

Excruciating Mental States

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Something has been missing from the study of suicide and mental illness. It is a phenomenon of major import, but it barely has a name (Meerwijk & Weiss, 2011): the subjective experience of extreme mental suffering. Properly understood, excruciating mental states explain the apparent relationship between mental illness and suicide. But suicide is the tip of the iceberg: excruciating mental states are themselves an enormous problem that current medical and mental health models do not address. Easing the suffering of excruciating mental states would be a moral accomplishment comparable to curing cancer—and the tools to do so already exist.

The Public Health Model and Mental Health Model

The Public Health Model asserts that suicide is a phenomenon that can be ameliorated by government surveillance and intervention. Typical interventions include means restriction (such as drug prohibition and gun restrictions) and public spending on campaigns to raise awareness about suicide and reduce the stigma of mental illness, in hopes that more people will seek treatment. The Public Health Model takes as a given the Mental Health Model of suicide: that suicide is caused by specific mental disorders, and that increasing the prevalence of treatment of the causal disorders will prevent suicides. Mann (2002, p. 308) restates the main claims of the Mental Health Model:

Suicide is a complication of psychiatric disorders. The probability of suicidal behavior also depends on a diathesis that includes hopelessness and increased life-time impulsivity that may be related to a specific impairment of serotonergic input into the ventral prefrontal cortex. The management of suicidal behavior involves an assessment of risk, the treatment

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of the primary associated psychiatric disorder, and the reduction of access to highly lethal methods for committing suicide, such as guns.

Psychiatric disorders are taken to have a necessary or near-necessary (but not sufficient) role in causing suicide. A biochemical and/or neurological mechanism is presented; technical language hints that all will soon be known. Three interventions are suggested: surveillance, the treatment of primary psychiatric disorders presumed to cause suicidality, and means restriction.

Taken together, the Public Health Model and the Mental Health Model form the dominant model in governmental and medical approaches to suicide. This model is ubiquitous in government communications about suicide. "Suicide is a serious public health problem" is a string that occurs in that exact form in hundreds of journal articles. If suicide is mentioned in a news story, it is rare that the connection between suicide and mental illness is not also mentioned. This model has been promoted in government-funded "suicide awareness" campaigns since the turn of the 21st century, and people are hearing the message: more people endorse the beliefs promoted by the Mental Health Model (Deacon, 2013). Unfortunately, anti-stigma campaigns did not reduce the stigma of mental illness, and may have worsened it (Deacon, 2013).

The Public Health Model had great success over the 20th century in reducing all-cause mortality, infectious disease, and motor vehicle fatalities. In contrast, suicide rates have remained stubbornly stable, both in the United States and globally. Despite "alarming rise" being an extremely popular phrase in research articles and news stories about suicide, the overall picture of suicide rates, as long as they have been measured, is remarkable stability (Liu, 2009). Individual countries, local areas, and subpopulations experience fluctuation in suicide rates, and this fluctuation is occasionally dramatic, but over 90% of the variation in suicide rates over time is between-country, rather than within-country (Liu, 2009). Of course, it is possible that suicide rates would have risen dramatically without public health intervention. But the Public Health Model has not seen an easy victory with suicide. (The ever-rising prevalence of obesity is another embarrassment for the Public Health Model.)

Many have criticized the Mental Health Model in some form. Hjelmeland, Dieserud, Dyregrov, Knizek, and Leenaars (2012) highlight the problems with the psychological autopsy method used to establish the link between suicide and mental illness. In this study design, researchers match known suicides with controls, then interview their family members or other associates in order to posthumously diagnose or rule out mental disorders, often years after the death. The authors conclude that psychological autopsies "cannot constitute a valid evidence base for a strong relationship between mental disorders and suicide" (p. 605). Milner, Sveticic, and De Leo (2013) note that psychological autopsy studies performed in non-Western countries typically find rates of mental illness in suicide much lower than that found in the West. But whether or not there is a strong relationship between mental disorders and suicide, the Mental Health Model obscures the role of subjective suffering.

