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Exceptional necrophanic experiences and paradoxical mourning: studies of the phenomenology and the repercussions of frightening experiences of contact with the deceased

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Abstract

Introduction: Exceptional experiences of contact with the deceased are the subject of renewed interest in the bereavement clinical practice. Several works have highlighted positive aspects of such experiences, while asking specific questions about their complex links with psychopathology. The rupture model, reinforced by the Freudian theory, promotes the acceptance of loss; while the model of continued bonds favours the maintenance of identifications and relationships with the deceased. The latter model is based on recent investigations of these "necrophanic" experiences, the prevalence of which is between 47 and 82% among the bereaved.
Method: We analyze 108 testimonies (English and French) from a set of 1004 questionnaires completed online. They correspond to a subset of the sample of respondents who described their experience of contact with the deceased as frightening or negative. Our mixed analysis of closed and open-ended questions sheds light on the content of the messages, the anxieties associated with these experiences, the ways in which subjects shared these experiences, and their aftereffects.
Results: We proceed to a phenomenological breakdown to requalify 20 cases of encounters with unidentified entities, generally associated with sleep paralysis; and 6 incomplete cases which cannot be categorized. The contents of the messages are mostly positive. The anxieties are rather ambivalent and transitory. Sharing such experiences is easily done with relatives, but is hardly addressed with clinicians. There is a retrospective perception of an almost unchanged religiosity and a significantly increased spirituality, with specific effects generally favourable to the grieving process.
Discussion: These data on spontaneous, so-called frightening experiences rather suggest that these experiences may be catalysts for non-pathological mourning. In contradiction with the rupture model, these results reinforce the model of continued bonds by suggesting a paradoxical mourning: bearevement is accomplished at the cost of always keeping the relationship with the deceased open and alive. Clinical guidelines of such experiences are presented and discussed.
Conclusion: Necrophanic experiences are frequent and powerful. Longitudinal investigations seem necessary to evaluate their long-term effects.

Keywords: exceptional experience; hallucination; mourning; complicated grief; survey

Freudian theory asserts that "death itself is unrepresentable" and that "in the unconscious, each of us is convinced of our immortality" [1]. More broadly, it is death and mortality themselves that struggle to take their place in the subject's representational system, because of the major anxieties of death and castration that they reactivate. In this context, the subjective experiences of contact with a deceased person (which we shall propose to designate under the generic term necrophany, literally “monstration associated with death” in ancient Greek) can be understood as constructions that fill this representational void. They thus allow clinicians to observe the meaning making efforts of subjects in the face of death, on the intrapsychic and interpersonal levels.

Necrophany experiences induce a sense of closeness to the afterlife. By rendering the border between the dead and the living porous, they can give some people the feeling of better acceptance of death, of no longer fearing it. According to psychoanalysis and its "model of rupture", this apparent acceptance constitutes a form of defensive process, as subjects living such experiences aim to escape the dictates of reality and the acceptance of finitude. Ultimately, these subjects would experience a barred death, trying to thwart death, in the reactivation of a fantasy of immortality. However, some current theorizations (the "Continuing Bonds Model") also argue that maintaining a link with the deceased would facilitate mourning. These considerations will lead us to propose the term "paradoxical mourning".

Necrophanies also raise questions about the place and the cultural vision of death in our contemporary societies. Among other things, an important question emerges: where do we place, nowadays, the boundary line between normal and pathological mourning? The criteria of intensity and duration of depressive symptoms and the presence of reactive comorbidities are the subject of recurrent nosographic debates [2]. The clinical investigation of these experiences is situated between psychopathological and parapsychological perspectives, prioritizing the question of how they can be received within clinical settings to the question of their ontological interpretations.

Finally, necrophanies raise questions about psychoanalytical conceptions of death and mourning, and about the treatment of bereaved persons by psychoanalysts and psychodynamic psychologists. In particular, these experiences sometimes prove to be frightening, thus motivating requests for care, and raising questions around how to welcome them, how to consider them, how to put them to work?

We will develop all these questions by placing them in a historical and psychoanalytical perspective, and by relying on data from an extensive survey [3-4] on subjective experiences of contact with a deceased person. After a historical part, we will develop a review of the current literature on the question of necrophanies and the bereavement clinic. We will introduce the notion of paradoxical mourning, then discuss the cultural sensitivity of the phenomena evoked and the cultural discomfort they can generate.

We will then expose the phenomenology of necrophany as it is presented in the literature, which will allow us to introduce the aforementioned survey, part of whose data we analyze here. We will focus specifically on the analysis of frightening experiences, to present a refined phenomenology of them, and use illustrative testimonies. All of these developments will lead to the discussion on care and support mentioned earlier.

