circuits contribute to phenomena such as misattributed voices in psychosis and rigid, punitive inner critics in depression. In borderline and dissociative states, split-off self-voices remain unintegrated, sustaining affective instability. Psychotherapy process research shows that the emergence of second-person self-address (eg "You need to calm down") often marks a turning point, enabling patients to observe themselves and create an internal conversation between parts that were previously disconnected. Clinical techniques such as chair dialogues, parts work, and guided imagery capitalize on this dynamic by fostering constructive self-to-self communication.
Conclusions: This analysis proposes that internal dialogue should be recognized not only as a coping strategy, but as a philosophically rich marker of recovery. It challenges models that treat intrapsychic conflict as pathology and invites renewed attention to voice, address, and dialogic structure in psychotherapy. Further research may explore how therapeutic interventions can facilitate this inner dialogic emergence.

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EPV1148

Universality, Temporality, and the Invisible Suffering of Menopause: A Philosophical Perspective in Psychiatry

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Introduction: Psychiatry often orients around pathological deviation from normative life stages. Menopause challenges this framework: a universal, predictable transition that nonetheless generates profound psychiatric vulnerability. This raises questions about psychiatry's conceptual boundaries — how suffering is defined, when universality shields conditions from recognition, and how temporality shapes psychiatric risk.
Objectives: To explore the philosophical dimensions of menopause in psychiatry, with emphasis on (1) universality versus pathology, (2) temporality and psychiatric risk, and (3) the ethics of invisibility in women's midlife suffering.
Methods: We conducted a focused literature review spanning philosophy of psychiatry, feminist theory, and phenomenology of time. Sources included theoretical texts on universality, stage transitions, and recognition, as well as psychiatric and philosophical scholarship addressing menopause and midlife suffering.
Results: Three philosophical tensions emerged. (1) Universality versus pathology: Because menopause is normative, its psychiatric sequelae are often excluded from nosological frameworks, revealing a bias toward deviation rather than transition. (2) Temporality: Menopause highlights psychiatry's difficulty conceptualizing time, since risk emerges not from disorder alone but from a predictable biological threshold—paralleling how PMDD ties affective change to cyclical temporality. (3) Invisibility of suffering: The underrecognition of menopause in psychiatric discourse perpetuates structural neglect, leaving women's suffering conceptually and clinically unacknowledged.
Conclusions: Menopause demonstrates psychiatry's need to reconceptualize universality and temporality within its frameworks of suffering. Recognizing menopause as both a natural transition and a psychiatric risk state unveils the invisibility of women's suffering, challenging psychiatry to reframe its philosophical boundaries. Such engagement would advance psychiatry not only clinically, but conceptually, by foregrounding life transitions as central to mental health.

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EPV1149

Seizure Threshold, Suppression, and Expression as Dynamic Ontology in ECT

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Introduction: Electroconvulsive therapy (ECT) discloses a paradox at the core of psychiatric intervention: its efficacy depends upon the induction of a seizure, yet the seizure is always already bounded by forces that both enable and constrain it. Stimulus technique, anesthetic mediation, cumulative exposure, and symptomatic change all act upon a shifting limit known as the seizure threshold. This threshold is not a fixed property but a dynamic frontier—rising across a treatment course, adapting with clinical response, and requiring continual recalibration.
Objectives: To reconceive the seizure threshold as an ontological problem rather than a purely physiological measure: a moving boundary where suppression and expression, risk and efficacy, converge.
Methods: Conceptual analysis, informed by psychiatric literature but oriented toward philosophy of science, interrogating how "threshold" functions less as a quantifiable marker than as a contingent interface that resists closure within static models.
Results: The seizure threshold emerges as a dynamic limit shaped by multiple forces. It rises with treatment progression and often in parallel with symptomatic improvement, forcing clinicians to adjust stimulus dosing upward across a course. Anesthetic technique modulates its expression, altering seizure duration and cardiovascular tolerability, while stimulus parameters (unilateral vs. bilateral, pulse width, dosing algorithms) influence its trajectory. Clinical response itself feeds back into the system: as patients improve, the biological substrate of excitability shifts, altering the very boundary psychiatry relies upon. Failure to recalibrate risks underdosing and therapeutic non-response on the one hand, or excessive dosing and physiological burden on the other. What seems at first a technical issue is thus a conceptual one: the threshold is less a number to be measured than a liminal zone where psychiatry and anesthesia, biology and technique, illness and recovery meet.
Conclusions: ECT's reliability is paradoxically grounded in ontological instability. The seizure threshold adapts with time, technique,

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and therapeutic effect, obliging psychiatry to recognize efficacy as relational and contingent rather than fixed. To think the threshold philosophically is to see that suppression and emergence are not opposites but co-constitutive: the therapeutic act is continually reconstituted at their border. For psychiatry, this has practical implications—thresholds must be anticipated as moving targets, not assumed as constants—and conceptual ones, challenging the discipline to acknowledge that its most effective intervention depends on unstable, shifting conditions of possibility.

