

“I am sure I can manage the Clonazepam. I will be very careful with it.”

Tom was taking a big step, accepting the use of drugs that for so many years he had told others to avoid. I told him that I respected his courage and that there was a fair chance he would be greatly rewarded.

Within weeks his sleep had restored, and his back pain diminished. His painful nocturnal voidings were reduced from three or four times nightly to one, and occasionally none. Even his bowels were calm. Two years into his treatment, he continues to do well. I see him only every six months for prescription refills.

*Anne was a sprightly matron with two years of pain in her mid-back and left flank.* Her internist and consulting neurosurgeon performed their obligations and found evidence of arthritic change in her spine appropriate to her age of eighty years. Epidural steroid injections were administered in a series of three. They were without effect, and the internist prescribed Hydrocodone 10 mg. four times daily. It did nothing, and Anne requested a stronger analgesic. Oxycontin was given, 20 mg. three times daily. Faced with the unhappy prospect of providing increasing quantities of opiates to an elderly lady, her internist referred her to me.

She was an utterly charming woman, graceful, alert, and intelligent. Her husband of many years had a successful career in the insurance business, and she was both socially and economically quite comfortable. I began my inquiries by asking if she was depressed.

“No, I am terribly frustrated, but I really don’t feel depressed, and for that matter, I have never had that particular problem. Lots of my friends do, and I have always considered myself lucky to never suffer depression. It must be a horrible illness.”

When I inquire about depression, and I invariably do, I am, of course, interested in the affirmative or negative answer but also in the manner in which my patient responds. Many victims of chronic pain are in depression but are either unaware of it or in denial. In the latter case, they often become, as we have already seen, defensive and over-reactive. Anne’s response, given so circumstantially, suggested that depression was not a central issue. Yes, you can suffer chronic pain and not be depressed. It doesn’t happen a lot, but it does happen.

“How are you sleeping? Does the pain keep you awake at night?”

“I sleep quite well at night. I take Oxazepam at bedtime, and it works quite well.”

“How long have you used it?”

“Oh, I suppose thirty years or so. I’ve had a problem with insomnia for a long time, but the drug works just perfectly.”

Oxazepam is one of the benzodiazepine drugs, akin to Clonazepam. It can be a very effective sleeping aid, and her physician made a very wise choice many years ago. It is remarkable when you think about it—that the drug could continue to work so well for thirty years.

I asked her about her energy, appetite, and mental focus. She denied any problem. Except for her history of disordered sleep, and that well controlled with pharmacy, she had absolutely none of the major symptoms that attend a state of chronic pain.

“Anne, you are taking both Hydrocodone and Oxycontin now. Are they helping you?”

“Very little, and that surprises me. I have never taken painkillers before, and I would have expected a lot more relief than I am getting. Can you explain to me why they are not working any better?”

“Not yet. Another question, please. Does your pain get worse when you are active, and does it get better when you rest or when you lie down?”

“Well, of course, if I am very active, it seems to bother me more. But most of the time it stays about the same.”

“Is there anything at all that you can do that makes the pain better?”

“Yes, there is one thing that works every time—vodka.”

“That really relieves your pain?”

“Absolutely. It removes the pain totally.”

“How much vodka does it take?”

“Two vodka on the rocks will do it, but usually a third one helps even more. I drink them in the evening with my husband. They relieve my pain, and for a few hours I am quite comfortable. Then I take my Oxazepam at bedtime, and I sleep quite well. The pain is bad, though, when I wake up.”

“So you have been drinking three vodkas every night since you have been painful?”

“Well, yes, but you need to understand that I have been drinking three vodkas a night for my entire adult life.”

“That is a lot of vodka, Anne. Do you feel like it has ever been a problem for you? Have you ever felt like you were drinking too much?”

“Well, to be honest with you, I do occasionally feel guilty about it. But I never drink during the day, and I never get any sense of inebriation. It is just the way I relax.”

“Let’s go back in time, Anne. You’ve had this pain now for two years. Was there anything going on in your life when it started—difficulties with your children or your husband? Was there any kind of change in the way you lived?”