1 Research history

The link between the subjective experiences of contact with the deceased and mourning interested clinicians in the context of the development of spiritualism from the middle of the 19th century [5]. This consoling belief in a continued, discarnate existence could also be held responsible for the aggravation of mental disorders in vulnerable individuals [6-7]. In the context of the mass graves of the great wars, proving the reality of spiritualist phenomena also had social implications [8].
From the 1950s onwards, this initial questioning spread because these experiences were described by individuals who were not directly connected to belief in spirits. A study by Rees [9] published in 1971 marked a turning point in this research, as it was based on evidence which until then rarely reached clinicians' ears due to cultural taboos [10]. Rees found a high frequency of what he called "post-bereavement hallucinations," especially in widows and widowers. Such accounts had, however, already been recorded since the end of the 19th century in the framework of the first international surveys on hallucinations in the general population carried out by Society for Psychical Research [11-13]. The "parapsychological" approach, notwithstanding the factuality of such communications with the dead, had led to the marginalization of these studies [14].

The terminological proliferation in designations for these experiences reflects their disputed place, between psychopathology and paranormality. As Kamp and his colleagues point out ([15], p. 2), each author seems to coin their own terminology, which does not favour the elaboration of cumulative knowledge[1]. Some more "emic" terms emphasize the paranormality of the experience, others more "etic" on their interpretation in psychopathological terms. The most common expressions are those of "after-death communications" and "subjective experience of a contact with a deceased" (*Vécu subjectif de contact avec un défunt (VSCD)*, [16]). These same authors selected the expression of sensory or quasi-sensory experiences of contact with the deceased [15].
We are no exception to the rule by making an original proposal, guided by the desire to develop as neutral an understanding of these experiences as possible, by integrating them into the broader field of exceptional experiences [17-18]. Several authors indeed emphasize that these experiences should not be judged prematurely or unfairly in a psychopathological way [19-21], and that the question of their factuality is not primary [22]. Thus, we favour a notion derived from the term idionecrophanies [23] when speaking of *exceptional necrophanic experiences* or, more succinctly, of *necrophanies*.
An additional difficulty in this field of research comes from the fact that the studies subsequent to those of Rees [9] consisted mainly of fifteen unpublished theses (including: [24-30]). The samples vary greatly in size, as does the methodology employed. In order to examine more closely the question of their clinical support, we are particularly interested in the subgroup of these so-called negative or frightening experiences.
In Rees's [9] sample, 8 of 94 respondents found their experiences both calming and unpleasant. MacKenzie [31] has collected a few negative accounts, but not related to a grieving situation. In Parker's [29] thesis, only one in 12 subjects had a negative experience.

[1] Kamp et al. [15] mainly identify the following designations: after-death communications, after-death spiritual experiences, bereavement hallucinations, continuation of bond initiated by the deceased, experiences of continuous presence, experiences of presence, extraordinary experiences of the bereaved, ghost illness, grief hallucinations, hallucinations and illusions, hallucinatory experiences during mourning, idiophany, idionecrophanies, ideonecrophic experience, perceived presence of deceased loved ones, post-bereavement hallucinations, post-death contact, post-death encounters, presence of the dead, sense of presence, sensing experiences sensory-perceptual experiences of bereaved individuals, sightings of the deceased, spiritual connections with the deceased, visions of a ghost.

Cooper [32], one of the current scholars on this subject, mentions only a few brief negative comments associated with these accounts.
The "negative" aspect of these experiences is expressed in several registers: the experience can be frightening at the moment; it can have a negative personal impact, for example by making one feel like they are going crazy; finally, attempts to share experience can be ridiculed by others. Jakeman and Cooper [33] also distinguish a regret or a nostalgia in no longer benefiting from these experiences, called “spiritual mourning”. The valence analysis of these experiences is similar to that applied in the case of near-death experiences [34].
The interest of these negative experiences stems from the fact that they are poorly represented in the literaturewhen greater appreciation of them could call into question the conclusions that researchers have already reached. Indeed, the current debate relates to the fact that these experiences can be associated with pathology, in particular with complications of bereavement. The recent synthesis of the *International Consortium for Hallucination Research* concludes that the vast majority of these experiences are benign and should be viewed in light of their biographical, relational and socio-cultural context [15]. Would the same conclusions be reached by integrating negative experiences?