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EPV1152

Ethical Perspectives on Suicide and End-of-Life from Aristotelian Virtue Ethics to Modern Psychoanalytic Approaches: a critical appraisal and review of literature

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Introduction: Ethical debates on suicide and end-of-life choices have evolved significantly over time. Aristotle's virtue ethics emphasized that human flourishing (*eudaimonia*) depended on moral character as well as sound judgment, including decisions about life and death (MacIntyre A. *After Virtue.* 3rd ed. Notre Dame: University of Notre Dame Press; 2007). However, modern debates are more focused on autonomy, beneficence, and the clinician's duty towards preserving life, particularly within psychiatric settings.
Objectives: To critically appraise historical and contemporary ethical frameworks on suicide and end-of-life decisions, with particular emphasis on the transition from virtue ethics to modern psychoanalytic approaches.
Methods: A conceptual literature review was conducted, analyzing philosophical, psychiatric, and ethical sources. Key themes included virtue ethics, principles of biomedical ethics, psychodynamic theories of suicidality, and relational models of autonomy.
Results: The review shows a continuous shift in ethical reasoning about suicide and end-of-life care, moving from character-based to principle-driven and relational approaches. Virtue ethics emphasized the importance of moral character and the pursuit of a meaningful life within the community, whereas modern frameworks focus on autonomy while also incorporating relational dimensions (Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 8th ed. Oxford: Oxford University Press; 2019). Psychodynamic perspectives enrich this discussion by highlighting the influence of hopelessness, guilt, and interpersonal dynamics in suicidality (Maltsberger JT. *The descent into suicide.* Int J Psychoanal. 2004;85(3):653–670). More recent research promotes relational autonomy, emphasizing family involvement and community values in guiding end-of-life decisions (Dove ES, Kelly SE. *BMC Med Ethics* 2015;16:45). Together, these perspectives demonstrate how ethical analysis has expanded from the individual to the relational and societal level, offering clinicians a more comprehensive framework for practice.
Conclusions: The evolution from Aristotelian virtue ethics to psychoanalytic and relational approaches marks a shift towards a more nuanced perspective on suicide and end-of-life care. Thus, integrating autonomy, beneficence, and relational ethics provides clinicians with a balanced and compassionate framework for practice.

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EPV1153

Modes of Attention and the Clinical Mind: Distinguishing Meditation, Mindfulness, and Contemplation in Psychiatry

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Introduction: The psychiatric incorporation of mindfulness has advanced without a parallel precision in definition. Within both clinical and lay discourse, mindfulness is often conflated with meditation broadly, or with forms of contemplation oriented toward ethical or spiritual ends. This conceptual slippage obscures distinct phenomenological structures and risks importing unexamined assumptions into psychiatric care. Drawing from philosophy of mind, phenomenology, and clinical literature, this project examines the attentional, affective, and epistemic contours that differentiate meditation, mindfulness, and contemplation, and their respective implications for psychiatric practice.
Objectives: To (1) differentiate meditation, mindfulness, and contemplation as distinct attentional modes; (2) map their cognitive-affective mechanisms and therapeutic relevance; and (3) identify ethical and clinical consequences of categorical conflation.
Methods: A targeted literature review was conducted across psychiatry, cognitive neuroscience, and philosophical sources on attention, self-regulation, and contemplative traditions. Reference mining from seminal works supplemented database searches. Analytical comparison was guided by phenomenological description and conceptual analysis, with emphasis on constructs applicable to psychiatric intervention.
Results: Meditation is best understood as a structured practice of sustained attentional modulation, which may include but is not limited to mindfulness. Mindfulness, when defined with clinical precision, constitutes a present-focused, non-reactive attentional stance aimed at reducing maladaptive cognitive elaboration. Contemplation, in contrast, privileges intentional reflection—often value-laden—toward moral, spiritual, or existential objects. These modes diverge in intentionality, cognitive load, and affective orientation, with empirical evidence supporting mindfulness as the most directly applicable to relapse prevention in depression and anxiety (Psychother Psychosom 2018;87:184-186). Conflating these constructs risks inappropriate application, ethical overreach, and dilution of therapeutic effect.
Conclusions: A philosophy of psychiatry approach clarifies that the clinical import of mindfulness depends on its distinction from related practices. When these attentional modes are properly differentiated, psychiatry can deploy mindfulness with greater epistemic transparency, cultural sensitivity, and therapeutic precision —avoiding the erosion of its conceptual integrity under the weight of undifferentiated wellness rhetoric.

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