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A "SMART" APPROACH TO COUPLES CARE

Pastor Nancy sighed. Her second conversation with Clara and Chuck had gone in circles, rehashing that morning's breakfast interaction—who said what and who didn't speak—over and over. It had ended just like their first appointment: Chuck barely responding, Clara in bitter tears and appealing to Nancy to "fix" Chuck. They left her office in silence. Nancy felt helpless and less than helpful.

"This just isn't working." She sighed as she watched them drive out of the parking lot. "I need some different tools. What do I do with them next week?"

Nancy needs three things: a theory of change appropriate to short-term spiritual care, a counseling method that offers clear steps toward the changes Chuck and Clara want for their relationship, and a counseling theory equal to the spiritual passions and sociocultural hurdles faced by covenant partnerships. A narrative approach can offer all three.

WHAT IS A NARRATIVE APPROACH?

A narrative approach to spiritual care draws on narrative psychotherapy,[1] a helping model developed in Australia and New Zealand during the mid-1980s and early 1990s. Narrative therapists believe we shape our lives and give them meaning through the stories we tell, as well as the stories that are told about us by larger sociopolitical and cultural systems—the Powers That Be, to use Wink's (1992) language. An endless number of stories can be told about any life, depending on the perspective from which that life is narrated. Often, people narrate themselves from the perspective of the dominant culture—the one that tells them that they are "depressed," for example, or "voiceless" or "unimportant" or "powerful" or "privileged." The same culture often sets the standard for what it means to be a "man," "woman," "parent," "lover," "spouse," and so forth.

As psychotherapist Stephen Madigan notes:

> The complexity of life, and how lives are lived, is mediated through the expression of the stories we tell. Stories are shaped by the surrounding dominant cultural context; some stories emerge as the long-standing reputations we live through, and other (often more preferred) stories of who we are (and might possibly become) can sometimes be restrained and pushed back to the margins of our remembered experiences. . . . But whatever the stories are that we tell (and don't tell), they are performed, live through us, and have abilities to both restrain and liberate our lives. (2011: 29–30)

This is where problems come from—the ways in which the stories we tell and don't tell restrain and oppress our lives.

Here's how it works. The dominant culture—the larger stories being told by society, our families, schools, workplaces, and other systems in which we are embedded—decides who and what is "normal." These prevailing ideologies become cultural and sociopolitical stories that shape people's lives. They come to seem "natural"; they are unquestioned; they are just the way things are. It's not that some powerful apparatus forces these larger stories on people; it's that people begin to live as if those stories are true—that is, perform and reinforce them—in their own lives. We actually believe that those stories tell the whole truth about who we are. But narrative therapists are "acutely aware that problems are created in social, cultural, and political contexts . . . that often serve to obstruct and marginalize the very lives of those whom therapists purport to treat" (Madigan 2011: xii). There are other stories that can be told, stories that contradict accounts that see a particular person as a problem, as abnormal, as somehow broken, or "less than."

In Pastor Nancy's conversation with Chuck and Clara, for example, it is clear that Clara believes that Chuck "never" talks to her. It's equally clear that she believes that spouses should talk to each other at the breakfast table. She has storied Chuck as a deficient spouse, and her way of talking about the problem reflects the fact that feelings and experiences are always lived out of the primary story being told; what we select as meaningful is what is given expression. Wouldn't it be interesting to know where Clara got the idea that spouses should always speak to each other at

breakfast? What might happen if we looked for other accounts of what kept Chuck from speaking that morning? How would the story change if we examined Chuck's stories about intimate relationships, which might tell him that silence between partners is a sign of deep comfort with one another? It is the meaning behind the behaviors, or, as Gottman (1999) might say, the perception of what is happening, that is important—the values, the hopes, the dreams represented by a husband who does or does not speak over coffee and toast in the morning—rather than the behavior of speaking or not speaking.

Fortunately, a narrative approach provides a map for caregivers that guides their efforts to help people understand and reauthor their stories so that new and preferred meanings can emerge. In the process, people transform problems into more satisfying accounts of their lives.

