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Roseburg: 541-673-3504
Salem: 503-588-2804

National Websites:

Alcoholics Anonymous (AA)
www.aa.org or
www.alcoholicsanonymous.org

Narcotics Anonymous (NA)
www.na.org

Cocaine Anonymous (CA)
www.ca.org

For Family & Friends:
Al-Anon & Alateen:
www.OregonAl-Anon.org

Adult Children of
Alcoholics (ACA)
www.adultchildren.org

Serenity Lane…
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www.serenitylane.org
www.slalumni.org

Stepping Together

Serenity Lane's Alumni Newsletter

Spring 2008

35 years

# of saving lives & putting families back together again

by: Mary Daniels

This May, Serenity Lane will mark its 35 year anniversary. If you are reading this, you are likely one of the many thousands of former patients who hold a special place in your heart for this organization. Serenity Lane has served more than 50,000 addicts and alcoholics since we opened our doors on May 3, 1973. Three patients enrolled that first day.

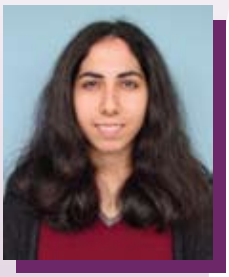
Thomas Kerns MD.

Many of Eugene's citizens and businesses were involved in starting Serenity Lane. Founder Dr. Thomas Kerns, counselor Sam Graves, Lois O'Connor and Monsignor Murnane raised the $100,000 necessary to open the doors. With the funds, they hired a skeleton staff and remodeled the former fraternity house on the corner of 16th & Patterson in Eugene that would become Serenity Lane's home.

Dr. Kerns' vision for Serenity Lane was born of frustration. As a family practitioner, he regularly saw patients who desperately needed alcohol treatment, but had no options in Eugene. Spurred by his own experience growing up in an alcoholic family, the good doctor regularly took his patients to AA meetings. The need for a treatment center that simultaneously helped alcoholics AND their families became his focus, and the formation of Eugene's first treatment center filled this essential role in the community. Dr. Kerns was always quick to deny that he was the source of the organization's success. Instead, he pointed to Serenity Lane's wonderful staff and their dedication. Former and current Serenity Lane employees have said Kerns was one of the most dynamic men they'd ever worked with. Nothing got in the way of his goals and his knowledge and compassion for this disease was a special gift. He passed away in June 2005 of renal failure.

continued on page 3

From your Editor



Dear Alumni,

After the long, dreary winter coupled with a severe cold and flu season, I have been anxiously awaiting the arrival of spring. As sickness has become more prevalent in recent months, I am reminded of the overwhelming importance of health. Among the many responsibilities we face in our families, our work and our finances, the fundamental task of taking care of ourselves is often neglected.

For those in recovery, an intervention serves as a wake up call, and the act of receiving treatment for drug and alcohol addiction is a major turning point in nurturing themselves by letting go of destructive patterns and taking necessary steps to improve their quality of life.

Through counseling and education, patients gain the tools to confront challenges in all aspects of their lives, while maintaining a commitment to their physical, emotional and spiritual well-being. Not only does this progress enhance the patients lives, but it also has a profound impact on their relationships with loved ones.

The lifestyle adopted in Serenity Lane's Residential Program is designed to offer an ideal balance of diet, nutrition and exercise, and incorporating these elements into your recovery plan will make lasting contributions to your overall health. In addition, I hope you have been able to benefit from the ongoing advice of our clinicians in the alumni newsletter, addressing topics like stress management and sleep deprivation.

With the radiance and growth of the new season, I'm approaching the future with optimism and motivation, ready to make the long-awaited changes that are essential for my own well-being, and I hope you will join me in this undertaking.

Take care,

Shely Rahimi

Alumni Coordinator

Newsletter Committee:
Angie Delaplain.
Mary Daniels,
Neil McNaughton
& Shely Rahimi.

Outpatient Happenings

After months of planning, digging, leveling, construction finishwork and inspection, we are proud to announce the opening of the new Serenity Lane facility in **Roseburg**. The 5,500 square foot building sits on a hillside overlooking the town to the south. Upon entering, the stairway leads to a beautiful reception area complete with a gas fireplace and comfortable chairs. Contemporary shades of green and wood accents complement the light filled interior. A stunning metal sculpture of a woodland scene is the perfect focal point over the fireplace, while a variety of framed artworks adorn the off-white walls. The patients are truly "wowed" and the staff are obviously thrilled to finally get moved in and organized.

An Open House was held on March 25th, when referral sources and other members of the community were invited for a walk through and met the staff. Everyone's reaction was the same... "WOW!"

If you are in the area check us out at 2575 NW Kline Street, **Roseburg**.