I argue that the dominant model excludes from consideration a most relevant phenomenon: extreme, prolonged mental agony. “Excruciating mental states” are the common factor among supposedly suicidogenic mental illnesses. It is this common factor, and not mental illnesses as syndromes, that is the necessary (but not sufficient) cause of suicide.

In fact, it would be surprising if psychological autopsy studies did *not* find an elevated rate of people who met the criteria for mental illnesses among suicides. This is because excruciating mental states are connected to mental disorders in three ways: mental disorders cause excruciating mental states; many mental disorders are themselves descriptions of excruciating mental states; and some mental disorders describe responses to excruciating mental states. The Mental Health Model fails to discriminate this factor common to mental disorder disease constructs and suicide.

The Excruciating Mental States Model

I provide an evolutionary account of excruciating mental states and argue that excruciating mental states themselves constitute an enormous problem, even aside from their connection to suicide. These mental states, much like chronic pain, impose an unnecessary burden of suffering; but unlike physical pain, the burden of excruciating mental states is one for which the Public Health Model offers neither acknowledgment nor help. The vast majority of people suffering a prolonged excruciating mental state do not commit suicide. I argue that they deserve *help* in the form of effective relief from this mental state; that effective tools are available to help them; that withholding these tools is not justified; and that the present public health and mental health system is not equipped to provide the kind of help that they need. If excruciating mental states, as I describe them, are a necessary causal element in suicide, then effectively treating these mental states could reduce suicide rates. But the more important reason to focus on extreme mental suffering is because, like excruciating physical pain, it is horrible in and of itself. It is also likely treatable in and of itself.

Direction and Magnitude of Allowable Error in the Evolution of Pain

Mental states are targets of selection, but selection’s aim is not always precise. Hunger and thirst are mental states (or qualia) used as signals to trigger a specific behavioral response. Minor thirst or brief hunger do not constitute suffering; a gentle nudge is usually enough to get the proper response. After days of thirst or weeks of starvation, however, thirst and hunger rise to the level of *excruciating*. Specifically,

it is extreme in intensity, prolonged in duration, and no available behavioral response can alleviate it.

Adequate food ensures that a specific behavioral response to hunger is possible. Under those conditions, signals like hunger and thirst must be tuned within precise limits. Hunger (and satiation) are signals used to regulate the timing, amount, and type of food consumed. In most people (at least for most of human history), the signal is effective. It can go wrong in two ways: false positives and false negatives. In severe cases of polyphagia, the hunger signal never turns off, no matter how much food is consumed. Similarly, in polydipsia—which is often associated with schizophrenia—sufferers are always thirsty, and frequently present with water intoxication (de Leon, Verghese, Tracy, Josiassen, & Simpson, 1994). These are false positives. The absence of appropriate hunger and thirst sensations over a long period of time make up the false negatives. Either error is potentially lethal. In the case of the false positive errors, the danger lies in repeatedly performing the behavior indicated by the signal: feel thirsty, drink water, feel thirsty, drink even more water, die of water intoxication. Not all signals are associated with a clearly indicated behavioral response, however.

Now consider physical pain. Physical pain encompasses a wide variety of possible sensations from a wide variety of causes. Some physical pain is limited in duration and has a clear behavioral response (e.g., the pain of sudden skin contact with a flame, or the prick of stepping on something sharp). Most pain, however, has no particular behavioral remedy. The pain of migraine has no signal value. Pain can persist years or decades after a traumatic injury with no behavioral remedy. Neuropathic pain is especially useless.

The absence of the capacity to feel pain (false negatives) is dangerous and lethal, contributing to mortality in congenital analgesia as well as acquired analgesia, as in leprosy. Experiencing a great deal more pain than is necessary, however, seems to be the normal state of human (and probably all animal) life. False positives for pain, since they have no clear behavioral remedy that might alter an equilibrium, do not seem to detract from fitness much. The poor Similaun Iceman (Kean, Tocchio, Kean, & Rainsford, 2013) frozen in the ice for 5,000 years had healed fractures, arthritis, and spinal damage, and must have lived with extreme pain. His tattoos, arranged near his painful injuries, may have been attempts to treat this pain. Opiates have probably been in use for almost as long (Guerra-Doce, 2015).