A "SMART" APPROACH TO CHANGE

The acronym SMART—developed by social worker David Nylund (2000)—describes a five-step, narrative approach to helping children diagnosed with attention-deficit/hyperactive disorder (ibid., 49). Keeping this basic approach, I have modified Nylund's steps to be appropriate for spiritual care with couples. The five steps are:

S*eparating people from problems and passions*. Wise caregivers engage couples in "externalizing conversations." That is, they separate the presenting problem from the relationship and from each partner. This allows the couple to give the problem a name that seems appropriate. Clara and Chuck, for example, might choose Morning Silence as a name for the particular passion that is threatening their relationship. This externalization has the effect of shifting the couple's attention from perceiving the problem as inside Chuck—or in Chuck's behavior—to understanding it as something coming from outside the couple, where they can face it together, less defensively.

M*apping influences*. Once the problem has a name and the couple experiences it as external to themselves, the caregiver begins to map influence—first, the influence of the problem on the couple and then the influence of the couple on the problem. This allows the couple to see clearly the ways in which the problem—the passion or passions that have been creating distance

between them—affects each of them, what it has cost in terms of their relational harmony, how it works to keep them from aligning as a team. It also allows the couple to identify ways in which they have some influence over the dividing passion(s), maintaining positivity, preventing the problem from taking over completely, standing up to it when its demands become too great. Chuck, for example, might learn that Morning Silence causes Clara to believe that she no longer matters to Chuck; Clara might discover that she can invite Morning Silence to leave by not bringing the newspaper to the table before Chuck arrives.

A*ttending to teamwork.* The caregiver listens carefully for hints of untold stories about times when the couple is relatively free of the problem (or the passions). In particular, the caregiver asks questions and listens in ways that bring forth accounts of teamwork between the partners—overlooked evidence of times when they worked together to overcome the problem or to neutralize the passions. These accounts become the basis for a new story in which the problem is no longer dominant. Pastor Nancy might find out that Morning Silence is only present on weekday mornings—it never shows up on Saturdays or Sundays because Clara and Chuck work together to keep it at bay through a different morning routine on the weekends.

R*eclaiming partnership.* Alternatives to the problem story become gateways to a new story about positive partnership, in which the couple works mutually as a team to resist the passions and overcome the dominant, problem-saturated story. The caregiver asks questions to enrich the new story of partnership, helping the couple incarnate the hopes, dreams, values, and beliefs that inform it. Further questions help the couple reclaim the partnership that has always existed alongside and at the margins of the problematic story. Enhancing the covenant friendship, as discussed in chapter 2, becomes a central focus of this step of the change process. Chuck and Clara decide, for example, that they want to invite their "weekend selves" to breakfast during the week and plan together ways to make that happen.

T*elling the new story.* In the final step, caregivers invite the couple to identify and recruit audiences for the new story of mutuality and positive partnership. The audiences help validate and celebrate the new story, providing new locations for its performance and helping to embed its reality in the life of the couple and their

community. Clara and Chuck might share with their best friends or with their grown children how their morning routine has changed and what it means to them to bring their weekend selves to the breakfast table Monday through Friday.

These steps toward change, of course, reflect a number of assumptions about the nature of people and how they experience reality. Making these assumptions clear can help caregivers use the SMART steps successfully. The traditions of brief psychotherapy and short-term pastoral counseling also provide useful assumptions for caregivers who seek to empower couples. I highlight eight of these assumptions below and then describe four caregiver attitudes that support and reflect them.

SOME KEY ASSUMPTIONS

Eight key assumptions are important to empowering couples through the SMART approach. You might be tempted to scan this information (or to skip it altogether) because of its "theoretical" nature, but I encourage a close reading. Narrative approaches to giving care are more a philosophy than a set of techniques, and the ideas presented here challenge some foundational assumptions of dominant North American cultures. These assumptions are also quite different from the psychological ideas that shape the ways in which the industrialized West approaches care giving. Although these assumptions are at odds with the dominant culture (as spiritual traditions often are, as well), they generally fit well with some religious wisdom about human beings and about the ways Spirit relates to the created order.

