Redirected Therapy

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The concept of redirected therapy endeavors to deal with the emotional problems with which a patient may be left after his biochemical problem has been corrected. Many of these patients have previously had psychotherapy which did not assess the proper role to biochemical factors in establishing the etiology of the illness. The reestablishment of correct cause and effect concepts is the function of redirected therapy.

Twenty-eight years ago, the first open heart surgery performed on "blue babies" successfully restored them to health, and they were able to develop normal, intact personalities. For a time, however, a generation of patients grew up as invalids and the miraculous surgery only came about when they were adults. With the stroke of the surgeon's knife, their bodies were restored to normal health and energy. But the consequences and prognosis for them was not as simple and dramatic as it was for the infants. These patients had been brought up as dependent

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human beings; this was their reality. In addition, the people they were generally involved with received satisfaction from this dependency. When the surgeon erased the underpinnings of these emotional needs, many patients then required psychotherapy addressed to their new needs. Some feared independence and some developed problems of guilt when they sought to throw off excessively caring relationships with persons who could not accept their new ability to function on their own. The problems were individual and varied.

We are now finding a new generation of patients who also require psychotherapy addressed to their new needs as a result of dramatic medical treatment. This time, however, there is not as clear cut a distinction. Many clearly medical symptoms have been erroneously diagnosed and treated as emotional problems. Patients have been incorrectly directed to psychiatric treatment. The entire focus of the psychiatric treatment needs to be re-evaluated.

This group of patients suffered symptoms ranging from hyperactivity, fatigue, depression, chronic pain to schizophrenia. These problems are gradually yielding the secret of their etiology to biochemistry rather than to

psychotherapy. Controlling hypoglycemia, megavitamin treatment, coaxing out subtle food or chemical allergies often can erase, sometimes with miraculous and dramatic speed, the seemingly psychological symptoms to which therapy had been addressed.

At this point, patients vary as to how much psychotherapy is required. This should be evaluated on an individual basis. As with the post-surgical patients, it must be evaluated in terms of the impact of the illness on the development of their personality. For example, consider the person who has believed (usually all of his life) the cause of lack of achievement is due to either his own inadequacies or poor parenting, then discovers the real problem is faulty body chemistry that can be easily corrected. Or the hyperactive child, who for years has been pressured beyond his actual, but unrecognized physical limits. He develops a poor self-image which does not necessarily disappear once the medical cause of his hyperactivity is detected and corrected. Also, the irritable person who does not understand his periodic irritability. He becomes overly solicitous at other times to make up for the guilty feelings. Spontaneous, healthy behavior gradually becomes impossible for these people.

The more years that this patterning takes place, and the more self-demanding the patient is, the greater the degree of impairment to the ego structure. With a leveling of the mood swings, an increase in energy and a greater utilization of intellectual capacity, the patient relates to the world differently. Relationships, for one thing, may turn out to be all wrong. The mate who lived with a fatigued, depressed person out of psychological needs of his own, may no longer fit the needs of a vigorous and more spontaneous personality. As a consequence, the healthier patient may suffer guilt or stress concerning his lack of satisfaction with the mate who stood by when the patient was not functioning well.

The problems are many and individual. As a general rule, the patient enduring a long-term, undiagnosed body chemistry problem will, by the time the problem is detected and treated, have developed such a poor self-image that this will require what I have termed redirected therapy. The individual has never enjoyed achievement appropriate to his ability. The earlier the age that the vitamin deficiencies or allergies are recognized and treated, the less the impact on the development of the personality.

It becomes obvious we need to understand and treat a large body of patients for whom the physical and emotional components of development are so synergistically related as to demand a total approach.

Typically, so much physical and emotional energy is required for any accomplishment that patients tend to develop compulsive, or rigid personalities. Usually, the biochemical imbalance has been present from birth or early childhood, and then evolves to an ever-increasing degree. The patient gradually accomodates, and the limitations become the norm. Therefore, the commitment to a single goal consumes the patient's physical and emotional energy, resulting in a rigid personality. The conscious control of physical movements and mental clarity precludes spontaneity. The extent of self-involvement can produce a degree of detachment from the outer world, a degree of narcissism, and a compulsive pattern of behavior.

