Changing Scripts: the poorly impeded interest-excitment version

> Since we are affected by the affects, especially shame, what script enables us to choose to modify them? So that behavior, for example, with shame, can become altered? If I have phrased the question clearly? And tell me, if you can, and there is one, a book or reference and page.
> - Chuck Yopst.

Jonathan L. Grindlinger, M.D., 1/7/99:

As the new Training Director of the SSTI, let me take a stab at responding.

What you have asked is the crux of what an effective psychotherapist does for a living! You have asked a question which goes to the heart of the Philadelphia System, the most efficacious psychotherapeutic system I have yet to witness for producing the most deep and lasting change in the most difficult of patients, for which "the book is still being written."

It is important to emphasize that script theory is vastly more complex than affect theory. In an earlier posting, Dr. Nathanson describes his analogy of the affect system as a bank of nine different spotlights. As you can see, the affect system in its innate form is complex on its own. But when we consider script theory, we are now dealing with affect co-assembled with cognition, memory, perception, imagery, and motor responses. I will present a couple of ways to illustrate this level of complexity. If the innate affects could be seen as analogous to the letters of the alphabet, then scripts represent the rules of grammar and syntax for which we construct sentences. Or, another way of illustrating this is to see the innate affects as analogous to the notes of the scale, with scripts representing the complex rules we use to construct a full composition of music, including which instruments go where, what parts they play, and all other aspects of the musical composition and arrangement. But overall, the affect system provides only the motivational piece. The interpretation, evaluation, prediction, production, and control of the various scenes in which we live is the realm of scripts. Only through scripts can affect co-assemble with other affect and amplify it (affect magnification) potentially indefinitely. Innate affect, on its own (in adults), is usually not extremely intense and it is always short lived. But when affect is amplified by other affect, which only occurs under scripted affective magnification, affect can grow in intensity and duration indefinitely. The clinical relevance of this fact is that scripts (at least the ones that we deal with in psychotherapy) are held together by intense and enduring affect and therefore, require counterbalancing intense affect to enable modification.

Regarding your first question, as I see it, there are 2 prerequisites that are necessary to begin the modification of a script. One is consciousness of the script and two is the presence of affect, usually highly dense affect, which is directed at modification of the script. Once the targeted script is brought under conscious control and starts to change, then the patient must continuously work on increasing their skill in perception of the script that one wants to change. Then the patient must be helped to perceive heretofore inconceivable perceptions and goals (new Images) which are only attainable by consciously preventing behavioral responses which had been part of the old, undesirable scripts. Finally, the patient must be taught new scripts that are required to manage these new perceptions (new Images).

One does not have to have memorized (I don't) all the categories and hierarchies of scripts which have been laboriously described in Tomkins's writings in order to be effective with helping a patient to change their scripts (I am). But one must understand 1) why they were formed, 2) how they function to prevent the patient from changing, 3) what is necessary to experience by the patient in order to change them, and 4) what that experience is like for the patient as it occurs. Oh, I forgot that add that we must also be able to differentiate very specifically those scripts which we are going to target for change and those that we want to leave alone or perhaps even utilize to help make those changes. How I see it, this is basically what psychotherapy is all about.

First of all, we want to be able to identify any scripts that preclude and/or impair following the 4 General Images, and then label these scripts as pathological. Any scripts that can be found in the patient that follow the 4 General Images will be identified and utilized to help make therapeutic change. Tomkins came up with the 4 General Images because he recognized that a system based on positive affects that are innately rewarding and negative affects that are innately punishing required following certain rules in order for the system to operate properly. Because we are wired this way, we must follow these rules in order to maximize our health, mental health in this case, and most likely physical health as a derivative (and sociocultural health as a further derivative). A term I often prefer to use when describing the 4 General Images is "The Blueprint." The 4 General Images are:

1) Maximize positive affect as much as possible 2) Minimize negative affect as much as possible 3) Minimize the inhibition of affect as much as possible; in other words, maximize the open expression and exposure of affect as much as possible 4) Maximize scripts that maximize skill in attaining the above three rules

I must emphasize at this point that Vernon C. Kelly M.D. extrapolated these rules into the realm of intimacy with great success and has written extensively about the use of these 4 General Images to treat problems with intimacy.

As we get to know the patient in psychotherapy, we seek out patterns which reflect rules unconsciously utilized by the patient to manage his affects, which is what affect management scripts are, by definition. These are highly skilled sets of rules that are unconscious precisely because the patient has become so skillful at utilizing them. Any skill that we become highly proficient at will become unconscious; we do not have to think about it in order to perform it. Those patterns which prevent the maximization of positive affect or the minimization of negative affect or the minimization of affective inhibition are sought for, identified, and then worked on with the patient so that consciousness of these patterns can be achieved.