It is useful to distinguish between two types of “errors” that we might imagine to be possible. First, if the pain system itself breaks down and signals pain when no stimulus is present, as in neuropathic pain, then this is an *empirical* error. Second, if the stimulus detection apparatus is working perfectly as designed by the process of selection, but causes the organism to suffer beyond reason, then this is a *moral* error. For instance, injury (in humans and other animals) often results in *sensitization*, causing the organism to experience innocuous stimuli as painful, and noxious stimuli as extremely painful. It may be the case that this pain response pattern evolved to protect injured animals against future predation (Crook, Dickson, Hanlon, & Walters, 2014), but people experiencing chronic pain have their own interests distinct from the pseudo-interests of selection. Since a great deal of pain

is useless (a “false positive”), relieving pain improves quality of life. From over-the-counter analgesics to opiates to anesthesia, the relief of pain *in and of itself* is a major priority for medicine.

Pain may play a role in suicide. Gray et al. (2014), for instance, found that 45% of Utah suicides in 1 year were experiencing acute pain, compared to 20% of accidental and undetermined deaths. Severe pain was also found to predict suicide in veterans (Ilgen et al., 2010). However, most people in extreme pain do not commit suicide. Only when the *excruciating mental state* of extreme pain is combined with other factors—such as hopelessness, a decreased perceived value of life, and available means—does suicide occur.

Finally, *mental pain* is often useful as a signal. The normal social emotions of longing, loneliness, jealousy, and grief are signals that help individuals form and maintain pair bonds and other social bonds (see, e.g., Fletcher, Simpson, Campbell, & Overall, 2015). Shame and guilt help individuals conform their behavior to social norms so that they may succeed within a group (see, e.g., Bowles & Gintis, 2005). As with all the examples above, however, mental pain can have false positives and false negatives. False positives are especially relevant here: as with physical pain, there is apparently little fitness penalty for mental pain signals that are excessive to signaling needs in duration and intensity. A physical injury may turn into a lifelong painful condition in which the pain is of no signaling value to the sufferer. Similarly, the loss of a job or a romantic breakup can sometimes result in a long period of excruciating mental suffering out of proportion to any behavior-conforming value. Judging from the prevalence of this kind of “false positive” mental pain, there is apparently little fitness cost involved in suffering needlessly. Like those experiencing severe pain, most people who suffer in this way do not commit suicide. Nature has had no reason to spare us suffering.

This category of suffering—“false positive” instances of prolonged excruciating mental states—has substantial overlap with the common mental disorders to which a causal role in suicide is attributed. Some mental disorders, such as schizophrenia, describe underlying etiologies that themselves *cause* excruciating mental states. Other disorders are, in part, *descriptions* of what excruciating mental states look like from the outside (e.g., depression). Still others describe *responses* to excruciating mental states (e.g., substance abuse disorders).

From this perspective, bipolar disorder appears to represent a cycling between “false positive” and “false negative” errors. However, the picture is more complex. When people with bipolar disorder were asked about their manic episodes, most reported experiencing negative emotions during these periods, including anxiety, irritability, depression, and even suicidal ideation (Henry et al., 2003). True “pathological euphoric states” are rare. Most of the errors of the emotional signaling apparatus appear to be in the negative direction.