2 Necrophanies and mourning clinic

Exceptional experiences form a complex relationship with psychopathology [35], and those associated with death particularly question the impact of such experiences can have on mental health. Some researchers have concluded that exceptional experiences should be viewed in a neutral way [36]: they are part of the entire continuum between psychological improvement and worsening mental disorders. For necrophanies, the issue has refocused around the benchmarks of the mourning clinic, with many authors emphasizing the salutary functions that these experiences could sometimes take [37]. This phenomenon is no longer so marginal and has begun to be addressed during the training of caregivers, particularly in palliative care [38].
For example, Steffen and Coyle [39] believe that the experience of sensing a presence following their demise could help give meaning to the loss. Those they interviewed expressed a feeling of loss that was partially reversed or reduced, which was a source of comfort. These researchers did not interpret these sensations as forms of denial of death or unresolved grief. They do, however, point out the existence of negative experiences, the meaning of which practitioners can explore, for example in terms of “unfinished business” with the deceased [21,40] or with regard to anxiety triggered by the experience [41].
The assessment of the impact of necrophanies depends, first of all, on the reference model. The psychoanalytic approach to mourning provides some notions capable of entering into dialogue with these experiences. Second, we will explore a broader perspective stemming from the anthropology of death in our societies.

3 Psychoanalytic approach

The psychoanalyst Jean Allouch ([42], p. 64) uses the term “liveliness” when a recently bereaved person thinks he recognizes, from a beckoning image, the real presence of the person he lost. He explains this phenomenon by the fact that mourning is “one of the possible experiences of the loss of reality” (…) “reality no longer shields the real” ([42], p. 67), in the sense that reality is put to the test by death. He conceives of mourning as a “parapsychosis” based on an *operation that is the reverse of foreclosure*: a hole in the real that calls for the

symbolic and the imaginary. The possible parapsychotic phenomena will then be the "quasi-hallucination" of the living, the attack on the image of the body of the bereaved, the summoning of symbolic elements linked to the dead, and "'collective follies' of the belief in ghosts" ([42], p. 333).

Pascal Le Maléfan [43-44] uses this Lacanian conception of mourning to show how we can understand certain exceptional experiences around the *ghost* (apparition, illusion of presence, haunting, etc.) as a transient disorder caused by the hole left by the deceased. This disorder would not then be of the order of psychosis (where hallucination is a return to the real of the foreclosed symbolism), which prompts him to speak of it as a *quasi-hallucination* of mourning or an *illusion*, in accordance with this structurally based difference and with what some specialists in the bereavement clinic suggest ([45], p. 351).

Thomas Rabeyron [18] argues that it is not a coincidence that some people have such experiences. They would come to metabolize an underlying anxiety, fear of death, of separation, of abandonment or of the unknown. Rabeyron ([18], p. 116) interprets them "as hallucinatory phenomena corresponding to a particular method of treating bereavement with potentially symbolizing virtues". The model of the hallucinatory satisfaction of desire is valid here for this overflow, by means of a regression, shifting an over-invested object representation to the status of perception. We would therefore be in the register of quasi-hallucination [46].

Rabeyron [18] also refers to an "object of mourning", defined by Matot ([47], p. 152) "as the place of an emergence, of a transitional nature, of a figure intermediate between perception of representations, which is both present and absent, and ensures, within the process of mourning, the continuity of the object investment by the promise of something else behind." Necrophanies could then contribute to the elaboration of mourning [48]. Rabeyron [18] nevertheless underlines the distressing forms that these experiences can sometimes take, and which would be the sign of a return, in the form of a compulsion of repetions, of an otherwise unrepresentable traumatic reality [47, 49]. Inter- and transgenerational processes are sometimes at play [50]. The recurring nature of certain "ghosts" would therefore place us "beyond the pleasure principle" [51]. In short, the necrophanic quasi-hallucination allows both to deny the loss and to represent its negative aspects. The hallucinatory thus appears as the negative of the trauma.

4 Paradoxical mourning, models of rupture and continued bonds

The psychoanalytic approach to bereavement is based on the *normative model of rupture* [42]. "Work of mourning" is a clinical principle interwoven with a cultural norm that necessarily involves acceptance of the reality of the loss [52]. However, spiritualism, like other cultural currents, have argued rather in favour of an acceptance of the continuity of "something" after death, in other words of a partial loss (the physical envelope) which would not deny some form of prolonged spiritual existence. This comforting statement frequently brings about relief that is not considered fully adaptive according to the rupture model. Failure to admit total loss can be interpreted as a clinical sign of complicated grief, a disorder that affects 10% of bereaved persons [53]. Indeed, a position so clearly in contradiction with the normative model of rupture would be qualified as inappropriate thought and/or behaviour relating to death or to the deceased, resulting in continued emotional deregulation with respect to death, two of the main signs of this disorder. However, few links have been made between necrophanies and complicated bereavement, and almost no studies correlate them with psychosis ([15], p. 9).

