HARRIE BLOMMESTEIJN

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Fine art photography, 24 x 36 in

MARTHA JOHNS

Suffering and Survival

Stories from my work in a narcotics recovery clinic

He staggers into my office in the methadone clinic clutching the left side of his face and jaw, moaning loudly. I have been warned by the young addictions counselor that Richard tends to whine and complain a lot, but he is acting as though he has just been punched in the jaw by a prizefighter. As I introduce myself and ask him some questions about his health history, our conversation continues to be punctuated by loud moans and grimaces.

I ask him to tell me about when the temporomandibular joint (TMJ) pain started. Pouring out, as if from behind a burst dam, comes a horrifying story of childhood physical and sexual abuse. Richard was chained to a fence and beaten for hours at a time, beginning at age four until he was old enough to escape, when he left to live on the streets of Dallas and do drugs, selling them to survive.

As he tells his story, tears stream down his face. He assures me, "I'm not crying. It's just the pain." Again later, "I'm not crying. Men don't cry." He is clearly crying. I sit quietly and listen, my eyes focused on Richard, my body position open, leaning slightly toward him. This is what I've spent years training for.

When he finishes talking, we move to the exam table. I notice he is no longer clutching his face, nor is he moaning. After the exam, and at the end of the visit, he says, "I've only told that whole story to one other person."

Just Another Homeless Guy?

A homeless client comes in for his intake physical. I see one or two homeless people entering the program every week. General appearance: unkempt, malnourished, with greasy hair and rough, grimy hands, dirt embedded under his fingernails. Sleepy: "The security guards harass me a lot at night" at the construction sites where he sleeps rolled up in his blankets. Not only sleepy, but in Tommy's case, a lost, vacant look in his eyes.

"How do you get enough money to survive?"

"I sell the street newspaper. I try to get one good meal a day, then a snack."

It seems a miracle that this man has made it into our medication-assisted treatment (MAT) program. Although Medicaid and some health insurance programs do pay for the program, a person has to be able to get himself to the

By the time a client is scheduled with me, he has already seen a clinic counselor, an addiction psychiatrist, and sometimes an RN, who have taken thorough drug, alcohol, tobacco, social, psychological, and family histories, and a partial medical history.

clinic every day between 5:30 A.M. and 1:15 P.M. to receive his dose of methadone or suboxone, and attend the appointments and groups.

The intake history and physical are legal requirements for every client entering a MAT program. By the time a client is scheduled with me, he has already seen a clinic counselor, an addiction psychiatrist, and sometimes an RN, who have taken thorough drug, alcohol, tobacco, social, psychological, and family histories, and a partial medical history. My thirty minutes are spent reviewing the medical and psychiatric history and filling in any gaps; asking about any current symptoms; explaining blood test and electrocardiogram results; confirming past and present medications. I then do a physical exam and must enter all this information into the electronic medical record.

It would be easy to focus on getting the facts, asking questions, looking for specific answers to specific questions. But in this case, as in many, without first asking open-ended questions and listening, I would miss critical information . . . like about the voices.

"How have you been feeling lately?"

"Sometimes I hear voices."

"What do they say?"

"Oh, not much, they're just talking."

"Do they tell you to do things?"

"No, they're just the voices of dead people. They come and go. The Seroquel they gave me when I was incarcerated made them go away."

"Would you be interested in taking Seroquel or some other medicine so that the voices would go away again?"

"Yes, I would," he replies eagerly.

"We can probably help you with that now that you're here in the methadone program."

"I'd really like that. How do I get started?"

"Let's go talk to your counselor."

Abscesses

The stench overwhelms me; it's all I can do not to flare my nostrils and back off as George drags into my office/exam room. The sweat and filth of four layers of clothes to keep him warm on the streets mingles with the unmistakable reek of infected flesh. But it's not just the smell, it's the shame. I am ashamed that I'm repulsed by this man; where is my compassion? And yet I sit as far away from him as possible. I put on a mask and gloves when I have to examine him.

George complains about the pain from red, raised sores draining pus, on both arms and legs, abscesses from injecting heroin. Not only is his body disgusting, but he gripes about the treatment he is getting. "They're only giving me 30 mg of methadone. That's not enough. I'm still having horrible withdraws. My muscles hurt and I have chills and sweats and nausea and vomiting."

I overcome my revulsion and my own nausea enough to say, "The addiction psychiatrists have to increase your dose slowly so that it's safe for you."

He doesn't care about safety precautions. "I've been through this before. I know what's safe for me. I'm shooting a gram a day anyway."