Overall, a narrative approach to empowering couples through spiritual care makes the following assumptions:

1. *Storytelling rights belong to the couple*. Identity is textual, constructed through the stories we tell and the stories that are told about us. Too often, people adapt themselves so well to the normative story of the dominant culture, reproducing it in their own lives, that they do not realize what other tales they might tell about who they are or what their lives mean. They are living a story being told by someone (or something) else. Therefore, an important assumption is that the couple retains the right to tell their own story—the caregiver should follow, not lead, the content of the story being constructed through the helping conversation.

This is an important way of enhancing a couple's agency, especially in view of power issues and structured inequalities. Honoring the storytelling rights of women may be especially important; pastoral counselor Christie C. Neuger (2001) says that the first stage of narrative work with women is that of "coming to voice," being able to tell their own story in their own words—including giving their own name to the problems that oppress them.

Preserving the couple's naming rights seems to fit the processes of introspection and confession in the desert tradition. Words—especially names—have power in many spiritual traditions; being able to name the demon or power that blocks one's freedom gives a person some control over it. The concepts of agency, freedom, and self-determination are also important to many religious communities and ethical systems.

2. *Alternative wisdom resides at the margins.* At the edges of any story—around corners, underneath thin-but-all-encompassing plots, behind totalizing descriptions such as "lazy, disrespectful woman"—are things that people know but might not have noticed. These understandings are rendered almost invisible by the glitz and glare of dominant stories. Postmodern philosopher Michel Foucault called them "local knowledges" (Madigan 2011: 45), alternative wisdoms that can call dominant stories into question but are silenced or unnoticed because of the power and volume of those dominant stories.

Narrative caregivers assume that couples have local knowledge or local wisdom about overcoming passions, problems, and the Powers That Be. They also assume that careful, curious questioning can bring that wisdom to the fore, where it can challenge or deconstruct problematic stories. In the context of working with women, Neuger calls this "gaining clarity"—helping people not only see how dominant stories have influenced them but also to understand where those stories have come from and how they themselves have participated in keeping them alive, even though those stories are harmful to themselves.

Identifying local wisdom and gaining clarity about dominant stories means that individuals and couples are uniquely placed to challenge and undermine the harm being caused by unhelpful stories. "In challenging the dispositions and habits of life that are fashioned by modern power," Madigan writes, "people can play a part in denying this power its conditions of possibility" (2011: 49).

One way of identifying local wisdom is to explore exceptions to the difficulties that couples face. Hidden wisdom often lurks unseen in these problem-free spaces.

3. *Exceptions to difficulties always exist.* Exceptions, or times when difficulties are absent or less troubling, always exist. Narrative caregivers call them "unique outcomes" or "sparkling moments." The trick is to identify those exceptions, make sure they are significant to the couple, and then amplify and expand the exceptions into a new plotline that creates the possibility of a different experience of life, one free of (or less influenced by) a particular problem or difficulty. From this perspective, change is inescapable and always brings a chance to make life better. Problems or difficulties are temporary; they exist only because of the power we give them by naming them (and focusing on them) as problems. A narrative spiritual caregiver assumes Spirit is always working to make life more abundant for all people; the task of the caregiver and couple is to collaborate with what God is doing to make a particular difficulty a thing of the past.

In some ways, this assumption reflects the discipline that Brother Lawrence, a seventeenth-century Christian monk, called the "practice of the presence of God." From this perspective, God is always present in our lives, a reality as near as our next breath. We must train ourselves, however, to be aware of God's presence that supports and sustains all of creation, always at work repairing the torn strands of the web of being. Identifying and building on exceptions to our difficulties is one way of identifying and responding to Spirit's presence in our lives.

4. *Re-storying is an act of resistance*. The process of identifying and telling a preferred story about their life together allows couples to resist the influence of the particular passions or powers that have worked to separate them. At a sociopolitical level, re-storying can empower couples to resist cultural and systemic accounts of "who they have been, who they presently are, and who they might become" (Madigan 2011: 22) in order to choose different accounts of their life together. In particular, re-storying a preferred, shared story allows couples to begin eliminating the distance that kept them apart for so long, reestablishing the teamwork that existed—to some degree, at least—when they first came together. Neuger calls this stage of narrative psychotherapy "making choices"—that is, choosing what elements to include in a new, preferred story and

what elements of the other, power-laden and problem-saturated story to reject. In many ways, this process reflects the Christian concept of "turning" from one way of life to another—the literal meaning of repentance. Performing the new story in front of a couple's friends and family members, helping to make it real and to function as a new norm in their life, is a stage that Neuger calls "staying connected." All stories are maintained through a web of interconnected relationships that tell, retell, feed, and sustain them.