Predictions of the Excruciating Mental States Model

If the Excruciating Mental States Model predicts suicide better than the Mental Health Model, we would expect that, within mental disorders, those symptoms associated with excruciating mental states would predict suicide more than other symptoms. Although the investigation of emotional pain as a cause of suicide has not been the subject of a major research program, there is some evidence that it is the case. The hallucination symptom in schizophrenia (not associated with extreme suffering) predicted *less* risk of suicide within schizophrenia, whereas symptoms associated with suffering, such as depression and fear of mental disintegration, did predict suicide (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005). Within depression, weight loss, guilt, insomnia, and feelings of worthlessness predicted suicide, whereas fatigue, difficulty concentrating, and indecisiveness predicted less risk of suicide (McGirr et al., 2007). Second, according to the Excruciating Mental States model, extreme mental suffering should itself predict suicide. Hendin, Maltzberger, Haas, Szanto, and Rabinowicz (2004) found that the experience of intense affective states, such as desperation and anguish, distinguished suicides from severely depressed non-suicide controls being treated by the same therapists. Hendin et al. reviewed therapists' notes of suicide decedents and controls, rather than relying on later interviews, as in the psychological autopsy method. "Intense negative affects" is likely a near-synonym of the construct here called excruciating mental states. This suggests that excruciating mental states predict suicide within the mental disorder construct of depression.

Verrocchio et al. (2016) reviewed 42 studies published since 1995 on the connection between mental pain and suicide, and concluded that there is evidence that mental pain itself predicts suicide and suicidal ideation in both clinical and non-clinical populations, even in the absence of a diagnosed mental disorder. De Leon, Baca-Garcia, and Blasco-Fontecilla (2015) have gone so far as to suggest abandoning the "serotonin model" of suicide in favor of the mental pain model.

The practice of treating mental pain itself (rather than an underlying mental disorder) has had relatively little attention. Shattell (2009) argues that mental pain should be treated much like physical pain. In a small trial, Yovell et al. (2015) treated patients with severe suicidal ideation (likely an indicator of excruciating mental states) who were not experiencing physical pain (Yovell & Bar, 2016) with ultra-low-dose opioids. The suicidal ideation of treated patients did decrease, compared to the placebo group, but more evidence is needed. The Excruciating States Model would predict that not only would treating excruciating mental pain reduce suicidal ideation and behavior, but also improve outcomes for those experiencing mental suffering.

Policy Implications

People experiencing excruciating mental states unrelated to physical pain have no medical recourse except within the Mental Health Model. If a person in an excruciating mental state presents to the emergency room, he will not be given immediate relief. He may be labeled a “drug seeker” or, at best, diagnosed with a mental illness or substance abuse disorder and given various forms of treatment for these conditions. The most common form of treatments are medications referred to as selective serotonin reuptake inhibitors (SSRIs) that typically take weeks to have any effect, and in the majority of cases, have little to no effect (Little, 2009). His treatment will not include relief from the excruciating mental state as such. Opiates, for example, are not given for excruciating mental states unrelated to physical pain; under the current system, a person employing opiates for this purpose is a substance *abuser*.

The Excruciating Mental States Model centers on the experience of extreme, prolonged mental suffering. Relief from this state is just as important whether it is physical or mental. Misery is not a medical condition, but some of the tools of medicine might be useful in treating it. However, nonmedical approaches may be more accessible, humane, and effective than services within the present medical system.

Most drugs that are effective at relieving excruciating mental states are illegal to purchase and use. Some drugs are banned outright (e.g., MDMA, cocaine, heroin, psychedelic drugs). Other drugs are only available through doctors, who act as gatekeepers in compliance with specific rules; a doctor has no authority, for instance, to prescribe ketamine or GHB for an excruciating mental state.

An institutional response within the Excruciating States Model paradigm would include a research program exploring the hundreds of substances and practices that are effective at relieving excruciating mental states, in order to identify those that can be used safely. The more safe, effective possibilities available to those experiencing excruciating mental states, the less they will have to suffer, and the less they will employ unsafe and ineffective means to relieve their anguish. Delivery methods outside of the present medical system should be explored in addition to medical options.