"I'm sure you know this, but you need to stop injecting for your abscesses to go away." What a stupid thing to say. Of course he knows that. He's caught in the disease of addiction. But George doesn't even seem to be trying. He's had repeated ER visits, hospitalizations, restarts in methadone clinics. He gets antibiotics, doesn't finish them, loses them, or sells them for money to buy heroin.

After seeing a patient like this, I feel exhausted, discouraged. Why am I still working here after three years? Many of my colleagues are surprised to hear it's been that long. Sometimes I feel like my skill at listening makes a difference to a patient—the opportunity to have another person witness your suffering can be healing. Other days I just want to get through the morning and leave.

My Uncle Tom and Aunt Marty both died of complications of alcohol and drug use. As a child I was vaguely aware of their troubles. Once, as a young teen, I overheard my father refusing a collect call from my aunt. I guessed she wanted something, probably money. As he hung up, he let out a howl like a wounded animal, followed by sobs, and he staggered through to the kitchen, where my mom was sitting. We never talked about it. I couldn't help Aunt Marty or Uncle Tom; maybe I can help others who struggle with addiction.

Grateful

Kathy is dressed on this hot autumn day in a black spaghetti strap jersey and worn capris. She wears light foundation, mascara, and pink lipstick, and she has a few tattoos on her arms, along with old scars and tracks. She lost all her teeth and wears dentures. She has been a MAT program client for five years.

Methadone is a synthetic opioid used since the early 1960s in MAT programs to help millions of people reduce or quit opiates. It has been dramatically more successful than simple detoxification and drug-free approaches, with success rates of 60–90 percent, compared with only 5–10 percent for recovery programs without medications.

There are many people like Kathy who have done quite well on MAT and have been in this or some other program for up to forty years. They have followed all the rules, attended group meetings, met with their counselors, had clean urine drug screens, and progressed to the point where instead of coming in for daily dosing, they come in every two weeks and get fourteen small plastic bottles of red liquid methadone take-home doses that they lock up in a metal case.

At forty-eight, Kathy has now lived past the age at which both of her parents committed suicide. I wonder if she thinks much about that. She certainly has other things to think about. She was cured of hepatitis C with new miracle drugs and lives with HIV thanks to multiple daily medications; however she now has to take antibiotics, probably for the rest of her life, for osteomyelitis, a chronic bone infection, in her foot. I'm not surprised to see that she's been diagnosed with bipolar disorder with depression and takes medication for that. More than 40 percent of people with substance use disorders also have mental health disorders; Kathy is fortunate in the sense that less than half of those people are ever treated for either problem—she is in the lucky portion.

Surprisingly, considering her illnesses, and unlike some of the people I see, she has few complaints or symptoms. Yes, she is constipated; yes, she has chronic pain, but she deals with it. Why has she been able to rise above childhood trauma and more than her share of illness and adversity, when others become resentful and refuse to take responsibility for their own part in their troubles? Kathy tells me that she is grateful for her doctors and the treatment she's received. She keeps active, attends church, exercises, sees friends. She works hard at cultivating a positive attitude and gratitude in her life.

Adverse Childhood Experiences

Steve comes into my office wearing a tank top that reveals large, colorful religious tattoos covering his upper body and arms. His hair is a short, indistinct brown and he is missing many teeth, a condition often associated with years of IV drug use. When I ask him to tell me a little bit about himself, he says, "I've got to get clean and get my life back on track." He's thirty-six years old and has only been using for a few years, unlike many of the people I see entering treatment.

Steve tells me about the bad ATV accident that caused multiple broken bones for which he was prescribed large amounts of opioid medications. When he got out of the hospital, he wasn't able to afford the prescriptions for the larger and larger amounts of opioids he needed. He was offered IV heroin by a friend and continued to use that "because it was cheaper." According to the Surgeon General's Report

on Alcohol, Drugs, and Health, published in November 2016, 80 percent of heroin users say their addiction began with prescription opioids. Once on heroin, Steve explained, "an addict will do anything to get what he needs." He stole, wound up incarcerated, and his life went rapidly downhill in only three or four years.

In addition to taking prescription painkillers, there are other known risk factors for addiction and mental illness, many of which are summarized in a ten-item questionnaire called Adverse Childhood Experiences (ACE). This questionnaire is often given to people when they begin treatment in a substance use clinic; a score over four is associated with an increased risk of drug addiction, mental illness, and certain physical illnesses, four times higher than the risk of people who score four or under. The ten questions ask about abuse (physical, mental, or sexual) and neglect (hunger) before the age of eighteen and family dysfunction (domestic violence, incarceration). Oh, how I wish that Steve had been given the ACE *before* being prescribed opioids.