5. *Avoid diagnostic labels and pathologies.* Because the problem, not the person, is the problem, narrative caregivers avoid diagnostic labels and pathologizing stories. That means a problem or difficulty faced by a couple is not seen as a fault or weakness located within the "family system" or one of the partners, but is viewed as something oppressing the couple from outside. A caregiver working from this assumption seeks to free people from those things that keep them separate from Spirit and from each other. For example, imagine that one partner says, "I'm too depressed to be a good parent." Rather than saying, "What's going on inside that keeps you from being a good parent?" a caregiver working from a narrative approach might respond, "How does the depression keep you from parenting as well as you'd like? Are there times you can stand up to or 'parent through' the depression? Where did your understanding of 'good parenting' come from, and what's its relationship to depression?"

The difference is subtle but important. This commitment to avoiding diagnostic labels and pathologies is consistent with classical spiritual traditions. The desert mothers and fathers who pioneered Christian spiritual guidance were less likely to label a person as "lazy" or "distracted in prayer" than to explore how a negative spirit was distracting the person from God or convincing the person to spend time in activities other than prayer. Beneath this assumption is a conviction that God empowers people to stand up to those things that turn them away from Spirit. God is at work to set people free from those things that oppress them.

This perspective also assumes that human nature is basically good. We are naturally oriented toward God and made in the image and likeness of God, but powers and passions at work in the world thwart our natural tendencies. Sinfulness is understood less as a problem of will or as an inner state than as a temptation or net that snares people from outside. Deadly thoughts and

behaviors attack us, luring us away from our original nature as the image of God.

6. *Negotiate rather than impose a caregiving process.* Through a narrative approach to empowering couples, the caregiver and the partners "cocreate" a new reality together. They share power in a mutual, collaborative relationship that respects the self-determinacy of the couple seeking help. That means caregivers try to avoid assuming that they know the goal of care or *the* solution to a couple's difficulty. Rather, they negotiate goals and solutions together with the couple. They seek to empower the couple to help themselves rather than to rely on a professional caregiver.

Behind this assumption is an expectation that human relationships should be mutual and empowering, based on consensus rather than on an imbalance of power. Narrative approaches to giving care emphasize that people need to feel heard and validated and that the process of receiving care needs to enhance people's sense of agency rather than requiring submissive attitudes or coercing them into particular ways of responding or relating.

7. *Focus on the present and future.* In narrative approaches to spiritual care, the past tends to be secondary to the present and future. Caregivers working from a narrative approach do not assume, as do many psychological approaches, that past experiences create the difficulties people face in the present. Rather, they believe that placing too much emphasis on the past can impede growth and change. Looking to the future is the key to nurturing hope for a different life.

Likewise, spirituality affirms that the present is the best guide to understanding how Spirit is active in a person's life and what ways God might be calling the person to be faithful to the future. An emphasis on the present and future keeps a couple focused on an appropriate response to Spirit's action in their lives *now*. This focus is consistent with the emphasis of the desert mothers and fathers, who used everyday, common activities—eating and sleeping, working and playing—as the starting point for spiritual guidance.

8. *Tailor care to the couple.* Narrative spiritual care is not a one-size-fits-all, cookie-cutter approach. Because couples are the experts about their own lives, narrative caregivers pay close attention to the needs and meanings of the people seeking care, shaping the process to a couple's particular circumstances. This approach respects the diversity of human beings.

Similarly, narrative approaches recognize there is no "protocol" or universal process that serves all couples equally well. The caregiver must listen closely to the couple, adjusting questions and interventions to accommodate the particularities of the partners and their unique relationship. Likewise, the SMART steps do not unfold in a rigid, linear progression, but circle around each other in a helical fashion, repeating themselves with critical differences over time as preferred stories are identified, authored, reauthored, nuanced, and performed until the distance between a couple dissolves and teamwork is reestablished.

These assumptions translate into four qualities or attitudes that the caregiver embodies during spiritual-care conversations.