Another exciting change within the Serenity Lane system is the opening of a third outpatient clinic in **Portland**.

In addition to our clinic on S.W. Barbur Blvd and our east-side location at 12780 S.E. Stark, we are pleased to bring services to Washington County. The new clinic at NW 167th and Cornell is easily accessible from Aloha, Hillsboro and Beaverton. Patient feedback has made it clear that traveling long distances across Portland traffic is a potential barrier to treatment, so we are glad to be able to provide better accessibility to the burgeoning Portland metro area.

by: Fritz Dygert CADCIII

The definition of words is often important in communication. Everyone must be on the same page about what a word or phrase means. Otherwise, there can be a huge misunderstanding followed by a lot of upset feelings. Here is an example of how this can happen.

A family was having difficulty with a simple household task. It was the assigned duty of the 12-year-old boy to take the trash out to the dumpster when the can was full, and the boy agreed to do that. However, during the week, his father started to bug him about taking out the trash, and the boy balked at the task. His mother would stand up for him and ask her husband why he was being so rude to their son. In frustration, the father would go about his business, but underneath he was beginning to fume because the trash was still in the house.

A day or two later, the father would again ask their son to take out the trash - this time with more force. The boy again balked, and this time the mother sided with the father. An argument usually ensued. Sometimes the trash was taken out and sometimes the trash stayed in the house, but there were a lot of hurt and angry feelings, resulting in deadly silence.

This family presented their case to a well-known family therapist. After they told their story, the therapist identified the problem. The family thought that the boy was being obnoxious and stubborn. Some saw the mother as the problem because she kept changing 'sides,' sometimes supporting her husband and sometimes supporting their son. Others saw the father as the source of the problem because there would be no conflict if he stopped insisting that the trash be taken out.

What do you think the problem was?

The therapist pointed out that the trash was to be taken out when the can was full. She asked each of them what they meant by full. The father said the trash was full when it was two inches from the top, the mother said when it was equal with the top, and the son said when you couldn't get anything more into it.

Obviously, they each had a different definition of full. Once the family decided as a unit what full was, they no longer had a problem with taking out the trash.

Other terms that can get in the way of family relationships are words like clean your room (what does clean mean?), working your program, and helping someone (how do they want to be helped?). You can probably think of many more examples from your own lives. ■

continued from front page....SL Anniversary

Lois O'Connor

Lois was the first Secretary of the Board of Directors and joined Serenity Lane in January of 1972. She originally served as a secretary/receptionist/bookkeeper and deposited the very first dollar given to her by Dr. Kerns to open a bank account for Serenity Lane. Lois went on to become a premier interventionist and admissions counselor before retiring from the company in June, 1995.

Sam Graves

Sam joined Serenity Lane on November 1, 1972 and was waiting in the lobby when the center's first patient arrived. Prior to joining Serenity Lane, Sam served as Senior Counselor at the Heartview Foundation in Mandan, North Dakota. During his career at Serenity Lane, Sam has served as Treatment Director, Manager of the Community Outreach Program, Manager of Intervention Services and as an inpatient counselor and family counselor. Sam has treated thousands of clients and family members.

Since those early days there have been nurses, doctors, clinicians and countless support staff that have contributed to the mission, each one offering the compassion and expertise to help those afflicted by this deadly disease of addiction.

As we move forward and expand in the coming years, we will never forget those humble beginnings or the people who made it possible. ■

Recovery & Relapse

Part 3: Partial Recovery

by: George Spurny MS, CADCIII, NCAC II

George Spurny is the Director of Clinical Services and is an Advance Relapse Prevention Specialist with over 16 years of experience working with relapse prevention and is actively working in teaching relapse prevention skills with all of the ExSL patients.

This is part three of a three-part series on Recovery and Relapse. The areas addressed included the Recovery Process, Partial Recovery and the Relapse Dynamic. All of the information is based on the work and research of Terence Gorski.

The Relapse Dynamic

The last part of the series will look at the relapse dynamic. The relapse dynamic starts with a stuck point that has not been addressed. It is usually caused by high-risk factors such as a high-stress personality, high-risk lifestyle, social conflict or change, poor health or other illness and not working with an adequate recovery program. The failure to address or resolve these issues leads to the next part of the process, which is a trigger event.

A trigger event can include high-stress thoughts, painful emotions or memories, stressful situations or interactions with other people. Again if these issues are not resolved, a person continues the relapse dynamic and works into the internal dysfunction phase. The internal dysfunction phase reactivates Post Acute Withdrawal (PAW), which involves difficulties in thinking clearly, managing feelings and emotions, remembering things, sleeping restfully, managing stress and physical coordination problems. As a result of this process, the alcoholic/addict can also experience shame, guilt and hopelessness. The alcoholic/addict knows that something is wrong inside them, but does not want to let other people know that they are having problems.

