When an individual’s grief cannot be openly acknowledged because of social stigma, it may be internalized. This type of grief has often been called *disenfranchised grief*, and it has been correlated with *complicated grief* (McNutt & Yakushko, 2013). *Complicated grief*, which effects between 3% and 25% of the general population, is grief that remains unresolved (Fujisawa et al., 2010). With complicated grief, bereavement symptoms can at times evolve...
DISENFRANCHISED GRIEF

Disenfranchised grief has been defined as the grief that is felt when loss is not "openly acknowledged, socially validated or publically mourned" (Doka, 1989, p. xv). For example, an individual may lose a fetus through an elective abortion or a loved one to a prison sentence following a serious crime. Because such losses carry social stigma, the grieving individual may feel shame surrounding his or her loss and may be unable to discuss these experiences openly. Thus, the bereaved may not receive social validation, sympathy, or time off work that is afforded to other types of mourners.

To further understand the issue of disenfranchised grief, Corr (2002) proposed that the concept of enfranchisement be evaluated. According to Corr (2002), enfranchisement means to be set free and admitted to municipal or political privileges. For example, if individuals are enfranchised, they may be given permission to vote. In such cases, the enfranchised are heard and their votes are counted. However, the disenfranchised may not be granted that same liberty or opportunity to participate in the affairs of a community.

In the case of holding a “franchise,” one is given permission to sell a product or service that is provided by a large corporation. Yet, with this privilege comes an obligation to uphold certain standards. Thus, disenfranchised grief goes beyond the limits of what is deemed socially acceptable (Corr, 2002). For example, homosexual individuals who do not uphold society’s traditional values in terms of relationships and family may not be afforded the same respect or support that is given to heterosexual individuals when they experience loss.

Categories of Disenfranchised Grief

Doka (2002) suggested five aspects of grief that tend to be disenfranchised:

- **Relationship not recognized.** Many relationships are not given social validity. These can include homosexual and extramarital relationships, as well as relationships between ex-spouses.
- **Loss not acknowledged.** Losses are often perceived as insignificant. Such losses might include miscarriages, abortions, or the death of a pet.
- **Griever excluded.** Disenfranchisement can occur when griever’s are perceived as being incapable of understanding death or of experiencing grief (e.g., children, mentally ill individuals, older adults, developmentally disabled individuals).
- **Circumstances of death.** Because some deaths carry stigma or evoke anxiety (e.g., AIDS deaths, executions, suicides), griever’s may be disenfranchised because such deaths inhibit the expression of grief or social support.
- **Ways individuals grieve.** If the expression of grief conflicts with social expectations, it can cause disenfranchisement. For example, an individual may show no or excessive emotion, or may act out his or her grief through socially unacceptable behaviors (e.g., excess anger, substance abuse).

Corr (2002) subsequently added additional categories of disenfranchisement to Doka’s (2002) work. The following is a paraphrased summary of these categories:

- Defining certain aspects of the grief response as inappropriate or illegitimate might include responses of physical illness, behavioral disturbances, and changes in social functioning or cognition.
- The process of grieving may be disenfranchised when it is not allowed public mourning or when unrealistic expectations are put on a griever. For example, an individual may tell the bereaved to “stop thinking about it.”
- Assuming that there is an endpoint to grieving or “closure” around grief implies that grief is an illness that needs to be cured. This denies legitimacy to grief and diminishes the impact of serious loss.

RITUAL AND PURPOSE OF MOURNING

Mourning is often socially supported through ritual, and one way ritual works is by touching individuals at the threshold of consciousness. Rituals speak to the conscious and unconscious simultaneously (Doka, 2002). For example, funerals make the implications of death real and help the bereaved work through the social integration of ongoing living (Corr, 2002).

Because disenfranchised loss is often associated with secrecy and shame, a ritual surrounding such losses may be unheard of. For example, one would not ordinarily hold a ritual around losing a job, home, or marriage. Yet, the absence of the public acknowledgement and support around such events, as is felt through ritual, may add to the difficulties that individuals face as they try to process these losses.