People in excruciating mental states cope as best they can. Alcohol remains legal in the United States, and is very popular as an acute treatment for misery. Marijuana is widely available, and some states are easing their prohibitions. Obtaining illegal drugs on the black market is an option that many choose, if they have the knowledge or social connections. Some people experiencing excruciating mental states engage in physical self-harm to cope, such as by cutting their skin (Chapman, Gratz, & Brown, 2006). This is not so far distant from the pain management strategies apparently used on the Similaun Iceman. Moderate or even severe physical pain is often preferable to an excruciating mental state, and can provide some relief.

People in excruciating mental states will attempt to use whatever means they have for relieving these states. Worse, many will simply give up, suffering helplessly. A small proportion will commit suicide. Providing more, better, and safer options allows suffering people to dispense with harmful, ineffective options. They

cannot simply be bullied into doing whatever the current public health policy prescribes.

The primary objection to providing effective remedies for excruciating mental states in and of themselves is the possibility of addiction. But the vast majority of people who use illegal drugs, even heroin and crack, do not become addicted (RTI International, 2008). The same is true of prescription opioids (Vowles et al., 2015). Small studies have recently been conducted using opioids in treatment-resistant depression, with results indicating effective relief and no withdrawal symptoms after treatment (e.g., Fava et al., 2016). And even if addiction occurs, this may be preferable to the sufferer compared with a prolonged excruciating mental state. As with severe physical pain, the risk of addiction is one of many factors to be balanced. Any treatment that is less addictive and more effective than the default choice, alcohol, ought to be given serious consideration. Note that the benefit is not just the possibility of decreased use of alcohol, but better and safer relief of prolonged mental anguish.

Hewitt (2013) argues that because mental pain is as real as physical pain, mentally ill people experiencing extreme suffering should not be categorically denied access to assisted suicide. I concur, but expand the scope of interventions to include access to substances and practices that might ease or relieve excruciating mental states, whether suffered by mentally ill people or people without a diagnosis. Taking mental pain seriously means a radical reevaluation of drug prohibition policies and the medical system itself, as well as an openness to practices and institutions that might work to alleviate excruciating mental states.

Inside Excruciating Mental States

The “excruciating mental state” phenomenon described here may be defined as:

1. An intense affective state, which may be described as anguish, desperation, misery, suffering, or hopelessness
2. That is higher in intensity and longer in duration than reasonably necessary to motivate appropriate behavior

Such a definition, however, is incapable of conveying the nature of the phenomenon. It is interesting that this phenomenon does not appear to have a generally accepted name, though there are many words that capture part of the sense. “Anguish” describes the mental state itself. “Desperation” connotes the unbearable-ness of the experience and the desire for relief. “Hopelessness” conveys the sense of a time late in the process, in which the sufferer cannot find an available remedy and loses faith that one exists. “Suffering” is too broad, for it includes mental states that have a function or meaning to the sufferer. In the most excruciating mental states, function and meaning are impossible.

Most people, thankfully, will never experience the most intense forms of this phenomenon. Authors writing about this state outside of modern academic

psychology have displayed a suspicion that it cannot really be conveyed to one who has not experienced it. In *The Varieties of Religious Experience*, William James (1902/1985) used long quotations from sufferers to communicate the phenomenon to his audience at the turn of the 20th century. He begins by explaining the phenomenon of anhedonia, the inability to take pleasure in activities. This grey world seems bad enough. But he goes on to describe a much worse state of existence:

So much for melancholy in the sense of incapacity for joyous feeling. A much worse form of it is positive and active anguish, a sort of psychical neuralgia wholly unknown to healthy life. Such anguish may partake of various characters, having sometimes more the quality of loathing; sometimes that of irritation and exasperation; or again of self-mistrust and self-despair; or of suspicion, anxiety, trepidation, fear. The patient may rebel or submit; may accuse himself, or accuse outside powers; and he may or he may not be tormented by the theoretical mystery of why he should so have to suffer (p. 124).

James calls this mental state “morbid-mindedness,” though not as a pejorative. The reality of this mental state is a problem for the prevailing religious mood, which James calls “the religion of healthy-mindedness”—“the method of averting one’s attention from evil, and living simply in the good” (p. 136). An adequate philosophical doctrine, James says, must account for the evil facts of the world, for they have much to teach us.

