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The Spectator Therapist

How Skilled Clinicians Watch From the Stands

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Picture a football game, two minutes left, one team behind. The quarterback throws the ball toward a player on the sideline, and a defender gets there first and catches it instead. From the stands, the mistake looks obvious. A spectator watching the whole field could see another player standing wide open in the middle, with no one near him. The spectator knows that the ball should have gone there instead. The spectator may be correct. That throw might well have worked. This observation does not require expertise, it requires distance--a clear view of the whole field, and the freedom that comes from having nothing at stake in the outcome.

The quarterback did not have that view. He had a much closer, more crowded picture: defenders closing in from angles the spectator could see easily and he could not, less than three seconds to decide, and habits built by years of practice pulling him toward the throw he actually made. What looked like an obvious opening from the stands did not look that way to him in the moment. The spectator, evaluating the throw afterward, can see what would have worked better. But the spectator cannot explain why the player made the choice he did in that moment.

A great deal of clinical work is conducted from the stands.

Call this posture *the Spectator Stance*. The spectator therapist watches what the client does, evaluates the outcome, infers the client's motives and meanings, and identifies what the client should have done differently, all without sufficiently investigating the psychological process that produced the behavior in question.

The spectator therapist may correctly recognize that a client would benefit from setting a boundary, leaving a destructive relationship, exercising, applying for a job, using a coping skill, tolerating disappointment, acting on a stated wish, or breaking a recurring pattern. *Recognizing the preferable action is a different cognitive task from understanding the process that has repeatedly prevented that action from occurring.* A therapist can

perform the first of recognition very well and still have accomplished almost nothing of clinical value, because *the client did not come to therapy to be told what a reasonably informed observer could already see from the stands.*

The client hired a professional to do something more demanding than that. The client sought an understanding of the psychological process producing the difficulty, an understanding specific enough to guide the clinical work that follows. A therapist who remains primarily in the spectator position, however insightful, empathic, theoretically sophisticated, or well-intentioned, is not performing that function. Spectating is not one legitimate approach among several. It is a failure to complete the central task for which the client is paying.

The spectator stance has several recognizable features, and none of them require a lack of intelligence or training to produce.

The first is that **inference is experienced as observation**. A therapist forms a thought such as "he does not really want to change," "she is resistant," "he lacks autonomy," "she is afraid of intimacy," "he is not ready," or "she is getting something out of staying stuck." Each of these statements can begin its life as a reasonable hypothesis. Within a session or two, it can begin to function as an established fact, something the therapist now knows about the client rather than something the therapist is still testing against the client's actual behavior. Once that shift occurs, the therapist stops looking for evidence and starts noticing confirmations.

The second feature is that **the therapist remains inside an existing explanatory frame**. New material from the client is interpreted through that frame rather than used to test or revise it. A client's account of a difficult week becomes further evidence of the resistance already diagnosed. A client's small success becomes an

exception to be noted rather than information that might require the therapist to *reconsider the formulation altogether.*

The third feature is the use of sophisticated theoretical language as explanation before the client's underlying process has been established. Resistance, transference, defense, attachment style, autonomy, unconscious conflict, avoidance, readiness, motivation, personality organization: these are legitimate clinical concepts, developed through careful theoretical and empirical work. The Specator Stance creeps in when this language becomes unexamined shorthand. If anything, theoretical sophistication can make spectator thinking harder to recognize, both for the therapist and for anyone supervising the work, because the resulting inferences sound clinically informed rather than speculative. The spectator therapist does not lack theory. The spectator therapist often has a great deal of theory. However when the theory is used to explain the client before the client has been sufficiently understood, the language becomes a label, not an understanding.

The fourth feature concerns what the spectator stance accomplishes for the therapist, whether or not this is intended. **When the client does not change, the explanation can remain focused entirely on the client:** resistance, lack of readiness, poor motivation, ambivalence, avoidance, insufficient insight, unwillingness to act. The therapist's own explanatory model is rarely examined as a possible source of the impasse. This produces a self-sealing clinical system. If the client changes, the therapist's original speculative stance appears confirmed. If the client does not change, the absence of change is folded into that same speculative stance as further evidence of the client's resistance or unreadiness. There is no action or development the Spectator Therapist could observe that would require the therapist to revise the account. A clinical theory that cannot be disconfirmed by the client's behavior has

stopped functioning as a clinical theory and has become something closer to a fixed belief about the client. A formulating therapist works differently.

The *formulating therapist* distinguishes observation from inference and tracks which is which. The therapist identifies what repeatedly happens: not a general trait but a specific, recurring pattern that can be pointed to in session after session. The therapist examines the conditions under which the pattern occurs, looking for what precedes it and what tends to be present when it does not occur. The therapist attends closely to what the client does in response to the pattern and to what happens immediately afterward, both internally and in the client's relationships. From this material the therapist develops an explanatory hypothesis about the process producing or maintaining the difficulty, and holds that hypothesis as provisional rather than settled. The therapist actively looks for observations that would support the hypothesis and, just as actively, for observations that would challenge it. The client's responses and the course of the clinical work are permitted to change the therapist's understanding, sometimes substantially.