“Well, I suppose you could say so. My husband and I enjoy traveling. We go to Europe at least once a year. We were in Germany on the occasion of the 9/11 attack. We were stranded there and had to extend our stay for several days. I suppose I had time to ponder about certain things, and I don’t really know why I did this, but I decided to stop drinking.”

“You stopped drinking on 9/11?”

“Yes, I did. I didn’t tell my husband about it. I just drank water while he was drinking his vodkas. A month later I told him about it. At the time I was quite proud of myself.”

“Did you have any kind of withdrawal symptoms? You’ve consumed a lot of alcohol in your life. Did you develop insomnia or nervousness or tremors when you stopped drinking?”

“No, none at all. I really didn’t feel any different. I didn’t feel better, I didn’t feel worse, but I was happy that I had stopped.”

“Can you tell me with any precision when your pain began?”

“You know, I remember being uncomfortable on the flight home. It wasn’t very bad, and I didn’t think much about it, but over the course of a few months it got worse and worse.”

“So your pain began shortly after you stopped drinking?”

“That is correct.”

“And now you have obviously resumed your vodka habit. When did that happen?”

“It was maybe three months after I started hurting. The pain was so bad, and the pain medicine wasn’t doing anything, so I took a couple of

drinks. The effect was just miraculous. I wish I could drink during the day because I know it will relieve the pain, but I am not an alcoholic, and I don't want to become one."

Anne's termination of alcohol after many years of its use should have produced some kind of withdrawal. In the worst case this would have been hallucinations and convulsions (delirium tremens), but more likely it would be less serious—perhaps an interval of anxiety, tremors, or at least insomnia. She had none of these. Just why her good fortune is uncertain, but I suspect it was because she continued to take her sleeping pill each evening. Alcohol and Oxazepam are quite different drugs, but they both stimulate the neurotransmitter GABA, the brain's calming chemical. I am rather sure that if she had stopped both her vodka and Oxazepam at the same time, she would certainly have experienced a withdrawal, perhaps even a convulsive seizure. Fortunately, she continued her Oxazepam, and she had no problem at all except that she developed chronic pain. And that, I suggest, was a symptom of alcohol withdrawal, just as it was in psychologist Tom. I have seen this scenario play out hundreds, if not thousands, of times. Usually the pain appears within a short while following the cessation of the drug, but I believe also it can occur years later.

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Anne offered me some interesting treatment decisions. Although she achieved temporary relief with the reinstatement of alcohol, it was incomplete. I was faced with the prospect of treating an eighty-year-old woman who was doing poorly on the combination of Hydrocodone, Oxycontin, Oxazepam, and vodka. I wanted to find a happy answer as, fortunately, I had found in Tom. It was not to be. She did get better ultimately, but in way I had hoped to avoid.

I told Anne to continue her Oxazepam, and I added Imipramine, the same drug that had been so successful with Tom. It didn't work at all. In turn, I tried Cymbalta and Effexor. These are splendid drugs for the treatment of depression and pain. In the absence of depression (and Anne really was not depressed), they work less well. I then undertook an

exercise that was intellectually attractive to me but turned out to be futile. I believed that Anne's use of Oxazepam had protected her, albeit incompletely, from alcohol withdrawal. Perhaps a bigger dose of Oxazepam, administered throughout the day, would relieve her pain. It didn't. I then prescribed in its place Clonazepam, a kindred drug but one with anticonvulsant properties and often helpful in the treatment of pain. It did no good either, and I had nowhere else to turn but to use more opiates. I offered Methadone.

Anne recoiled at the suggestion. "No, not Methadone, that is for heroin addicts. I am not going to take Methadone."

Many patients fear Methadone just as they often fear Lithium. Why these two drugs are so odious in the minds of the lay person is, I suppose, the connotations they invoke. Methadone for heroin addicts and Lithium for crazy people. I increased her dose of Oxycontin from 40 mg. to 60 mg. Just a week or so later, I received a note from her.

*Dear Dr. Cochran:*

*I have been having second thoughts about increasing the dose of Oxycontin. The first dose I take in the morning makes me so drowsy, I doze off while trying to read the paper, and I fear that taking more would be a bad idea. If you agree, I would like to change to Methadone as we discussed on a previous visit.*

*Thank you for your help and patience,*

*Anne*

At our next meeting I prescribed Methadone in a tiny dose, 5 mg. three times daily in addition to the Oxycontin and Hydrocodone. It worked—and beautifully.