Even when a loved one dies and a formal ritual (e.g., funeral) takes place, some groups feel excluded from these ceremonies. One population that may feel excluded from funerals is lesbian, gay, bisexual, and transgender individuals. One study reported that, in 83% of funerals in a given population, the funeral arrangements and headstone were connected with traditional family ties. Members of the nuclear family of the deceased were often seated at the front of the church and were the first to approach the coffin and bid a silent farewell. Obituaries focused on
significant relationships, which usually included immediate family in a hierarchical order (e.g., heterosexual spouse, children, parents) (Reimers, 2011). In a discussion of homosexual deaths, Green and Grant (2008) wrote that even when the family accepts the surviving partner, they often do not want the relationship publicly revealed at the funeral.

Scott (2000) explored the grieving experiences of ex-spouses. He found that although many individuals feel significant loss around the death of an ex-spouse, the ex's presence is often resented at funerals by the deceased’s surviving spouse or family.

As indicated, ritual plays a serious part in healing from loss; when grievers are deprived of ritual, it may impede their ability to mourn. Thus, the role of ritual is worthy of exploration in any discussion of disenfranchised grief.

**SELF-DISENFRANCHISEMENT AND SHAME**

Individuals are less likely to seek support when their loss is not socially recognized (Cohen, 1996). Kauffman (2002) delves deeper into this phenomenon in his analysis of self-disenfranchisement, which he defines as the silencing of the self because of social expectations or perceived social expectations. A griever may not only be disenfranchised; they may become the disenfranchised. Self-disenfranchisement in these situations becomes a bondage to grief that is not allowed and cannot be mourned.

Allowing and disallowing are the psychological functions of shame. Shame is a psychological regulator that prevents the experience of grief from occurring. When shame takes place, the self turns inward and disenfranchised grief can create an injury to one's relationship with oneself (Kauffman, 2002).

Prior disenfranchisement from childhood especially can function as a rule as to how grief is “done.” For example, children may be shamed for a grief reaction or learn that certain types of loss are not deemed important. In response, children may feel a need to stay strong and protect themselves against shame and may be unable to recognize the significance of their loss. This can shape a child's future reaction to grief and old grief can remain unresolved. Old disenfranchised grief can be passed through generations as familial, social, and cultural norms. The passage of grief through generations serves to reinforce the parameters of what will and will not be grieved (Kauffman, 2002).

**PSYCHOLOGICAL LOSS**

Included in the causes of disenfranchised grief is psychological loss. At times, an individual remains living, but relevant aspects of his or her personality are gone. This can occur when someone has an illness (e.g., Alzheimer's disease), is in a coma, or has developed a mental illness. A loved one may mourn the loss of an individual who has entered a cult or who suffers from alcoholism. However, this mourning may not be acknowledged by society or even by the mourner (Doka & Aber, 2002).

**THE POLITICS OF DISENFRANCHISED GRIEF**

According to Reynolds (2002), all grief is disenfranchised when living in a death-defying culture, which is referring to the fact that expansion, acquisition, and unlimited possibilities are the foundations of many economic systems. Thus, society may pay limited attention to death and, in a culture where “time is money,” bereavement time is “costed” by corporations. Workers are allowed inadequate time to grieve and can only get time off work for the death of specific relatives (e.g., parent, sibling, child, heterosexual spouse).

When looking at disenfranchised grief through a political lens, the psychology of oppression may serve as a possible guide. When an individual is oppressed, it can lead to alienation from his or her culture, personal identity, and social support. Oppression can also impede a person’s capacity to take part in certain actions (e.g., ritual) that might assist in healing from loss.

**HEALING FROM DISENFRANCHISED GRIEF**

**Clinical Tools and Interventions**

Neimeyer and Jordan (2002) proposed that empathic failure is a central problem with disenfranchised grief. The griever fails to receive empathy from the community, him- or herself (in the case of self-disenfranchisement), or both. When grierees lack empathy, they may have trouble making meaning around their loss. Meaning making is a collective enterprise and meanings are ideally developed in interactions with others. When done alone, the process is solitary and complex. Thus, a major component of any therapeutic intervention is to provide empathic support. A helper should also assist the bereaved in analyzing the factors that inhibit the expression of grief.
Empathy can be offered through active listening and in assessing how empathic failure has occurred. Neimeyer and Jordan (2002) advise helping a mourner break down the “who, what, where, and why” of disenfranchised grief, and thus set the stage for appropriate interventions. For instance, a helper might ask, “Who contributes to the empathic disconnection experienced by the mourner? What features of the loss, or the mourner’s reaction to it, are disenfranchised? Where in the system does the empathic failure occur? When in the course of bereavement does empathic attunement break down?” (Neimeyer & Jordan, 2002, pp. 100-101).