The Spectator Stance is not about modality, orientation, technique. There is no conflict between schools of thought, orientations, direction vs non-direction, etc. The spectator stance can occur inside any theoretical orientation, and formulation can be practiced inside any theoretical orientation as well. **The difference concerns the quality of the clinical reasoning underneath the technique, not the technique itself.**

Consider a client who begins therapy after a spouse delivers an ultimatum. A spectator therapist may quickly conclude that the client has no genuine wish to change and therefore lacks autonomy, arriving at this conclusion within the first session or two. Notice how many untested inferences have already been compressed into a statement that sounds like a simple observation. It assumes what the ultimatum means to the

client. It assumes what the client hopes to preserve or accomplish by attending. It assumes that showing up under pressure is equivalent to an absence of any authentic motivation. A clinically responsible stance would investigate each of these questions directly: what attending therapy means to this particular client, what the client hopes to preserve or accomplish, how the client actually experiences being given an ultimatum, and what patterns become visible only through continued, careful observation. *The spectator therapist has a conclusion. The formulating therapist has a set of questions still being answered.*

Consider a therapist who identifies "resistance" almost immediately, then asks the client, "What are you gaining by staying?" or "Why can't you act on what you say you want?" Both questions may sound exploratory. Both already contain an explanatory theory: that the client is gaining something from the difficulty, or that the client is choosing not to act despite a clear and settled wish. The question has been built on top of an inference that has not yet been tested against the client's actual experience, and the client's answer will now be shaped by a frame the client did not choose and may not recognize.

Consider a third and more ordinary example. A client repeatedly fails to follow through on an intervention that appears entirely sensible: a communication exercise, a scheduled activity, a boundary rehearsed in session. The spectator therapist, watching this pattern from the stands, focuses on motivation or compliance. Perhaps the client is not ready. Perhaps the client is ambivalent about the goal. The formulating therapist becomes interested in something more specific: what happens in the moments immediately before the client fails to act, under what conditions the failure occurs and under what conditions it does not, and what the client's response accomplishes in that moment, whatever it costs the client elsewhere. The Spectator Therapist has identified

that the play did not work. The formulating therapist is investigating what actually happened on the field.

The Spectator Therapist knows what the client should have done and remains **insufficiently curious** about why the client did what he or she actually did. The spectator therapist analyzes the play without investigating what determined it in the first place. Both types of stances can coexist with genuine warmth toward the client, real theoretical knowledge, and years of clinical experience, which is why the spectator stance is difficult to recognize in one's own work rather than in someone else's.

The spectator stance is sometimes the default setting produced by the ordinary conditions of clinical work: fifty-minute sessions, a full caseload, and a diagnostic vocabulary built for rapid pattern recognition. Clinical training rewards a therapist who can notice a pattern quickly and name it with confidence. That same skill, applied to a single case before enough has actually been observed, produces the premature explanation on which the spectator stance depends. A therapist who notices this habit in his or her own thinking has not discovered a personal failing. He or she has discovered a structural pressure built into the pace and training of the profession, one that shapes careful, experienced clinicians as reliably as it shapes anyone newer to the work.

Recognizing the pattern is what makes correcting it possible, and correcting it does not require new theoretical commitments. It requires a small number of concrete habits, practiced deliberately until they become automatic.

The first habit is separating what was actually observed from what has been concluded about it, and doing this in writing rather than only in thought. After a session, a therapist can record, in one column, what the client said and did in language specific enough that a colleague reading it would recognize the session. In a second

column, the therapist records what he or she believes that behavior means. Therapists who try this exercise honestly tend to find the second column longer, more confident, and less tethered to specific evidence than the first. The distance between the two columns is the spectator stance made visible on the page, and seeing it there is often enough to prompt a different question in the next session.

The second habit is testing an explanation rather than protecting it. Once a hypothesis about a client's process has formed, a therapist can deliberately search for the observation that would count against it, not only the observation that would confirm it. A useful check, applied honestly, is to ask what the client could say or do that would require the current formulation to change. If several sessions pass and no answer to that question comes to mind, the explanation has stopped functioning as a hypothesis and has hardened into something closer to a verdict.

The third habit involves **noticing which questions carry a conclusion inside them before the client has answered.** "Why can't you act on what you say you want?" already assumes a settled wish and a failure to act on it. A therapist practicing formulation can catch that assumption and ask instead what happens in the moments right before the client decides not to act, a question that requires an answer built from the client's actual experience rather than one that confirms what the therapist already suspected. The same substitution is available almost anywhere the word "why" has taken the place of a genuine unknown without the therapist noticing the substitution: replacing it with a question about sequence, about what came immediately before and immediately after, tends to produce material a spectator theory would have prevented from developing.

The fourth habit is **treating a formulation that has not changed in weeks or months as a signal worth investigating in itself**. A case presented to a colleague, a supervisor, or even described aloud in plain language without clinical shorthand often

reveals inferences that had gone unquestioned simply because they were familiar. Saying "he is not ready" out loud to another clinician, and then being asked what specifically indicates that, is frequently enough to expose how much of the explanation rests on inference rather than observation.

Recognizing that a client would benefit from a different course of action is often accurate and often useful to say. But when we mistake that recognition for clinical understanding, we stop short of the clinical thinking our clients should expect. A therapist who builds these habits into ordinary practice has not adopted a new technique so much as restored the kind of curiosity that formulation depends on, the same curiosity that clinical training, under enough pressure and enough caseload, tends to erode.

The client is paying for professional clinical thought, not for a well-informed opinion about the better outcome. A reasonably attentive friend, relative, or colleague can often see what a client should have done differently. The therapist's professional responsibility is to understand enough about what is producing and maintaining the difficulty to establish a clinical target, choose a reasoned direction for the work, observe what actually happens, and revise the explanation when the client's behavior requires it. That responsibility extends past identifying the better move. It requires investigating the process that produced the move the client actually made.

That is the difference between watching a client's life from the stands and doing psychotherapy.