"The perfect combination," said Anne. "There is no sedation, and I am comfortable now. I have almost no pain at all."

Years later, Anne remains well on Methadone, Oxycontin, Hydrocodone, Oxazepam, and three vodkas daily. It reads badly, but it is really not. She is happy, functioning well, and free of pain. The outcome

wasn't perfect, but it was pretty close. In the pain business, you take whatever you can get.

I want to pause now and return to some of the material on neurotransmitters presented in chapter two. Let's look again at those systems that provide us with the sensations of comfort, pleasure, reward, and elation. These wonderful experiences occasionally occur in the course of our lives, when we fall in love or have some sort of spiritual revival. Recovery from serious illness (including recovery from addiction) often generates this kind of feeling, known as the flight to health. It can also be generated, and most commonly is, by the administration of pharmacy, both legitimate and recreational. The major neurotransmitter systems that are involved are GABA, which calms; opioid, which relieves pain; and dopamine, which is actually the reward or pleasure neurotransmitter. These three systems can, under provocation, collaborate and make us feel very good. They work with each other and work through each other. They are interdependent.

Now let's look at two recreational drugs, marijuana and alcohol, both of which can relieve pain (this effect is widely recognized). Marijuana stimulates the cannaboid receptors, and alcohol the GABA. In turn, both cannaboid and GABA stimulate the opioid neurotransmitter system, and it is the release of opioids that actually relieve the pain. We know this because Naltrexone, the opioid antagonist, will block the analgesic effects of marijuana and alcohol.

Marijuana and alcohol cannot only relieve pain, they can make us feel very good. This is because of the opioid release that they engender stimulates, in turn, dopamine, the pleasure and reward and sometimes craving inducing neurotransmitter. It is for this reason that Naltrexone, which antagonizes opioids, is actually being used for the treatment of alcohol addiction. Because of the blocking of opioid systems, dopamine cannot be stimulated, therefore, the pleasure derived from alcohol and marijuana—and the cravings—are diminished.

Now let's turn it around. If alcohol and marijuana can stimulate the opioid system and relieve pain, could not withdrawal from alcohol or marijuana create pain? Yes, almost certainly. Look at it this way. The frequent user of alcohol or marijuana is constantly stimulating the brain's pain-relieving opioid transmitters. As a result of this constant stimulation,

the opioid system becomes, in a sense, fat and lazy. It is incapable, physiologically, of reacting as it was designed to do—that is, respond to the experience of pain. And this is exactly what happens on withdrawal from alcohol and marijuana abuse. The opioid system has become insensitive

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and nonreactive. It can no longer respond with the accustomed and nature-ordained purpose, and therefore the drug abuser in recovery may face, following painful injury or illness, a life of chronic pain.

I know I may have tested you with some of this, but I assure you the conclusions are physiologically quite sound. There are many examples of vital body functions that grow lazy and unresponsive when they are no longer required to exercise their proper functions by the administration of pharmacy that gives them no need to do so.

*Candy escaped from her abusive, alcoholic father at age sixteen.* She moved in with an older man, who she was soon to discover was a pedophile. That is when she started drinking, a habit that was to continue for some twenty-five years. She worked as a bartender and waitress and entered a lifestyle characterized by promiscuity and risk-seeking diversion. She was an aggressive mountain biker and rock climber. She told me she handled her liquor well—no DUIs, no loss of jobs. She was married for a few years, but it was unsuccessful and was terminated about age thirty. That was when her depression first appeared. She remained under psychiatric care off and on until I saw her some fifteen years later. She had been on several different antidepressants—Prozac, Wellbutrin, and Effexor—first one and then another. She was also on Alprazolam to control her progressive, alcohol-fueled anxiety. About age forty, following a drunken impulse to suicide, she made a phone call to Alcoholics Anonymous. Under the sponsorship of that organization, she entered sobriety and remained there for several years. She experienced, as many in recovery from drug or alcohol abuse do, the flight to health. She felt empowered by her achievement (as well she should have). But her