As this dynamic continues, the alcoholic/addict experiences the external dysfunction phase. In this phase, old drinking and using behaviors return except that the alcoholic/addict is still sober. The alcoholic/addict exhibits the following behaviors: avoidance and defensive behaviors, crisis building, immobilization, confusion, overreaction and depression. Because often alcoholics/addicts do not share their relapse warning signs with their family or significant others, they do not understand what they are experiencing. Consequently, the family or significant others think that the alcoholic/addict has returned to alcohol and/or drug usage and may not believe the alcoholic/addict when they deny this accusation. If the alcoholic/addict does not reach out to identify the stuck point at this time, they will go into the next phase of the relapse dynamic, which is the loss of control phase.

In the loss of control phase, the alcoholic/addict exhibits poor judgment, the inability to take action or resist destructive impulses and conscious recognition of the severity of loss of control, which cause option reduction and can lead to emotional or physical collapse. At this point, the alcoholic/addict thinks that the only choice is to return to alcohol and drug use. An external intervention will be necessary at this point to get the alcoholic/addict back into recovery. Although the alcoholic/addict still has not used alcohol and drugs yet, the thinking

process will allow them to relapse.
The last part of the dynamic is the lapse/relapse phase. The lapse/relapse phase starts with the initial use of alcohol and/or drugs and then severe shame, guilt and remorse over drinking and/or using. The consequence is a loss of control over use, leading to the development of health and life problems. At this point, a person will need to return to treatment for stabilization. The purpose of relapse prevention counseling is to teach a person their warning signs and intervention points to deal with stuck points and stay in recovery and not relapse.

This article was adapted from the following books by Terence Gorski:
Staying Sober, A guide for Relapse Prevention
Counseling for Relapse Prevention
Passages through Recovery: An Action Plan for Preventing Relapse. ■

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Pearls...of Wisdom

I really don't have any "pearls of wisdom"...I just feel like one of the counselors who works on the front line and goes into the trenches, offering a hand to pull people out who have a desire to be clean and sober. I'd like to think I guide them out of the darkness into the sunlight of the spirit even if they only see a glimmer of hope (that's often all it takes). I believe at Serenity Lane we don't treat our patients and their loved ones like a chart number, but as an extended family striving for recovery from addictions.

At the workplace, I am usually the one who re-evaluates former patients after they returned to drinking or using. Some of the reasons I see patients seeking treatment again are because they didn't make *Recovery their #1 Priority* and did *not* make changes concerning *"People, Places and Things"* which includes maintaining healthy and honest relationships, attending and being involved in 12 step groups, outside counseling as needed and last but not least, being intrinsic with the first step on a daily basis.

An old-timer in Hawaii once told me that if I have one hand holding the Big Book/12 steps and another reaching to my higher power and helping others, I wouldn't have a free hand to pick up a drink or drug.
Thanks for listening...

Sincerely, Sherrie Jensen-Riel
Intake Counselor in Serenity Lane's Portland clinic

Awareness VS Surrender...

How ready are you?

by: Neil McNaughton, **MSW**

In a previous issue, I talked about the role defense mechanisms play in the development and treatment of addictions. I mentioned that defenses are for the individual's psychic comfort, and they are by definition automatic and unconscious. Over-utilization can grossly distort the addict's perception of reality (consequences of drinking and using) and can greatly diminish motivation for treatment. Combined with an overwhelming compulsion to drink or use, it is devastating in terms of solving problems. Failure at problem solving leads to a profound sense of negative self-worth and mega-stress, which can be motivation to drink and use. The result is a cycle of self-destruction.

Dr. Harry Tiebout, a pioneer and expert in the field took the first step of Alcoholics Anonymous and broke it down into five stages of readiness for treatment in most alcoholics. These stages correlate generally to how rigid and effective the defenses are in blocking feedback to the alcoholic. Over time, with the support and feedback available in a treatment setting, the individual's understanding and motivation will likely increase. Seeing and accepting the problem clearly is primary for the addict to progress. The first stage is Awareness, which is characterized by full denial, but there is conscious recognition of the idea of the illness concept. Second is Compliance in which the individual is conflicted about the necessity of treatment versus continuing the belief that there is no problem. He or she may pretend to agree and goes with the flow, but usually with a lack of enthusiasm. Third is Recognition in which the individual, although fearful and anxious, begins to acknowledge needing help and is questioning or searching and asking for some feedback. Number four is Acceptance. Here we begin to see much more acceptance and cooperation with the illness concept coupled with some conviction, yet still exhibiting some struggle. The fifth or last stage is Surrender, which is highlighted by a whole-hearted acceptance and conviction of the diagnosis, punctuated by a motivation to accept treatment and implementation of the 12 step process.