Achievement becomes limited and emotional control disturbed to a gut level awareness that he is not functioning as other people do. The patient blames himself or develops hostility to people in his immediate or past environment. This sets up a deep, chronic stress situation, further burdening the body chemistry and complicating the situation. The complexity of the patterning compounds itself. The greater the body chemistry imbalance, without the patient's awareness of any functional accomodation to the condition, the greater the emotional stress. This stress exacerbates the physical imbalance. In a sense, the harder the patient tries, the more quickly he becomes exhausted and fails. Depression and poor self-esteem result from the cyclic relation between the physical and emotional components as they impact on each other. The compounded pattern is totally

interrelated and must be seen as a synergistic whole.

Breaking the dynamics of the cycle by first recognizing and addressing the biochemical problem and then treating the emotional overlay can bring about a redirection toward wholeness.

Although the patient knows something is amiss, he is often told there is nothing wrong. As a result, he develops a fear of actually feeling his feelings. This becomes so deep and pervasive that he finally refuses to accept and feel his feelings. Behavior becomes rigid and lacks spontaneity. To get away from the world of feelings, one may become an overly intellectual personality. He is not comfortable with himself but does not know why. His satisfactions become restricted to the intellectual sphere.

Another development may involve a great degree of self-loathing. Self-confidence is impossible when achievement is not commensurate with abilities. The greater the achievement gap, the greater the degree of confusion and loss of self-esteem.

There are several broad categories of people who should be looked at with this complex etiology in mind. The most obvious is the alcoholic. All alcoholics should be tested for hypoglycemia and allergy. Of course, as time goes on, the lack of vitamins in an alcoholic's system adds another negative to the problem. The lack of self-esteem becomes pervasive and a catalyst for further deterioration.

The workaholic is another broad category of observed personality deficiency. This person finds a different method of getting away from his deep fear and poor sense of self. He becomes an intellectual and controlling personality. In the safety of his intellect, he need not experience the world of feelings. His control is very rigid, however, and his behavior cannot be autonomous. He continues to prove to himself and the world that he is OK. Thus, he can separate himself from the fear and knowledge that he is not. For him, alcohol is not an acceptable crutch. Because he needs desperately to be accepted, he is apt to be addicted to something more socially acceptable. A chronic addiction to a specific food continues to give him his "quick fix". By riding the crest of his addiction, he always has a supply of artificially obtained energy. More study of the etiology of the workaholic with attention to the biochemical factor as one aspect of his development needs to be done.

Another group can be found within the broad category of those who fit into a rigid structure within society, such as the civil servant, the military man or the clergyman. Why do they surrender spontaneous movement for a rigid structure? Not all, but perhaps some have bartered unresolvable inner tension for the comfort of a structure within which they need not be fearful or alone. Perhaps their body chemistry imbalance has been one of the causes of the development of these types of restrictive behavior patterns.

Therefore, the child born with an undiagnosed body chemistry problem has choices. Depending on his basic temperament, capabilities, and family environment, he will develop in many different directions. However, at the core of his development is the common thread of poor self-esteem and lack of spontaneity. He cannot understand why he is not comfortable within himself. Doctors, parents, and teachers incorrectly see him as whole and healthy. This then makes it obvious to them his problem is purely emotional.

The emotional problem needs to be seen as a result of the impact on the personality of an undiagnosed chronic physical disability. This is quite different than what the patient has been told is the cause of his problems. This can be very confusing, producing the need for redirected therapy. This therapy actually is based on two aspects. First, clear up the confusion concerning the real cause of the problems; and, second, build a healthier ego structure with supportive therapy.