The goal of any intervention, according to Neimeyer and Jordan (2002), is to “promote dialogue across the interface at which empathic failure occurs” (p. 102). To achieve this goal, the authors recommend that a client have a conversation with a “community of selves” (Neimeyer & Jordan, 2002, p. 102). There are many confounding thoughts and perspectives that an individual might deal with in grief. The Gestalt empty chair technique is one way that mourners might converse with different aspects of themselves or even with the deceased loved one. These dialogues can provide more focal awareness of a client’s inner thoughts and feelings. The dialogues can also build an empathic bridge between isolated or suppressed elements of the self and help integrate these elements into the mourner’s account of the loss (Neimeyer & Jordan, 2002).

**The Role of Ritual in Healing**

Doka (2002) encourages the practice of ritual for disenfranchised grievers. He also suggests the use of alternative or belated rituals for those who feel excluded from ritual in previous losses. Mourners should be included in the process of choosing and designing a ritual and they should be aided in processing their feelings after the ritual is completed.

**Support Groups**

As with any kind of grief, support groups can play a significant role in helping individuals who experience disenfranchised grief. Within groups, members can develop relationships and explore the impact of loss on their lives. Members can also find validation for their loss by connecting with others and by listening to and offering suggestions for coping. In addition, mourners can increase their self-esteem by helping other group members. Groups are especially effective if members share similar losses, and facilitators should be warm, empathic, genuine, and educated in the grief process (Pesek, 2002).

**Assisting Clients Who Experience Psychological Loss**

As with other grief situations, the goal in psychological loss is to educate, validate, and encourage the expression of emotions. A helper may also assist the griever in exploring the manifestations of guilt. Connecting the mourner to others who are going through similar losses (e.g., sending the families of alcoholics to Al-Anon) can be especially helpful (Doka & Aber, 2002).

**HEALING WITHIN THE CONTEXT OF LIBERATION PSYCHOLOGY**

When seeing disenfranchised grief through the psychology of oppression, grieving itself may become an act of liberation. Kauffman (2002) clarifies that in such an act, one does not find liberation from grief, but instead the freedom to grieve. Giving oneself permission to grieve without social sanction can be seen as highly heroic.

Liberation, or community psychology, may offer a framework in which to better understand the above concepts. Liberation grew out of the social justice movements of the 1960s and was formally introduced in 1965 when a group of psychologists envisioned a new type of psychology that focused on prevention and moved away from the medical model of mental illness. In subsequent decades, community psychology evolved into a process of personal empowerment. In recent years, community psychology has been associated with psychological liberation (Todd, 2011).

Liberation has also been connected with liberation theology (Duran, Firehammer, & Gonzalez, 2008). Liberation theology emerged from grassroots community struggles in which religious organizations, spiritual teachings, or both were used to identify and confront the oppression of marginalized groups. A well-known form of liberation theology took place within Black churches during the Civil Rights Movement. The poor in Latin America have also used liberation theology to understand and address their oppression (Duran et al., 2008).

Latin American liberation theology has been widely influenced by Freire’s (1972) theories of conscientization, or a change in consciousness. Freire (1972) believed that if individuals were educated about the impact of oppression and injustice, they could alter their perspectives of themselves and the structures in which they live. This could not only have beneficial psychological effects, but could also potentially lead individuals to take action to create social change. This sentiment is illustrated in a quote by the well-known, anti-apartheid activist, Stephen Biko: “The most potent weapon in the hands of the oppressor is the mind of the oppressed” (Duran et al., 2008, p. 288).