James (1902/1985, p. 135) connects the intense negative affective state to the need for help:

In none of these cases was there any intellectual insanity or delusion about matters of fact; but were we disposed to open the chapter of really insane melancholia, with its hallucinations and delusions, it would be a worse story still—desperation absolute and complete, the whole universe coagulating about the sufferer into a material of overwhelming horror, surrounding him without opening or end. Not the conception or intellectual perception of evil, but the grisly blood-freezing heart-palsying sensation of it close upon one, and no other conception or sensation able to live for a moment in its presence. How irrelevantly remote seem all our usual refined optimisms and intellectual and moral consolations in presence of a need of help like this! Here is the real core of the religious problem: Help! help! No prophet can claim to bring a final message unless he says things that will have a sound of reality in the ears of victims such as these. But the deliverance must come in as strong a form as the complaint, if it is to take effect; and that seems a reason why the coarser religions, revivalistic, orgiastic, with blood and miracles and supernatural operations, may possibly never be displaced. Some constitutions need them too much.

James (1902/1985) offers another method that may sometimes be useful for excruciating mental states: sensorily intense religious ritual. Baumeister (1991) proposes that charismatic religion, using provocative, tactile rituals like snake handling, laying on of hands, and glossolalia, allows participants to escape from excruciating affective states related to the self. Religious rituals that seem alarming from the outside may in fact be very effective in relieving mental suffering. Attending a boring church service would likely not have the desired effect.

A particularly important description of the extreme end of excruciating mental states comes from fiction. David Foster Wallace, who himself later committed suicide, suffered from severe depression. In *Infinite Jest* (Wallace, 2011), he describes the phenomenon from the perspective of a character called Kate Gompert. Like

William James, Wallace begins by explaining the phenomenon of anhedonia, and then contrasts this with the more severe form (pp. 662–698). Gompert refers to the excruciating mental state as “It,” conveying Wallace’s suspicion that the phenomenon cannot be named. This passage of fiction is more valuable than 100 science journal articles in conveying the texture and contours of the phenomenon. I quote it at length, but recommend the entire section to those interested in understanding the phenomenon from an inside perspective:

It goes by many names—*anguish, despair, torment*, or q.v. Burton’s *melancholia* or Yevtuschenko’s more authoritative *psychotic depression*—but Kate Gompert, down in the trenches with the thing itself, knows it simply as *It*. It is a level of psychic pain wholly incompatible with human life as we know it . . . *Its* emotional character, the feeling Gompert describes *It* as, is probably the most indescribable except as a sort of double bind in which any/all of the alternatives we associate with human agency—sitting or standing, doing or resting, speaking or keeping silent, living or dying—are not just unpleasant but literally horrible.

The sufferer is unable to obtain *help*, in part because she is unable to communicate her condition. Like a “drug seeker” who cannot demonstrate a physical basis for pain, Gompert’s suffering is not real, proper suffering, because there is no cause for it that others can see and verify:

The authoritative term *psychotic depression* makes Kate Gompert feel especially lonely. Specifically the *psychotic* part. Think of it this way. Two people are screaming in pain. One of them is being tortured with electric current. The other is not. The screamer who’s being tortured with electric current is not psychotic: her screams are circumstantially appropriate. The screaming person who’s not being tortured, however, is psychotic, since the outside parties making the diagnoses can see no electrodes or measurable amperage. One of the least pleasant things about being psychotically depressed on a ward full of psychotically depressed patients is coming to see that none of them is really psychotic, that their screams are entirely appropriate to certain circumstances part of whose special charm is that they are undetectable by any outside party . . .

