

Editorial

The Dysfunction of Dysfunctional

A commonly held belief about "dysfunctional families" as abnormal families filled with pathology and dis-ease permeates North American culture and language. The Menendez brothers' trial, child abuse, incest, wife battering, and alcoholic families are cited as just a few examples of families gone awry. Even professionals such as John Bradshaw (1988, 1990) would have us believe that many of us are victims of dysfunctional and disordered families. Barbara Ehrenreich (1994), in a *Time* magazine essay on the family, observed that it often seems as though we are all in recovery-in most cases, from our families.

Neither the nursing literature nor the family health literature is immune from the term dysfunctional. It is not unusual, given the strong biomedical influence of health professional education, to distinguish and draw forth pathology and dysfunction at the risk of being blind to health and strengths. The influence of this deficit model is subtle and dangerously pervasive. Frequently, problems are seen to reside within individuals or families, and the need to find the cause of a problem-such as being a member of a dysfunctional family before a cure can be suggested invites blame and accusation.

An alternative viewpoint is offered by Anderson, Goolishian, and Windermant (1986), who conceptualize problems as being distinguished by language rather than as residing within individuals. Based on a constructivist view, there is "no single objective reality about a family and its problem waiting to be discovered. There are multiverses, each valid in its own right. None of these exist independent of the observer" (p. 4). Problems do not exist until there is consensus through language that there is a problem. A "problem-determined system" is not an individual or family but a language system with boundaries marked by who communicates about a shared problem.

I take the position that a description of families as dysfunctional is *less* than useful for the shared language system known as the nursing of families. My ideas have been strongly influenced by viewing the expert clinical practice of my colleagues Lorraine Wright and Wendy Watson and participating with them in conceptual discussions about their practice with families. We have concluded that there is no such thing as a dysfunctional individual or family!

What is the dysfunction of "dysfunctional"? I offer three points for your consideration:

1. To label a family as dysfunctional suggests that the clinician is, in the words of Mendez, Coddou, and Maturana (1988), operating in the domain of "objectivity without parentheses" (p. 149). Whose point of view is being drawn forth in the label of dysfunctional? Whose objective reality is being privileged? This stance frequently honors the clinician's observations and judgments as the "truth" about a family. It implicitly and hierarchically values the clinician's observations over other observations and descriptions.
2. The term dysfunctional also serves to trivialize and minimize problems-offering only one label to capture a wide range of difficulties that families experience, from behavioral problems through incest. It may perpetuate a belief of powerlessness in

one's ability to effect change or perpetuate hopelessness about the future, that is, family members may feel trapped and burdened by the past.

We have found it useful to think about difficulties as problems that reside in language between persons rather than within persons. This removes the temptation to get trapped by linear thinking through conversations of causation (i.e., "why" questions) or through conversations of accusation (blaming particular individuals). Instead, a systemic description of interactions between people, which maintain or perpetuate problems or which are focused toward solutions (i.e., "how" questions), provides many more possibilities for intervention.

3. The term dysfunctional limits both the clinician and those being labeled dysfunctional from proposing other distinctions about themselves. We believe clinicians should abandon the lens of pathology in favor of adopting a view of the family as resourceful. If clinicians were to believe that all families possess strengths and abilities necessary to solve their own problems, there would be a concerted effort to draw forth those strengths and to draw forth language about them.

Families generally seek help for problems once their own efforts at problem solving have been exhausted or the families have reached an impasse. They come seeking professional help feeling inadequate, exhausted, fearful, frustrated, and/or incompetent. We believe that when families get stuck in their problem-solving efforts, they may benefit from being reminded about forgotten strengths and abilities or from having these strengths brought into their awareness. Through an understanding of the family's experience of health and illness, the clinician looks for opportunities to invite them to a new view of their strengths or to help them regain an old view of their competence that has been lost. In this conversation of strength and resources, a new language system-a new reality-is coevolved.

Nurses who work with families have tremendous opportunities to influence the beliefs of families and of other health care professionals. We can call for an alternate view of dysfunction, intently look for family strengths, and eradicate the word dysfunctional from our professional language. In doing so, we honor our long-cherished ideas of promoting health and wellness rather than pathology and disease.

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