ATTITUDES THAT INFORM THE CAREGIVER

Caregivers guided by these assumptions adopt four attitudes that shape the way they interact with couples. These SMART attitudes set the stage for empowering care; the more they are present, in my experience, the more empowering care will be. Nylund, in fact, identifies the first three of these attitudes as "ethical postures" (2000: 51), suggesting that they are less attitudes than principles that embody the good. He argues that they help caregivers make good use of the SMART steps. "These attitudes help them ask the kinds of questions that create possibilities and open space for new stories," he writes (ibid.).

The three attitudes identified by Nylund are curiosity, respect, and hope. To these, I add detachment as a spiritual virtue present in Buddhism, Christianity, Islam, and other religious traditions.

Curiosity

Traditional psychotherapies teach practitioners to be certain of their expertise and authority in treating the problems that people present to them. They tend to tell stories about their patients from within a medical framework, which gives them the power to diagnose "problems" and then dictate "best practices" to address the diagnosis, often without taking into account the particularities of the person sitting in front of them—or the fact that the "problem" has been created in a certain way through the act of diagnosis.

Caregivers taking a narrative approach, on the other hand, privilege the expertise and authority of the couple seeking guidance.

These caregivers are inquisitive, intensely curious, and never certain that they have understood fully what is being said. They ask question after question—questions they couldn't possibly know the answers to already—to elicit rich accounts of the stories the couple is telling. They are able to live in the ambiguity of not being certain, of not understanding, not knowing (see Bidwell 2004a), and always being on the way to understanding.

Respect

The local wisdom that has been silenced, subjugated, pushed to the margin, and rendered invisible by problematic dominant stories contains great riches. New lives are possible because of the narrative, social, and cultural capital it contains. Narrative caregivers understand and respect this. They show great patience in luring, coaxing, and co-constructing these marginalized local knowledges into the light of day, where they can be developed into preferred narratives if the couple desires. In the process, narrative caregivers are collaborative, always deferring to the preferences of the couple they are empowering, never assuming that the caregiver knows best. They are also vigilant against any bias they bring to the process. They respect the agency and self-determination of the couple at all times—even when that means not exploring or developing local wisdom that the caregiver thinks might be useful or helpful.

Hope

The only bias that narrative caregivers persistently introduce into empowering conversations, Nylund writes, is hope or "tempered optimism" (2000: 52). They continually communicate to couples through verbal and nonverbal means the conviction that the partners, individually and together, have the skills and resources necessary to overcome the passions that are pushing them apart. This hopeful conviction grows from the caregiver's certainty that the textual nature of identity and meaning will yield subjugated wisdom and subplots that allow partners to resist the passions and powers that are creating difficulties. A narrative caregiver believes in a future free of the problem, a new story in which the couple works as a team to resist and conquer the passions that divide. This calm, consistent attitude can empower couples to think and feel the same way about their futures.

Detachment

Caregivers taking a narrative approach are detached from the outcomes of their conversations with couples. After talking about curiosity, respect, and hope, this might seem a paradoxical statement. But I am not talking about detachment as disengagement or lack of compassion and care; rather, I am using the term to signal an attitude similar to the virtue of equanimity described in chapter 2. Detached caregivers do not have a vested interest in the outcome of empowering conversations; they are not attached to a particular story that a couple "should" or "ought" to tell themselves. In fact, detached caregivers confront vested interests and selfish motives in themselves in order to create space to listen to Spirit's leading. Being detached from outcomes is an act of spiritual freedom.

Being attached to a particular outcome or story line can lead caregivers to evaluate one story as superior or inferior to another—placing a limit or bond on their minds, shutting out curiosity and respect. In this state of mind, caregivers begin to advocate for a particular story; this subtly begins to subjugate other possibilities. They cease to ask curious questions; instead, they ask leading questions that they already (think they) know the answers to. They try to sway the couple's attention in a particular direction. They stop discerning what the couple's preferred futures are and begin to recruit them into their own story for who the couple should be and what the couple's relationship should mean. This sets caregivers up for disagreements with the couple—often unvoiced, but disempowering nonetheless.

