARY:
Dreams have held interest for individuals and cultures for millennia and in the last century were thought to be a "royal road to the unconscious". Concurrent with growing cultural interest in fast news and medical/economic interest in fast cures, many clinicians' interest in dreams has waned. Nonetheless, the creation of a dream and the place of dreaming in a person's life and in the context of a clinical treatment offer unique points of access to personal meaning and clues to a patient's strengths as well as his/her psychological challenges. The way a dream is understood and discussed holds great potential for enhanced resilience.

This Symposium will offer three different psychoanalytic perspectives on dreaming and emphasize the value of dreams clinically and pedagogically. An analytic session with a dream embedded in it will be presented. Three psychoanalysts representing Freudian, British School and Jungian perspectives will discuss their understanding of the dream, show how they would use the dream in the clinical hour with the patient and describe how they would introduce a psychiatric resident to analytic theory and technique as it relates to understanding and discussing a dream with a patient.

NO. 1
A DREAM WITHIN AN ANALYTIC SESSION
SUMMARY:
The presenter will first introduce the clinical context for an analytic hour in which a particular
dream was reported by her patient. This is the dream that three analysts will discuss from
three different psychoanalytic perspectives. After commenting on how she herself thinks
about dreams and their use in a psychoanalytic treatment, the presenter will read the entire
clinical hour in which the dream appeared and will repeat the dream to help the audience hold
it in mind.

NO. 2
A FREUDIAN PERSPECTIVE ON THE PATIENT'S DREAM
Speaker: Harriet L. Wolfe, M.D.

SUMMARY:
A Freudian perspective on dreaming is often focused on the symbolic meaning of dream
elements and on references to unconscious aspects of a patient’s conscious experience and
symptoms. Contemporary Freudians are also interested in how the dream informs the
patient’s transference to the therapist (its relational meaning) and the developmental level of
the patient’s effort to solve an aspect of his/her dilemma. Technical questions related to if and
when to interpret a dream directly and how to listen to a patient's associations to a dream will
be discussed.

NO. 3
A BRITISH SCHOOL PERSPECTIVE ON THE PATIENT’S DREAM
Speaker: Adam J. Goldyne, M.D.

SUMMARY:
This discussion will focus on a number of aspects of British thinking about dreams and
dreaming. First, for British psychoanalysts influenced by Bion, the colloquial/Freudian
definition of “dream” (a conscious experience occurring while asleep) coexists with use of the
term “dream” to denote the mental function that generates unconscious meaning from raw
emotional experience. It is possible for a patient to have a dream in the colloquial sense, but
not to be “dreaming” in the Bionian sense. Conversely, dreaming in a Bionian sense can occur
while asleep or while awake (“waking dream thought”). When the dreaming function is
working, everything that the patient says during the session may be heard as a waking dream,
narrating the patient's here-and-now emotional experience of the session and the
transference. We will consider the patient’s dream (colloquially defined) and the rest of the
session (the waking dream) with these ideas in mind.

NO. 4
A JUNGIAN PERSPECTIVE ON THE PATIENT’S DREAM
Speaker: Barbara Zabriskie, Ph.D.

SUMMARY:
In a Jungian approach, as in contemporary emotions research, dreams emerge from the
experience of an individual as a mind-body continuum. Stimulated by charged emotions
arising from a psycho-physical self, they employ narratives, images, and personifications to
represent and symbolize unmetabolized affects and states of mind. Integration of the issues
emerging from dreams can enhance the dreamer's capacity to calibrate feelings and projections. Dreams focus attention on unconscious dynamics which complement or compensate daytime consciousness, called the "remembered present" by the neuroscientist Gerald Edelman. In an analytic process, when patient and clinician engage a dream together, the insights often augment, amend, and relativize embedded attitudes. References to similar images in mythologies and religions place dreams in a historical and generational perspective.