However, the prevalence of this “spiritualist” belief remains strong in the West. For example, in the United States, 33% of adults believe that the living and the dead can communicate with each other [54]. Many clinicians question these patterns and come to support a "paradoxical mourning"[2] that would not go through this crucial step of recognizing the entirety of the loss.
A continuous bond is established, defined as “the presence of a continuation of the intimate relationship with the deceased by the grieving individual” ([57], p. 477). This model points to the benefit of such an attachment perpetuated in many “normal” settings, such as traditions, stories, images [58]. In short, “maintaining connections with the deceased would be normal and for the benefit of the bereaved” ([15], p. 11). Spontaneous necrophanies have a designated place in such a model, and individuals who have them are invited to communicate them. They would be the “externalized” form of the bond perpetuated “internally” ([57], p. 7).
A difference can be made between cases where necrophanies are spontaneous, i.e. apparently initiated by the deceased, and cases where they are actively sought [60]. These models of “continued bonds” [61-62] go hand in hand with the interest in therapeutic devices to facilitate such necrophanic experiences [63]. One of these devices is based on the ancient principle of psychomanteum, that is, a space for the evocation of the dead [64]. Another more recent one uses bi-alternating sensory stimulation or EMDR to induce such experiences and allow their resumption in the therapeutic setting [65]. First studies show positive effects on bereavement, even if these facilitating devices have no effect on one in three people [66-67].

Another device seems to be heading in the same direction: the use of mediums to reduce the deleterious effects of grief, or "assisted post-mortem contact experiences" [68]. While addictions to mediums are also observed by psychiatrists [69], some studies are beginning to highlight the benefits of receiving messages transmitted by a third party that allow the bereaved to identify the deceased, to understand that he has been observing him since his death and to be able to interact with him (farewell, advice, unresolved issues during his lifetime, etc.) [70]. In the United States, the Windbridge Research Center and the Forever Family Foundation (a centuries-old NGO) establish certifications for psychics who are then consulted by individuals seeking help.

Finally, post-mortem contact requests through the use of technologies or psychoactive drugs, without the assistance of a medium or a clinician, visibly allowing a similar phenomenology to be evoked. However, no systematic study has yet verified their therapeutic value on the grieving process ([61], p. 17-20).
Apart from these studies indicating that continued bonds can bring some support to the bereaved [71], some studies show a negative impact on them [72-74] It is therefore important to examine the conditions which allow paradoxical bereavement to be beneficial for psychic life. Researchers encourage systematic clinical studies involving disruptive necrophanies in order to identify the key principles of this new bereavement clinic ([15], p. 11).
Sara Stemen [75-76] has conducted several studies on continued bonds. In a study of 18 adults [75], she found that 89% of them continued to include their deceased within the representation of their social network, in a place that often remained unchanged. Ten of these 18 participants (56% of the sample) had experienced at least one spontaneous necrophany [76]. The qualitative analysis of their narrative shows their attempts to normalize these continued bonds with interlocutors perceived as critical. These two studies point to a distinction to be made between paradoxical mourning with or without necrophanies. Indeed, an individual can adopt a model of continued bonds without having been personally marked by such experiences (6 of 18 people in the Stemen sample). These two registers of belief and

[2] The notion of "paradoxical mourning" has already been proposed in the literature, to cover other forms of contradictions with the doxa, for example the joy of living of the bereaved [55] or a mourning that requires to be repeated and reinvented every day [56].

experience do not therefore systematically overlap. As our study is anchored on the underlying experiential dimension, it should be complemented by studies that focus more on the register of beliefs.

5 Cultural sensitivity and intellectual discomfort

These psychological and psychiatric studies frequently refer to the question of the cultural relativism of paradoxical mourning [59]. The distress associated with certain necrophanies may arise from unresolved issues with the deceased [77] or from deviations from locally prevailing socio-cultural rules [78]. Numerous cross-cultural examples show that the model of continued bonds constitutes a more acceptable cultural norm than the model of rupture in many countries [79-80]. In Hong Kong, for instance, the deceased is expected to remain on Earth as an insect, leading to frequent grieving behaviours interacting with insects [81]. In other cultures, such as the Navajo of North America [82] and the Kagwahiv and Matsigenka of the Amazon [83-84], necrophanies are sources of fear and avoidance. These cultural variations have important clinical implications. Shimabukuro and colleagues ([85], p. 225) urge not to pathologize behaviours that might appear unusual to a culturally incompetent practitioner, when they are fully appropriate from the cultural perspective of the bereaved". The authors agree on normalizing necrophanies which do not cause distress, but to address clinically those which are not well received by the patient or an outside observer [86].