A goal of treatment is to assist the patient in achieving the Acceptance and Surrender stages of understanding and motivation by the time they leave residential or intensive outpatient programming. Some patients don't make it to this level and may still be at the Awareness or Compliance stage for a variety of reasons (detoxification issues, finances, resistant defenses, distractions, co-dependency issues with employers, professionals, family, etc.). What is of further concern to treatment staff is that a patient may achieve Acceptance or Surrender and regress to the Awareness stage again. In other words, progress achieved in treatment may be reversed just as the intensity of treatment is ending. There is no guarantee that the self-delusions won't return and constant feedback and self-evaluation is of primary importance. Vulnerable behavior is easily recognizable because the patient wants to quit attending treatment, AA or NA and starts minimizing or rationalizing such actions. Secretive relapse plans may have already started. This is a dangerous and vulnerable time for all addicts who wish to recover. That is why good treatment programs stress follow-up programs and total commitment to 12 step participation. It is also why there is a lot of repetition. They know that constant feedback and support directed toward the addict is life saving. ■

Our listening creates a sanctuary for the homeless parts within another person.

~Rachel Naomi Remen

Service OR Relapse

by: Luis Rivas

In 1951, Bill Wilson penned the introduction to the "AA Service Manual" and began the publication with some rather strong statements, among them one which captured his experience with regard to service – "We must carry the message, else we ourselves can wither and those who haven't been given the truth may die." It seems like an extreme statement for the co-founder of a program advertising a message of hope, doesn't it? Is it possible that this is an aberration - that Bill was just putting to paper a bit of ire he might have held onto from some dispute with a new member? A deeper look at the literature indicates otherwise.

The opening statement of the 7th Chapter of the primary text of Alcoholics Anonymous indicates that its authors have learned, "nothing will so much insure immunity from drinking as intensive work with other alcoholics." This opening to a chapter regarding work with other alcoholics reflects the experience found in the chapter titled "A Vision for You" and is a reflection of the agony a newly sober alcoholic felt in a hotel lobby, gazing longingly into a lounge before calling churches in search of an alcoholic to work with. Here the wall between a man thirsty for a drink and the bottle was simply the hope of finding someone he could help. Many others have held to the wagon on such terms. But why? How is it that the renewed attention to those less fortunate brings respite from the mental obsession to the alcoholic? Is it that service itself, as a selfless act, relieves one from the bondage that the Big Book discusses?

Certainly, service is a manner of addressing selfishness and self-centeredness, but then what of the alcoholic who engages in service for the purposes of appearing dutiful to his fellows, perhaps to his sponsor? When he receives the fruits of service, what are we to believe? It is here that the essence of service to a fellow alcoholic appears - the act being a way in which the server, often in spite of him/herself, encounters a renewed recognition of his own First Step experience. Whatever defenses have been constructed since his last drink, however the cobwebs of time have crowded out that "suffering and humiliation," the disease is undeniable in another. It is this juncture of necessity, where self-awareness and selflessness join under the title of service that another day without drink is attained. A new sense of purpose is acquired.

Balance in early Recovery

by: John DeRoin

Now that we are no longer under the lash of our active addiction, we feel better. Our acute symptoms have been treated, but this is a chronic disease. We run the risk of overdoing it with our newly found health. Making up for lost time is an area of early recovery that could prove to be an obstacle.

Addiction is a primary, progressive, chronic and fatal disease. Since it is primary, we must first stabilize the symptoms of our addiction before we can experience the rewards of a healthy life. We must also maintain a program to attend to the chronic nature of our disease. Then, we can experience more gifts of recovery and the promises.

Prioritizing the maintenance of a program is vital. For example, 10 weeks of intensive outpatient with a minimum of two outside 12 step self help meetings during this time requires approximately 12-13 contact hours invested per week. Assuming we take a balanced approach to our jobs (40 hours per week), we are left with precious little time for exercise, proper nutrition, quality time with the family and fun. This makes it clear that adding anything extra would be highly stressful.

Tips for meeting the early recovery balance challenge: 1) Call your sponsor and consult family, friends or anyone else on your relapse prevention team before you make a major decision. 2) Make your plan and have it ready ahead of time. 3) Think globally. In 10 weeks after you graduate from intensive outpatient, you will be confronted with another challenge. What to do with all of your free time! 4) Continue to set both short and long term goals. Always run plans by those who care about you. Remember, this is a WE program.

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~Denny Johnson, Touch Starvation in America