

Book review

Jeffery Smith

How Psychotherapy Works. Navigating the Therapeutic Space with Confidence

Preliminary Version (Advanced Reader's Copy)

Abingdon, UK; New York, NY, USA: Routledge Publ.

Introduction

In this clearly outlined monography, we are dealing with the multicolored retrospection and outlook about the work of an experienced psychiatrist, who emphasizes his integrative (and not specialized) approach, which is open to diversified diagnostic and therapeutic ways.

Jeffery Smith is a psychiatric generalist in the best meaning. He received a top education (among others, Stanford and UCLA), and claims to receive many of his experiences from the patients, who he calls clients ("I never specialized, so I have seen everything"). He offers this work to learning psychotherapists who embrace integration. Smith is extraordinary professor at New York Medical College, guides an institute (Howtherapyworks) and is active in podcasts. His work methodologically is integrative and focuses on affects, which, in his words, are "nonconscious emotions". They are the key to understand psychiatric diseases as well as the their therapy. Time will tell if we here are observants of a new school of integrative Psychotherapy. What we can say already now, is, that Lester Luborsky (1984) has developed integrative psychotherapy early in Topeka and verified its efficacy later in Philadelphia.

Frame

Smith introduces a diagnostic and therapeutic view on „Affect Avoidance Patterns (Smith, 2019)“, which is an actualization and widening of earlier concepts of diagnosis and therapy: Franz Alexander's Chicago School (Alexander, French, 1946: "corrective emotional experience"), Hans Strupp and Jeff Binder (1984) from Vanderbilt in Nashville ("Psychotherapy as a New Key" to "cyclic maladaptative patterns"), and, from Berlin, Germany, Günter Ammon (1973: structural diagnosis, group and

milieu therapy) and Annemarie Duehrssen (1988: “Dynamic Psychotherapy”). Jan Panksepp (1998) validates the diagnostic evolutionary roots of affective limbic patterns with his “laughing rats”.

Smith completes now with his New York School the circle in adding Neuropsychoanalysis (Kaplan-Solms, Solms, 2003) by coining and using the term of neuroplastic concept as “memory reconsolidation“ (Luborsky, 1984, Lee et al., 2017) through affective “disconfirmation“.

He intends to connect clinical observations and current science with a fresh approach to interpret psychotherapy in a modern form, which we may call integrative on an eclectic basis.

Construction

The 14 chapters are structured in Principles (chapter 1-5: foundation of success, psychotherapy treats EMP, EMP and layers, the authors of EMP, the plan);

Deepening (chapter 6-10: Inside EMP, five questions, seeking accurate empathy, 3 mechanisms of change, bringing affects into the room, art of disconfirmation);

Therapeutic Outlook (Chapter 11-14: Hope, development, motivation, boundaries and pitfalls, framework, end of voyage).

It is handy and reader friendly, that the references are at the end of each chapter listed separately.

The author offers rich casuistic material and a wide range of therapeutic instruments, and it is a didactic masterpiece because the shifting from casuistic sketches to theory is fun to read.

Terms

EMP: Entrenched Maladaptive Pattern: the pattern of suffering, the avoidance of pathogenetic affects.

CEN: Central Executive Network

DMN: Default Mode Network

Dread: What is the reason for this avoidance and of the concomitant anxiety?

Hypothesis: Why must the client protect this avoidance?

Response: What kind of therapeutic reaction can replace the old pattern?

Antidot: The new corrective emotional experience in the therapeutic room.

Layers: Different levels of EMP, from cognitive (prefrontal cortex, central executive network, CEN) to limbic structures (amygdala, default mode network, DMN).

Process

1. The instrument is “accurate empathy”: the deep emotional understanding as well as cognitive comprehension. Accurate empathy activates nonverbal subcortical affective patterns of memory, which the author locates morphologically in the Limbic System of the patient.
2. The work: Accurate empathy causes “disconfirmation”. The presence of the empathic therapist deletes the old pathogenetic pattern (memory reconsolidation). Accurate empathy shows the patient, that there is “another way of response in the therapeutic room”.
3. The Healing: Memory: Reconsolidation through affective disconfirmation leads to re-writing the patient’s pattern after deleting the old one. This is a neuroplastic approach understood as a process within the limbic system.

Model

The author assumes that psychiatric patients basically are burdened by EMP (entrenched maladaptive patterns), i.e. hidden pathogenetic affective memory patterns, which also trigger cognitive functions and behavior.

They are defining some kind of the fearful symptoms which lead to avoid painful affective memory, thus creating EMP. Some researchers may call them “early cumulative traumata”.

With this, the autor leaves Freudian metapsychology diagnostically, but he at the same time varies the Freudian (Freud, 1895) “Catharsis” through replacing cathartic release of affects by deeper re-writing of the EMP (through memory reconsolidation) by using accurate empathy (therapist) and disconfirmation (patient).

These basics are ringing true in all relevant psychiatric diagnoses, Smith claims. The task of the therapist is, to recognize the nonverbal diagnostic elements, and the value of chronification as a factor for prognosis.