Walter [87] has identified, in a schematic fashion, the cultures in which the living and the dead are expected to watch over each other ("cultures of care") and those in which the dead are relegated to the status of reminiscences ("cultures of memory"). This contrast is not fully effective, however, as the two tendencies can co-exist within the same culture. Magali Molinié [88] has thus analyzed the evolution of these two cultures in the West. This shows that, historically, death was part of continuity, of interaction, and not of cut-off. Saint Augustine, questioned on the cult of the dead within the framework of Christianity, had given clear indications to fight against these "heterodox" practices:

> "In a struggle against the practices of divination through dreams and through the dead, so widespread in Antiquity, Augustine recognizes the reality of the apparitions of the dead in dreams, but on the other hand disputes that the deceased had something to do with his dreamlike apparition. For him, the dead only exist as a *fantasy* [fantasma], an illusion." ([88], p. 17)

The rejection of some beliefs in favour of others has led to renegotiating the boundaries between the living and the dead. The model of rupture which will gradually dominate the West will be widely disseminated, in a secular and rational form, starting with the work of Freud [1]. The notion of "mourning work" [89], extracted incorrectly [42] from the Freudian text "Mourning and melancholy", written in 1915, develops a naturalistic model of mourning which necessarily involves intrapsychic processes of reshuffling of the bond, by "the acceptance of the irrevocability of the loss, the progressive detachment from the lost object, which frees the bereaved and allows him to create new relationships and find new satisfaction" ([90], p. 549.) This view comes from the original Freudian formulation of the grieving process, which states that the grieving problem is essentially of an economic nature: the reality test having shown that the loved object does no longer exist, it "enacts the requirement to remove all the libido from the bonds that hold it back to this object" ([1], p. 147).

In doing so, this model cuts itself off from the previous ones, whose goal, noted by Freud, was "to establish a lasting alliance with the dead" ([88], p. 50). Initially, Freud did nothing with this, instead retaining only the task of detachment, preferring to emphasize the fear and

ambivalence of the bereaved towards the deceased [89]. In a little-cited article, Gaines [90] recalls, however, that the founder of psychoanalysis was gradually led towards a recognition of the task of continuity, based on his growing appreciation of the role of identification in the development of mourning.

To describe this evolution briefly, let us recall that Freud initially considered that identification was a pathological process, the loss of the object transforming into a loss of the Ego, which led the subject into melancholy [1]. Then he reconsidered his words, in "The ego and the id", writing in particular these lines: "It may also be that identification is the condition without which the id cannot renounce its objects." ([91], p. 198). Freud was therefore already suggesting that the fact of managing to live without the external object was facilitated by the strengthening of the internal relation to the latter, even if he did not specifically comment on this apparent contradiction. Thus, the preservation of a privileged relationship with the love object beyond its loss – which would be the hallmark of melancholia – could be a necessary step in the normal mourning process. In the model of continuing bonds, this would not imply a displacement of this libido onto another object, but onto the same object that continues to subsist *elsewhere* and *otherwise*.

Freud's emphasis on the solitary acceptance of loss makes another radical break. Thus, Geoffroy Gorer [92] underlined Freud's failure to take into account the ritual question by Freud based on a large survey carried out in 1963, in Great Britain among 359 people who have lost a loved one:

> "[Gorer] correlates the inability to recover from one's affliction and the absence of any ritual, individual or social, secular or religious to guide the inconsolable, them and those around them, and stresses the "support that rituals can bring by marking out the affliction and providing patterns of behaviour (…) ". He proposed to view rituals as channeling the intrapsychic processes of mourning. His thesis, which associated the absence of ritual and pathological mourning, influenced a number of subsequent works, notably in France those of Philippe Ariès and Louis-Vincent Thomas." ([88], p. 72)

Such surveys have been reproduced recently with the same findings [93]. According to Patrick Baudry ([94], p. 96): "No society has ever accepted that people disappear without cultural intervention, that is to say without the cultural intervention of giving a place to the dead". However, the same author condemns claims of spontaneous communication with the dead, because they would induce the idea of a marvellous continuity between the dead and the living. The "routinization" of the belief in the afterlife would be deleterious, while disbelief would be the order of the day.

According to Marc-Antoine Berthod's analysis, the deceased thus have a paradoxical status in our society: "affirming a break with them becomes the very condition for the living to be able to think of their presence" ([95], p. 200). He underlines the intellectual discomfort that this paradoxical bringing together of the presence of the deceased can produce and exemplifies certain ways of dealing with this dissonance. However, the clinician, informed by anthropology [96], must deploy a cultural sensitivity that leads him to neutralize the biases associated with the cultural norms that condition him. This radical limit between the living and the dead must not be attacked in order to impose new beliefs on the patient, as certain approaches do [70], but a form of active tolerance must make it possible to support the patient in his frameworks, according to the position of undecidability which befits clinical practice with exceptional experiences [17, 97]. Taking all these aspects into consideration, our study will aim to evaluate the impact of these experiences on the mourning process and in particular when they present themselves in a frightening form.

6 Phenomenology

Before presenting the data resulting from our study, it is necessary to take stock of the phenomenology usually associated with necrophanies. Kamp and colleagues ([15], p. 3) describe a phenomenological continuum from clear and distinct experiences to subtle or partial impressions. Thus, the sensation of presence is sometimes depicted as a diffuse "sensation" and other times as a perception of a clearly localizable entity: for example, a subject will say "It is really as if he were sitting next to me." [39].