Finally, suicide is understood as a desperate flight from this mental state, when it has become unbearable and no relief is available:

The so-called “psychotically depressed” person who tries to kill herself doesn’t do so out of quote “hopelessness” or any abstract conviction that life’s assets and debits do not square. And surely not because death seems suddenly appealing. The person in whom *Its* invisible agony reaches a certain unendurable level will kill herself the same way a trapped person will eventually jump from the window of a burning high-rise. Make no mistake about people who leap from burning windows. Their terror of falling from a great height is still just as great as it would be for you or me standing speculatively at the same window just checking out the view; i.e. the fear of falling remains a constant. The variable here is the other terror, the fire’s flames: when the flames get close enough, falling to death becomes the slightly less terrible of two terrors. It’s not desiring the fall; it’s terror of the flames. And yet nobody down on the sidewalk, looking up and yelling ‘Don’t!’ and ‘Hang on!’ can understand the jump. Not really. You’d have to have personally been trapped and felt flames to really understand a terror way beyond falling.

Again, only a small proportion of people experiencing excruciating mental states will commit suicide. However, a higher proportion of people long for, pray for, wish for, or fantasize about death, in the absence of suicidal action or even intent. A

“passive death wish” is not uncommon; a general survey of adults 50 years and older in Europe found that 15% of those 75 years and older reported a death wish (Ayalon & Shiovitz-Ezra, 2011). This percentage decreased with age group; just under than 5% of those 50–64 years reported a passive death wish. Fantasizing about suicide may even be a form of relief for some people (Maltsberger, Ronningstam, Weinberg, Schechter, & Goldblatt, 2010). Although not necessarily a predictor of suicide, the presence of a passive death wish or suicide fantasies is a common feature in excruciating mental states. It is not clear how common passive death wishes are outside of excruciating mental states; if happy people rarely long for or pray for death, the passive death wish could be used along with other criteria to identify the presence of excruciating mental states. Certainly, a person who longs for death is in need of help and relief.

Communicating the Hidden Obvious

In evaluating physical pain, doctors employ pain scales to gauge the severity of pain. Patients who can communicate verbally can be asked to rate their pain on a numeric or graphic scale; those who cannot communicate (because they are too young to speak, or in a coma) can be evaluated based on outward signs (e.g., Voepel-Lewis, Shayevitz, & Malviya, 1997).

There are at least six numerical scales or instruments for assessing mental pain (Tossani, 2012), but none of these is commonly in use. If excruciating mental states are to be studied and treated, a widely accepted intensity measure would provide a basis for evaluation and comparison.

The person experiencing an excruciating mental state has two communication problems. First, he may be unable to describe his mental state. Second, even if he manages to describe it articulately, others capable of helping him have no mental category with which to understand it. “Mental illness” is the nearest category, but this concept barely connotes the excruciating mental state. “Whining” is another possible match, and I have already mentioned “drug seeker.” The mere existence of a socially accepted name for this category of experience could allow more suffering people to get help.

A common moral intuition, affirmed by theoretical work in ethical philosophy, is that those who are worst off are especially deserving of help. People suffering from extreme forms of excruciating mental states are at the bottom of the utility distribution. Under the present system, not only are they denied help, but they are denied the ability to help themselves. Policies that would help sufferers of excruciating mental states are not without risk. But these risks should be considered in light of the burden currently placed on people suffering the worst forms of human experience. There is no suicide crisis, but their situation is truly an emergency.

Conclusion

Current models of suicide emphasize the connection between suicide and mental illness. The focus on mental disorders and the rare phenomenon of suicide has shielded a more important problem from view, one that is obvious upon reflection but rarely named: extreme subjective mental suffering or excruciating mental states. Excruciating mental states mediate the relationship between mental illness constructs and suicide. Prolonged excruciating mental states do not serve any purpose that can justify refusing to ameliorate them. Excruciating mental states can be relieved directly, rather than as a hoped-for consequence of the treatment of a mental illness. Unfortunately, drug prohibition policies preclude the use of safe, effective solutions. The difficulty of communicating extreme mental pain prevents sufferers from being helped; simply having a conceptual category for the phenomenon may ease the difficulty of communication.

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