Here, he mirrors his results to the patient in a therapeutic space, in which the patient’s affects are now dwelling (bring the affect to the room). Now the re-writing can start (memory reconsolidation through affective disconfirmation).

The first step (seeing the EMP) is a diagnostic procedure with depth-psychology, the second step (using accurate empathy for memory reconsolidation) is the therapeutic process which leads to healing (change and growth).

Pathogenesis

The pathogenetic root of EMP is early traumatic experience, (core vulnerability leads to learned fear paradigm), which causes avoidance of unbearable affects associated with these roots (entrenched dysfunctional patterns, EDP). Accurate empathy is the instrument of learning (therapist) and re-experiencing (patient) “how and why“ these patterns have lead to that crucial and harmful avoidance.

Therapy

The therapeutic way is the reconsolidation of affective memory contents through empathy and disconfirmation, which brings an affective incongruence (disconfirmation) in the patient’s emotional memory, comparing the new (therapeutic) with the old (pathogenic) pattern. The fearful expectancy is dissolved by the therapist’s empathic presence and emotional answer, and, thus, positive disconfirmation.

Now, neuroplastic changes are beginning, first in the layer of CEN (central executive network); then, deeper, within the spontaneous action of the limbic DMN (default mode network; term coined by Raichle et al., 2001). This is memory reconsolidation, the center of Smith’s therapeutic concept.

It reminds me of Freud’s (1895) catharsis as well as of Alexanders (1946) “corrective emotional experience“ and can be compared to Strupps and Binders (1984) “Psychoanalytic Therapy in a new Key“.

This is the historical background: Smith’s central tool is the “accurate empathy“ for the affective space of the patient. This changes the patient’s memory pattern, it is now re-written by affective reconsolidation. This is the key for the new arrangement of the therapeutic space. Freud’s thesis (“Where Id was, I begin“, Freud, 1933: 111) and the thesis of the Chicago School of “corrective emotional experience“ (Alexander, French, 1946: 66-70) are both transcended by Smith, because he now uses the neurobiology of memorial re-writing and memory reconsolidation (which is “The queen of change mechanisms“).

This approach is the closing of the circle from analytic orthodoxy (Freud) through Self- and Ego-Psychology (H. Hartmann, Kohut) across analysis

of relationships (Mahler), attachment theories (Bion), structural theory (Ammon), dynamic psychotherapy (Duehrssen) and mentalization (Fonagy) to neuro-science (Raichle) and neuro-psychoanalysis (Solms). What a giant leap.

Neuroplastic Details

Smith uses experience and intuition for a neuroplastic connection of networks:

CEN: Central Executive Network: the cognitive level (prefrontal Cortex);

DMN: Default Maladaptive Network (Limbic System).

The therapist's task is to bring the patient from the neurological "highway" CEN to DMP to reverse the old pathogenic and avoidant pattern. The CEN works on the level of insight, the DMP works on the level of the limbic system. Working with CEN is not enough.

The therapist's understanding of the patient has to be affective (bring affect into the room) through "accurate empathy". This kind of understanding is implicit. The therapist reaches the patient through the meta-level of communication.

Then he will induce affective disconfirmation, this is deleting the old pathogenic affects. The change consists of memory reconsolidation, which is rewriting the patients' DMN-contents.

Critical Aspects

The total identification of the therapist with the patient is a desideratum. It also implies scotomata. One of those scotomata is the financial aspect. Who pays for this therapy? If the patient is paying, we have a massive bias in the casuistic selection. In Germany, the public insurance payment for intense psychotherapy is cut short by law heavily (April 2026), and it is an illusion to assume that the treasure of Smith's therapy is available for the poor, the addicts, the borderline patients and psychoses in the way it should be available. This reminds me of Freud's situation, who was directly dependent on wealthy and self paying patients from the upper social class.

In Smith's mind, the patient is always right and is not willing or capable to manipulate the therapist. In reality, we know that this is not true. Although Smith mentions the possibility of the patient's resistance against

therapy (p. 41), he does not fully picture the importance of patients using morbid gain. There are quite a few patients who enjoy being passive and regressive and enjoy being cared for. Who can blame them?

Conclusion

The merit of this monography is the compression and density of long term experience with numerous diversified clinical pictures, leading to a therapeutic red thread, the efficiency of which is, that many forms of therapeutic techniques are bundled into a picture which recognizes the shifting of early affective – and often traumatic – patterns, understands their “why“ and “how“, and dissolves them through affective dialogue in the therapeutic space – in favor of reaching the target of healing, which is the step from standing to moving. The entrenched patterns are getting flexible. The limitations of this process are located in the duration of therapy, in financial issues, and in the ever changing spirit of reality’s time.

Beside the wonderful hope, which is given to the therapeutic reader with this monography, I should mention, that the author calls every form of standing still as antitherapeutic.

This is a challenge for every patient, and at the same time the therapist learns from the patient. This is connected with the opportunity of taking chances. And Smith sees every therapy as a chance – for both sides.

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