Steve mentions that when younger he had been diagnosed with PTSD, bipolar disorder, depression, and anxiety. When I ask what the PTSD was about, he describes a childhood and youth of instability and pain; family dysfunction; mental, physical, and sexual abuse. He says that he was put on medication "for the bipolar and depression, but it was terrible. I would rather have heroin." He has never had any counseling.

I listen to his story. In contrast to the muscled, tattooed biker he resembles, Steve is open and vulnerable, a wounded boy, crying out his story. I suggest that psychiatric diagnoses and labels are often thrown around loosely and I wouldn't take any of those past diagnoses too seriously, especially if he was under the influence of drugs and alcohol at the time.

"What matters is your current state of mind and what you do from here on out."

Does Your Heart Just Stop?

He could have been someone my daughter was dating—or a sincere religious missionary coming to the door to discuss my salvation—the fresh-faced twenty-six-year-old who sits down next to my desk. He's there to get off heroin and says "Yes, ma'am" with alarming regularity.

Diagnosed with anxiety, depression, and ADHD at age eleven by his elementary school, Cody was sent to a psychiatrist. His parents, not knowing what else to do, went along with it, although his mom secretly told him he didn't have to take the meds. He used to hide them in the sofa because he didn't like the way they made him feel: Concerta, Lexapro, and Ativan. He took the pills sporadically, had no counseling, and things did not improve.

Later, he discovered that he *did* like some pills—pain pills. And as happens so frequently, as his addiction grew, he couldn't afford the burgeoning cost, and a friend told him that heroin was cheaper. He began using, selling, stealing—the whole catastrophe.

"Did you use other drugs?"

"I stopped using benzos in 2010 after my fifth or maybe sixth friend died of an OD from benzos and heroin."

That friend fell asleep, never to awaken. The young man looks up and asks me, "That's really common, isn't it? Does your heart just stop?"

I explain how both drugs decrease the brain's signals to the respiratory system. Your breath becomes more and more shallow and then you stop breathing altogether. Your heart, starved for oxygen, beats more and more slowly. It's all very peaceful and very deadly. He nods his head solemnly.

Nearly 13,000 people died from an overdose of heroin and more than 15,000 from prescription opioids in 2015. More than 64,000 overdose deaths were reported in 2016, and the numbers continue to increase.

I get furious thinking about Cody being prescribed three psychoactive drugs at age eleven. Who were the psychiatrist and school officials who felt they knew enough about this child's brain that giving him chemicals was the right solution? Even if he did have anxiety, depression, and ADHD, weren't there other approaches that might have been tried? Behavior modification or a resource teacher? Might everything have turned out differently if he had had individual and family counseling and no drugs?

Slight Case of Paranoia

Like many people with a diagnosis of paranoid schizophrenia, Carlos's life has been a daily struggle that those of us without this affliction can scarcely imagine. He's had bad reactions to antipsychotic medications, even some of the newer, supposedly better, ones like Seroquel. His disease has gotten him into trouble because he annoys people: he was stabbed in the back, collapsing his right lung, and he has a rod in his leg from when another guy hit his leg with a metal bar, fracturing the femur. He's used heroin, morphine, and diazepam to try to quiet the voices and make himself feel better; and he has been homeless for a long, long time.

When he comes in for his physical, he seems nervous and tells me, "I have a slight case of paranoia; sometimes I see a shadow and I look and there's nothing there." In another city, he was given medicine that helped him, but he is not currently taking anything. He smokes some marijuana and says he drinks two beers a week; I think he probably drinks a lot more than that, because his gamma-glutamyl transferase (GGT)—the enzyme that is most sensitive to how much alcohol you drink—is more than ten times normal. It almost goes without saying that he has smoked tobacco for more than forty of his fifty-eight years.

Throughout the interview I speak with Carlos in as quiet, calm, and matter-of-fact a voice as I can. When I feel his neck for lymph nodes, he says, "That feels good." I keep palpating and throw in a little neck muscle massage; he probably rarely experiences any human touch, and particularly not in a kind manner.

Before he leaves, I retake his blood pressure, wrapping the cuff around his left arm. It had been 152/108 initially. "That room was very small," he says of the screening room. "It felt like the walls were closing in on me." His blood pressure has decreased to 110/76. "It's completely normal now," I tell him.

"You're very comforting," he says. I smile.

"Thank you," I reply. After he leaves, and again as I write this, tears come to my eyes at my own extraordinary good fortune and the honor of being allowed to meet another person in this way.