Undoubtedly, most oppressed individuals are well aware of their oppression and do not necessarily need a professional (e.g., a nurse) to teach them about their oppressed state. However, engaging individuals in discussions about these issues and bringing together those who share similar social backgrounds can help facilitate psychological healing. Such interventions can break the isolation that comes with oppression and prevent individuals from sinking into the despair, self-hatred, and shame that can internally accumulate when part of a disenfranchised group.

Todd (2011) suggested that community psychology and liberation theology can be used in conjunction with one another. Both community psychology and liberation theology focus on con-
KEYPOINTS

1. Disenfranchised grief can potentially result in unresolved grief or serious mental health problems; it is essential for nurses who work in the field of mental illness to be aware of disenfranchised grief.

2. Nurses can better serve clients with disenfranchised grief by understanding the dynamics and categories of disenfranchised grief and educating their clients about this issue.

3. Numerous interventions that can be performed by a nurse (e.g., group facilitation, active listening, therapeutic writing) can assist individuals with disenfranchised grief in a variety of patient settings.

Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal at jpn@healio.com.

Several interventions would involve education and dialogue. Through these processes, clients could learn about community psychology and liberation theories and explore how their lives and methods of grieving have been affected by laws and social norms.

If a nurse is working with a client who does not share his or her social status, including defining characteristics of gender, age, or race, the nurse needs to examine his or her own position in society. If that position involves certain privileges, the nurse may have difficulties seeing the injustices that underline disenfranchisement. An awareness of how oppression affects diverse groups is essential for any health care provider. This awareness is particularly important when approaching care through the lens of community psychology (Duran et al., 2008).

Several exercises can help the bereaved look at how oppression has affected their lives. Fair, Connor, Albright, Wise, and Jones (2012) used expressive writing assignments in their work with adolescents with HIV. The youth, who could be considered a disenfranchised group, often encountered stigma and a lack of support for their HIV status. Through therapeutic writing, the adolescents purportedly experienced increased confidence, communication skills, ability to solicit support, and a desire to share their experiences with others.

Duran et al. (2008) encouraged Native American clients to draw a genogram that defined points in history where trauma to Native American individuals occurred. By locating their own historical place in this trauma, clients with mental illness or addiction were able to move out of the perspective of being “personally defective.”

LIMITATIONS OF CURRENT RESEARCH
Few quantitative studies have been conducted about disenfranchised grief and little random sampling has been
performed within this research. In addition, most participants in these studies have been recruited from grief support groups and college classes. Thus, the results of these experiments may lack external validity (Thornton & Zanich, 2002).

Further problems arise when evaluating such a sensitive topic as grief. Because scholars are reluctant to intrude on the personal process of grief, researchers have often resorted to testing hypothetical, rather than real-life, situations (Thornton & Zanich, 2002). Recall bias on the part of study participants, as well as inaccurate reporting due to the sensitivity of the topic, contribute to additional concerns when evaluating the experience of disenfranchised grief (De Simone, 1996).

Further empirical research is needed on disenfranchised grief. However, for now, existing studies (including those with qualitative and anecdotal evidence) provide a good starting point in understanding and addressing this issue.

CONCLUSION

The concept of disenfranchised grief is relatively new and the empirical research on this topic is limited. Nevertheless, current literature offers compelling evidence that disenfranchised grief exists and affects individuals in wide ranging populations and situations (Doka, 2002).

Although grief itself is not pathology, the ramifications of unresolved grief can be severe. Because disenfranchised grief has been associated with unresolved grief and subsequent mental health issues, awareness of disenfranchised grief and support of disenfranchised griever seems paramount in the field of mental health nursing.

REFERENCES


Dr. Mortell is Adjunct Professor, School of Nursing and Health Professionals, University of San Francisco, San Francisco, California.

The author has disclosed no potential conflicts of interest, financial or otherwise.

Address correspondence to Susan Mortell, DNP, RN, CNL, Adjunct Professor, School of Nursing and Health Professionals, University of San Francisco, 2130 Fulton St., San Francisco, CA 94117-1080; e-mail: smmortell@usfca.edu.

Received: December 25, 2014
Accepted: February 27, 2015

doi:10.3928/02793695-20150319-05