According to Beischel [63], necrophanies take the following forms: conviction of feeling the presence of the deceased; visual, olfactory, tactile and auditory phenomena (voice and sounds); conversations with the deceased; powerful dreams; hearing meaningful songs on the radio or music associated with the deceased; messages from objects; finding lost items; communication through electrical devices (e.g. flashing lights); communication through telephones; natural phenomena including unusual behavior by animals or insects; unusual behaviour in an animal or on the part of insects; symbolic messages; coincidences or synchronicities; other unusual incidents or inexplicable phenomena. This extended phenomenology corresponds to the one reported in our database. Other typologies restrict these experiences more to sensory phenomena, sensations of presence and strange dreamlike experiences, without including aspects related to coincidences between the internal world and the external environment. Kamp and his colleagues ([15], p. 4-5) summarize in two tables the sensory modalities of spontaneous necrophanies and the prevalence rates encountered in previous studies.

The first modality is therefore the sensation of presence, on the border between interiority and psychic exteriority. This has been the subject of special studies. These experiences tend to occur in unexpected ways [98] and are generally perceived as comforting [99-100], pleasurable [101], and helpful or positive [41, 81], although there are negative ones. Regarding the latter, Tyson-Ramson [40] observed that the feeling of an unwelcome and intrusive presence was often linked to unfinished business in the relationship with the deceased [39].

Some difficulty arises in distinguishing necrophanies from other experiences such as sleep paralysis. These experiences share the immediate sensation of a presence in a domestic environment, very often with the impression of intentional agency, but sleep paralysis often involves a malicious presence with an anonymous identity [102]. We will propose a categorization to distinguish these two experiences.

According to the synthesis of Kamp and colleagues [15], necrophanies are found in all cultures, in all age groups and in all types of relationship loss. They are not dependent on religious affiliation or the cause of death. They appear more widespread among women, and more frequent among widows when the relationship had been harmonious and the marriage long. From the perspective of psychological characteristics, they have been associated with openness to experience, neuroticism, extraversion, and the tendency to adopt avoidance coping. A link has also been identified with hallucinations, as well as mystical and exceptional experiences [103].

Kamp and colleagues [15] point out that hallucinations and other unusual sensory experiences are often associated with a psychiatric disorder, but that they can also occur in subjects without any particular pathology, but on the occasion of a life event such as mourning. Their prevalence in this context is estimated between 47 and 83% depending on the studies [104-105]. Much of the research on necrophanies is conducted in the field of bereavement, and reflects the general debate on the pathological or non-pathological nature of hallucinations [15].

7 Description of the study

Thanks to a grant from a foundation, an ambitious multilingual project was conducted from February 2018 to January 2020 entitled *Investigation of the phenomenology and impact of perceived spontaneous and direct After-Death Communications (ADCs).* The project was led by Evelyn Elsaesser from Switzerland, an independent researcher specializing in experiences related to death. The principal investigators are psychologists Prof. Chris A. Roe and Dr. Callum E. Cooper from the University of Northampton, UK [3-4, 106].

An online questionnaire of 194 questions remained accessible for six months. A total of 1004 questionnaires were completed, 416 in English, 440 in French and 148 in Spanish. The whole of the accounts of these experiences counts more than two million words. This makes this study the world's largest collection of data on these experiences, leaving room for a qualitative and quantitative analysis of the results.

The first objective of the study is to examine specifically the phenomenology of these experiences. Who are those who have them? In which circumstances? In what forms? We will examine in particular the **content of the messages** thus obtained.

The second objective of the study is to analyze the impact of these experiences and in particular their influence on the grieving process. In this context, we will analyze the **anxieties associated with the experiences**, the **ways in which the subjects shared their experiences**, and the **repercussions of these experiences** on their religious and spiritual attitudes, as well as on their grieving process specifically. To meet these two objectives, we identified the relevant items for each of these categories and then analyzed the data collected.

As part of this large study, our role was to analyze a portion of the English and French accounts for which participants said they were frightened by at least one aspect of the experience. As we found in the literature review, the majority of the research carried out has focused on pleasant necrophanies ([15], p. 4). Several authors have indicated the importance of exploring this counterpoint of unpleasant experiences, in the way in which negative near-death experiences have changed the overall view of these experiences [34].

Our various interrogations made it possible to sculpt, from the database and descriptive statistics, several representations of these experiences that remain relatively unknown. Since the survey medium has both closed and open questions, we have developed a thematic analysis for open questions, which we combine with responses to relevant closed questions.