A Really High Dose

"Hey, Doc, I'm glad you could see me early. I need to get home to charge my wheelchair." Rafael wheels into my office, his white straw cowboy hat jauntily atop his dark hair. "Yesterday I was having such bad withdrawals 'cause they reduced my dose, the cops took me to St. Mary's [Hospital]; they thought I had OD'd. I used to be on 360 mg."

"I was in the federal pen and they were trying to get my jewelry and stabbed me three times." He seems proud of his battle scars. He has survived.

My face must have registered surprise at the highest methadone dose I had ever heard of. "That's not a high dose," said Rafael.

"Yeah, that's a really high dose." Although there isn't agreement on exactly how to convert from chronic use of oral methadone to oral morphine, 360 mg of oral methadone would be approximately the equivalent of at least 700 mg of oral morphine daily.

"Not for a big drug user like me—lots of heroin, cocaine since I was seventeen?" (He's now sixty-five.)

Affable and friendly, Rafael is surprisingly nonchalant about the chronic pain from diabetic neuropathy, sores on his leg and buttocks, and the fact that neurologists haven't been able to figure out why he hasn't been able to stand up for the past five years.

I have him lean back in his wheelchair and loosen his shirt so I can examine his heart, lungs, and abdomen. I immediately notice the scar three inches wide indenting his abdomen from top to bottom, ruining the symmetry of his colorful tattoo. "Hey, that's quite a scar you have there."

"Yeah, I had surgery for gunshot wounds. I've got three other scars up here from when I was stabbed. If it had been just a little lower, they would have gone right through my heart," he proclaimed. "I was in the federal pen and they were trying to get my jewelry and stabbed me three times." He seems proud of his battle scars. He has survived.

"While you were *in* the pen? What did they stab you with?"

The exam over, I sit down in my chair by the corner of the desk, lean forward, my attention riveted as he draws a diagram and conjures up a scene straight out of an Al Pacino film. "A butter knife—filed down to a sharp point. Oh, yeah, they have all the tools of the trade there." He explains to me how it was done—how a harmless butter knife could be turned into a weapon. You would think that, having worked at big city hospitals in Boston and Los Angeles, nothing would surprise me. It is hard to believe this guy is for real, but there are his scars as proof.

We proceed on to more prosaic matters, talking about needing reading glasses. I'm thinking that I've already heard all the surprises I could hear in thirty minutes when toward the end of the visit, he says, "I wish we had met under other circumstances, maybe had a cup of coffee."

I quickly recover and say, "Well, thank you, I've enjoyed meeting you, too." As I think back on this conversation, I take his remark as a compliment. He could have just been bullshitting or manipulating me, something that former addicts are prone to do; but I prefer to believe that he was responding to my having met him as a human being, having listened without judgment and accepted his telling of his story. Or maybe a little of both.

Bad Arthritis—Good Attitude

Carol is forty-nine, smiling, and delighted to be here. She's happy to finally be able to stop smoking heroin after a full year of using it to supplement the Vicodin from her rheumatologist and the Percocet from the pain management clinic for severe osteoarthritis of her hands.

"I'm pretty normal," she says. "I just had to do something about this awful pain. I couldn't do *anything*. I was sitting at home all day. I had quit taking my dog for walks. I couldn't do anything I enjoyed anymore."

"When was the last time you used heroin?" I ask.

"Yesterday night about 3 A.M., and I want it to be my very last!" Many patients spend their time with me whining about the withdrawal symptoms, the muscle aches, the sweats, the nausea, the slow rate of increase of their methadone dose. Not Carol—she's grateful to be enrolled in the program, to have a chance to control her pain without the insidious growing dependence upon narcotics. She welcomes every suggestion I have, which of course makes *me* feel good. I pull out my special stretching handout and spend extra time demonstrating some back stretches.

Why is Carol positive and open, while other patients are negative, unreachable, refusing to take responsibility? I know that the negativity and resistance come from all the adverse childhood experiences, poverty, abuse, or simply the length of time they have been addicted and the devastating consequences of addiction. We health professionals love the Carols of this world. They reinforce us, make us feel good, whereas others can make us feel as hopeless, discouraged, and angry as they feel themselves. But the angry and hopeless need our help as much as the positive and hopeful, probably more so.

I would like to always respond with as much empathy and compassion to a complaining or angry patient as to someone like Carol. But I know that I don't. Some days I am frustrated or sad about something unrelated to that patient, or in pain myself, or just plain exhausted; and my state of mind and body affects my ability to be fully present with the patient. Despite my deep belief in the inherent worth and dignity of all individuals, I observe myself reacting in ways that are shocking to me. So I pause. I take a deep breath. I remind myself of the years of struggle and suffering of the person in front of me. And I reset my course.

Names and identifying details have been changed to protect the identities of the patients.

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