Narrative caregivers must turn themselves over to the process of constructing whatever alternative stories the couple values. They cannot be invested or attached to particular alternative stories as "best" or "right" or "more adequate" for those with whom they care.

A "SMART" APPROACH IN HOLISTIC PERSPECTIVE

Humans are holistic beings, made up of bodies, senses, emotions, thoughts, and consciousness. Taken together, these dimensions constitute the soul—that unity of being signified by the Hebrew word *nephesh*, the Greek *psyche*, and the Arabic *nafs*. The practice of soul care, then, is literally the care of the whole person—what Christians traditionally call body, mind, and spirit. These dimensions of the person interact and influence each other, as noted in chapter 2.

The state of your body, for example, shapes the way you behave and interpret events; if you are extremely stressed, your behavior will show it, and you will tend to interpret things as a threat. The way you interpret a partner’s words and actions influences the body; if you interpret your partner’s statement and tone of voice as a threat, your heart rate and respirations are likely to increase. The way you act in response will influence the way your partner interprets what you are saying and what happens in your partner’s body.

One of the strengths of Gottman’s (1999) model of marital therapy is that it accounts for this totality of the couple as human beings by attending to physiology, interactive behavior, and perception. In fact, Gottman’s research suggests that the body is one of the most important dimensions of a couple’s interactions; the frequency with which *diffuse physiological arousal* (DPA)—the body’s general alarm system—becomes and remains activated is one of the most reliable factors in predicting whether a couple will stay together.

In DPA, many bodily systems are activated at once so that the body can be safe in physical emergencies or cope with situations perceived to be dangerous. The heart speeds up; blood stops flowing to certain organs and to the periphery of the body; blood pressure rises; glucose, a fuel for the body, floods the bloodstream; and fight, flight, or freeze reactions become more likely. “The attentional system becomes a vigilance system,” Gottman writes, “detecting only cues of danger, and at this point is severely limited in its ability to process other information” (1999: 75).

This state of arousal is extremely helpful during a car accident or a mugging. It is not so helpful during an argument with your partner. But it is precisely what can happen during an argument. In fact, Gottman says that “(m)arital conflict appears to be ideally suited for generating this kind of diffuse physiological arousal” (1999: 76). When DPA occurs during an argument, the behavioral and interpretive effects can be devastating. It is harder to process information and learn new things, and easier to fall into old habits and old ways of thinking. Men are especially prone to DPA, and their recovery takes longer than women’s. Gottman’s conclusion is that the best approach to couples therapy is a “gentleness model” (ibid., 85) that promotes the soothing of behavior, perception, and physiology.

This is where a narrative approach to empowering couples becomes helpful. Time and again, I have watched externalizing conversations, curious and off-the-wall questions, the caregiver's respectful and hopeful attitude, and a detached stance toward outcomes diffuse low-level physiological arousal. A SMART approach interrupts habitual, problematic exchanges that would usually lead to DPA. Externalizing, in particular, is helpful because it locates the problem outside of the partners, often eliminating the defensiveness and blame that trigger physiological arousal. When a body does not receive negative stimulation, it will not erupt into DPA. This is one strength of a narrative approach: it helps protect against diffuse physiological arousal. By working directly, in unexpected ways, on the perceptive dimension of the three elements of relational balance, a SMART approach has tremendous effects on the physiological and behavioral dimensions as well.

MUTUALITY, PARTNERSHIP, AND A NARRATIVE APPROACH

By now, I hope it is clear that a narrative approach to spiritual care can provide a model for couples of a way to talk together that is mutual, collaborative, and resistant to both the Powers That Be and the passions that create difficulties for covenant partnerships. In addition, it fosters mutuality by leveling the playing field between partners, placing the problem outside of them and allowing them to become allies in a team against it rather than criticize, defend against, and confront each other over perceived insults and injuries. In this way, partners learn to share relational power, to influence and receive influence from each other, and to build a positive partnership in which both contribute to the emerging story of a problem-free (or problem-resistant)[2] life.

The SMART steps allow caregivers to do two things. First, they provide empowering guidance and promote mutuality and positive partnership. Second, they help couples resolve the issues that led them to seek guidance in the first place. The next five chapters describe, teach, and illustrate each step in turn. We begin with *separating people from problems and passions.*