In the portion of the database that we analyzed, the population is made up of 108 individuals, including 45 English and 64 French, 11 men and 97 women. The average age of the sample is 47.75 years. Socio-demographically, these are mainly people who are married (43%) or in cohabitation (17%). 48% of them have a university level or intermediate between high school and university (23%). They are mainly part of the working population (full time 46%, part time 17%) or are retired (13%).

8 Phenomenological analysis of frightening experiences

Out of the 108 experiences reported, we identify three categories.

The first relates to **perimortem[3] signs of an identified deceased**: they are manifested in the form of announcements, apparitions using one or more sensory modalities or apparent spontaneous communications, with a deceased either clearly identifiable, or in the context of mourning. This is the most common category (82 cases, or 76%). Often these signs occur in dreams or around sleep.

[3] Around the time of death.

Examples:
(F153, Female, 48 years old): “While I was sleeping, I saw the person [her boss] in very bad physical shape pushing a walker and in a hospital gown, although I did not know that he had died that same day [of fast spreading cancer]."

(E392, Female, 37 years old): “About midnight, sitting on couch. Felt a presence. Saw reflection on TV and saw a human shape walk behind me and down the hallway. I just knew it was my great grandmother. I was hyperventilating and my phone goes off. It was a text from my mom saying that my great grandmother has just passed, 1000 miles away. I went to bed with my door cracked open. Lying in bed, not yet asleep and my door opens all the way. I felt a warm squeeze on my hand. No one was there. I knew it was her saying goodbye.”

- The second corresponds to **experiences of encounter with unidentified entities**: bedroom visitors who are not immediately recognized; elements of sleep paralysis associated with a presence or interaction; experiences of haunting in a familiar or unknown place. In total, 20 cases (19%) present this phenomenology. For three cases, people report having experienced this type of encounter with strangers at the foot of the bed during their childhood, but that their main necrophany rather falls into the first category.

Example:
(F042, Female, 57 years old): “My husband and I restored a very old house that was two hundred or three hundred years old. This event happened in the bedroom. The bedroom was the only room not yet restored at this time, but we still used it. One morning lying in bed, I daydream, I reflect but I insist: I am not sleeping! It is 8:15 am, I plug in my electric blanket because I am a bit cold and at 8:20 am exactly, several people at the end of the bed pull me by the feet, they are very angry and I see them! In the foreground I make out a woman with her mouth wide open, dressed poorly… Full of anger. At this moment I feel my body lift up… I am levitating. I cannot do anything, I cannot speak, I am completely paralyzed, my eyes see since I saw the time on my alarm clock, but I just endure it and then everything stops. I get up without really being afraid but still the heart is beating a little faster! In my head... just one question, ’What was that?’ ’Just the obvious ... these people wanted to kick me out. I have the feeling that it happened to me yesterday, it is still very present despite all these years that passed, and very strong in intensity... no doubt, I was disturbing! "

- The third category contains all the cases for which too much information is missing or which cannot be categorized (6 cases, or 5%).

The phenomenology of necrophanies would deserve to be refined because there seem to be important differences between an experience, sometimes recurring, of sleep paralysis [102] or of apparitions of unknown beings at the foot of the bed, on the one hand; and the single or rare occurrence of contact with a deceased (identified in 84.9% of the 1004 cases surveyed, cf. [3], p. 11), often in the context of their death, on the other hand. The small size of our sample does not allow us to consider statistical comparisons between these two major categories.

9 Content of messages

Overall, 49 of 108 people (45%) retain some kind of message, either perceived directly through hearing (or "telepathically") or inferred from a non-verbal attitude or situation. We have identified five thematic categories to reflect the content of these messages:

- Message of consolation, reassurance or farewell: 27 persons (55%)

Examples:
(F038, Female, 32 years old): “I thought I perceived the following: he wanted to see me before leaving, he wanted to have one last contact on Earth before leaving for good."
(F407, Woman, 33 years old): "He told me to stop crying, to move on, that he was fine, that I should also tell my mother so that she would stop crying and let him go."

- Preventive or announcement message : 9 persons (18%)

Examples :
(F387, Female, 43 years old): “Something is going to happen, but all is well."
(F083, Woman, 29 years old): "He wanted me to go to his room because his letter was there"
(F436, Female, 65 years old): “I'm leaving. It's time for me to go. "

- Message of apology, restauration/resolution of the relationship: 4 persons (8%)

Example:
(F265, Female, 47 years old): “He needed to explain the reason why he had made this gesture that he did not want fatal and to apologize to his mother."

- Message communicating knowledge about the afterlife: 6 persons (12%)

Example :
(E395, Female, 37): "Death isn't what we are taught to believe (religious)”.

- Threat or request for help : 3 persons (6%)

Example:
(F042, Female, 57 years old): “That I should leave the place, that it was their place, that I had nothing to do here."