After I really get to know the patient and begin to understand how he manages affect, I then help him to identify in himself (make conscious) these affect management scripts while encouraging the experience, including expressions of, as dense affect as I can get the patient to tolerate. I'm most satisfied when I can get my patients to see the scripts in action in the office in our presence and at the same time allow them to become extremely pissed off about its consequences for their life. Actually, any sufficiently dense negative affect they experience about the consequences of these scripts on their life that I see them experience will give me great satisfaction. Not to mention that when they experience dense negative affect in my presence, it gives me the opportunity to provide compassionate and empathic soothing. In other words, their experience and expression of negative affect allows me to provide them with the experience of effective affective attunement, which in most cases is a completely new experience for the patient and can become the foundation for the development of completely different affect management scripts than the ones they originally came to me with.

So as I think about it, it's like I'm beating them up with compassion in an effort to help them first see profoundly important patterns in themselves and then, using this information, make profound changes in themselves. Of course that's a facetious oversimplification of the process; however, the only way one can effectively help someone see scripts which have been hidden for so long and have been utilized in an effort to manage enormous and enduring pain is to be exquisitely sensitive and responsive to the huge amount of shame we all experience when engaging in such a self-revealing process. Attention to and the minimization of shame is critical to the success of this process.

The main reason that we have scripts is so that we can classify the various scenes we encounter in life and make sense out of them. The good part about script formation is that it makes processing information very efficient. The bad part about script formation is that it prevents us from responding differently or perceiving differently scenes that are genuinely different. Scripts tend to make us perceive and respond to various scenes in ways that we have already learned instead of finding new ways to perceive and respond to scenes. Most patients come into therapy because they have scripts that prevent them from adequately modulating negative affect or prevent them from obtaining sufficient positive affect; in other words they don't know how to attain the Blueprint. And I must emphasize here, that an inability to minimize the inhibition of affect will prevent maximizing positive or minimizing negative affect because all affect must be expressed for it to be modulated. And furthermore, it is my opinion that human beings are unable to modulate affect if they lack experiences of affective attunement, again emphasizing the importance of affective expression. Another person cannot attune to affect if one does not first express it. But of course, most of our patients have lacked compassionate affective attunement and instead have found these experiences historically punishing. They have learned that attempting to express affect will at best do no good and at worse result in further punishment. They have then formed scripts based upon these experiences that are totally appropriate under conditions of empathic failure, but unfortunately, prevent them from obtaining or even perceiving as possible, experiences of empathic success and all the attendant awards of such an experience. One of the most important ways to minimize shame as the patient is becoming aware of such terrible scripts is to help them realize that forming these scripts was totally appropriate under the conditions of their earlier life and that they just simply don't work under conditions of life they find now. The feelings of powerlessness and helplessness come from a time when they really were powerless and helpless. But now they are adults. One must be vigilant for the tendency for Attack-Self (and other expressions of shame and the Compass of Shame) responses to awareness of this and quickly intervene to reduce self-blame and help them understand that under the conditions which they learned these patterns, they had no choice and acted in a very adaptive and skillful manner. And it is because of scripts, which we all have, that it feels the same now as it did then. Scripts make everything stay the same.

One of the most important functions of the scripts we work with in psychotherapy are their scanning functions and how these scanning functions are constantly seeking out analogs to fit into the script and therefore validate and reinforce the script. Helping patients see how they scan for analogs is critical to making them conscious of their scripts. Because scripts deal with how we interpret, evaluate, predict and overall perceive our world, knowing this allows a therapist to empathize in more deeper and effective ways. Helping a patient to see their own scanning functions is essentially helping them to learn how to perceive the ways in which they perceive things. In terms of inducing change, I believe that the starting point has to be with perception, because all responses and interpretations that drive (motivate) responses begin with perceptions. And since perception is nothing more than a critical part of a script, this is the first thing I try to make conscious and work on changing. Human beings seem to prefer being right (having their perceptions validated) instead of being happy (and minimizing unhappiness).

Now, once the patient begins to learn how to question the ways in which he perceives things, he can begin to enter the realm of experience for which he has no scripts - so far. It is important to empathize with and normalize the confusion, uncertainty, and fear that is experienced at this stage. One can never learn something truly new until one is first confused. And, of course, helping the patient deal with shame that is related to emerging awareness of incompetency (which is normal and expected) is critically important at this stage.

Once the patient is finally comfortable with operating outside of their previous scripts and comfortable with "not really knowing what to do," then the real work of teaching them scripts that follow the Blueprint can began in earnest. So, in summary, one can view following the Blueprint as knowing how to "take care of yourself properly." Psychotherapy is essentially (and blatantly oversimplified) the process of showing the patient what he does to not take care of himself properly and then showing the patient how to take care of himself properly.

I welcome all questions and comments with open arms.
Jonathan L. Grindlinger, M.D.