Take the case of the fifty-five year old woman who had been in and out of therapy for thirty years, until she consulted Dr. Theron Randolph. Clearly, she felt being a middle child was basic to her so called emotional problem. Dr. Randolph was able to demonstrate that food allergies were the basis for her depression and fatigue. After

the initial exhilarating response, she found it difficult to really believe at a deep meaningful level that what she had been told and believed for thirty years about the family relationships was not relevant. It required a process of relearning about her past. She felt, in terms of her future, "lost as a nun would be if she came out of a convent after thirty years". She was totally unequipped for a new role in life in terms of her ego strength and her job expectancy.

After an initial period of excitement about discovering the tangible and treatable cause of problems, many experience a great deal of anger concerning the incorrect diagnosis and treatment they had previously received. Part of the function of the redirected therapy is the need to deal with the phase and channel this non-productive anger into more positive energies.

Unfortunately, the family who could have been a supportive system for the patient, has at times been blamed for the problems, at least partially. With the newer insight into the etiology of the problems these relationships need to be reevaluated, and many times can become real strengths. Certainly, the parents benefit by being relieved of the guilt that has been thrust upon them.

Consider the case of Nora. When she came to me at age twenty-six, she had been diagnosed as a schizophrenic. After three years of psychotherapy she had not improved at all, and in fact, had attempted suicide several times. The concept of a metabolic disorder made no sense to her, and it was several months before I was able to convince her to take some vitamins. She agreed to do this if I would not "bug her" about giving up sweets, which was one of her few pleasures. A month later she felt improved enough to be willing to have some testing. She was relieved to the extent of being euphoric when she saw a basis for her problems that gave her the ability for the first time to be hopeful about eventual recovery. Her testing showed a great number of food and chemical allergies as well as numerous vitamin and mineral deficiencies. She responded gradually to the medical aspects of the program and it was necessary for me to follow her in a redirected therapy situation for about a year.

First of all, she came to understand the hostility to her mother, which she had been told in previous therapy was the basis of her problem. Her therapist had her hitting a punching bag and hollering at it to express this hostility. She told me with tears that she never really felt this hostility but the therapist had convinced her it was so deeply buried that she was not in touch with it. The friction with her mother, she came to understand, was not the deep-seated cause of her problems but the result of her irritability. It was difficult for her mother to cope with her because of her underlying metabolic problems. She was deprived of the support system that she might have had from her mother by the divisiveness of the previous therapy. This relationship had to be reestablished and proved to be a strength for her.

She was a very dependent, insecure girl whose life experience had been filled with bewildering failures. As her body improved, she was able to take the small steps and achieve small successes. She needed to be greatly encouraged at each step of the way, and each success compounded the next. The process of establishing a positive ego structure was infinitely slower than her medical progress, although each fed on the other.

The depth of her poor self-image and fear of failure is best exemplified by the following instance. Her most intractable symptom was the visual fogginess which plagued her constantly. One morning she woke up and for the first time in years, her vision was clear. Her first instinctive reaction, she confided, was of fear, "My God, what do I do now?", followed by a real sense of joy. She had to come to terms with the fact that her positive drive, which she certainly had, was matched by a lifetime experience with failures. This proved to be the focus of the redirected therapy. Her improvement was gradual. It came through the combination of addressing her body chemistry problems in conjunction with the personality difficulties that had become the corollary factor in an ever-increasing cyclical pace. She is now planning to go back to school and finish her

college education, and become involved in the field of nutrition.

Now that we are uncovering the metabolic basis of emotional problems, we must be careful to avoid the pitfall of the either/or concept. It is important to go one step further and evaluate for each patient how much emotional overlay exists.

The concept of redirected therapy should be added to the tools available to us so that each patient can be treated as a whole person. In that way, therapy can be integrated more accurately and more readily into the framework of the total personality. Each patient who is receiving Orthomolecular treatment or treatment for allergy should be evaluated in two ways. One is the extent to which therapy is required to correct the previous misconceptions of the etiology of the problems. The other is to determine how much help each patient requires to face the future as a more effective, whole person. We have then done a complete job.

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