We can see that despite the fact that we analyze so-called frightening necrophanies, the messages are very rarely seen as being of the order of malicious will imposed by the entities. The vast majority of messages turn out to be positive, some focusing specifically on relationship failures, others preparing for the announcement of a demise or a future negative life event. Messages communicating knowledge about the afterlife could also correspond to another form of consolation, intellectual rather than directly emotional.
The purpose of such messages seems to be to facilitate acceptance of loss; the conviction that the deceased is well where he is allows the bereaved to feel at peace. In the process of accepting the loss, this type of message decreases psychic tension and in particular the unconscious alliance that is source of guilt. The idea of an extended life elsewhere facilitates a transition: if the loved one is “still alive,” and even happy, in a comfortable space, then worry is no longer necessary. In spirit, the person can now conceive of a psychic space which welcomes the reality of death.

The multisensory experience of the after-death communication updates in the present the relationship with the object, by making it possible to repair it where the bond was potentially damaged due to death. If the physical body no longer exists, the psychic object is not dead! It must therefore henceforth occupy another position in psychic space. The necrophany seems to manifest this work of subjectivation and repositioning of the psychic object.
It allows an outlet for residual tensions. De facto, the subject is no longer deprived of the object relation with the deceased; they are now authorized not to terminate this relation: it must evolve post-mortem. The other is, in the best cases, situated in the position of an omnipresent and omnipotent object of love, which watches over the happiness of the living. This representation of survival offers a beneficial compensation for the obstacles to relational continuity in a culture that makes death a radical discontinuity.
It is interesting to note that announcing or forecasting messages, or those for which the person is only the medium or the channel of a message to be conveyed to others, re-enact an essential scene of psychic life. The fact of passing phantasmatically through another allows the subject to feel less his share of responsibility in his psychic life, in a process more respectful of his defense mechanisms.
Given the globally positive dimension of the messages extracted from these experiences, we can therefore legitimately ask ourselves what are the sources of the anxieties associated with them.

10 Content of anxieties

Our sample has the special feature of having experienced its necrophanies with fear. This represents about 12,1% of all respondents to the survey ([3], p. 13), which is in itself an important information because data in this area is scarce.
In detail, 79% of the sample analyzed say they were frightened by the contact allegedly initiated by the deceased (Q108), while 18% are not sure and 3% do not expressly comment on this item. The fear was continuous throughout the duration of the necrophany for 46% of the individuals, only at the beginning (24%) or only at the end (15%) for the others (Q109).
The reasons for fear are broken down as follows (Q110): "I was destabilized by the fact that the deceased was apparently able to establish contact with me" (39%); "I feared losing my mind/hallucinating" (16%); "I thought the deceased's intention was to harm me" (13%); “Other” (22%).
We again performed a thematic analysis of the responses to open-ended questions on item Q111 completed by those who had indicated "Other" for Q110. Four categories emerge:

- Continuum from surprise to dread

Examples:
(E014, Female, 69 years old): “I was surprised. (…) I wondered why there was someone in my bedroom. (...) I put my head under bedclothes.”
(E238, Female, 53 years old): “I wasn’t frightened at all....it was just a new and strange experience and I felt a little shocked and alarmed but then went back to sleep unbothered.”

- Loss of physical control

Examples:
(E056, Female, 67 years old): “I felt a strange electric jolt through my body when I reacted to the visit and flipped over in bed.”

(F139, Female, 37 years old): “It's my body that feels that he is there. My heartbeat quickens. It is a surprise. Afterwards I take a breath and I try to control it because it is the surprise effect that is the most difficult to deal with.”

- Intention perceived as malicious

Example:
(E079, Female, 57 years old): “When the deceased first started making contact it was quite aggressive, like moving my dog for example which was upsetting for both of us.”

- Exclusively positive aspects

Example :
(E299, Female, 86 years old): “I am a channel for a higher Spirit and experience this kind of communication all the time. In fact, I'm writing my third book from that Source.”

This last example is relatively atypical, because the respondents are mainly people who have spontaneously lived this experience and not individuals who actively seek to provoke it.
The monstrous manifestations of dangerous spectres, whose cultural representations of the ghost deluge us with, are clearly absent. The fear comes mainly from the surprise effect: it is the shock of the unknown, a shock that is at once perceptual, emotional and rational. Questions can emerge very quickly about the intentions of the entity and the meaning of the encounter. Sometimes it is the phenomena that seem to occur in the physical world that cause misunderstanding. Other fears relate rather to emerging doubts about the mental health of the person and the possibility of sharing this incongruous experience.
Often, this anxiety regresses when the person expresses their fear (verbally or by withdrawing from the situation), because they feel obeyed and not harassed, thus maintaining a sense of control. This is not always the case in the few seconds or minutes that episodes involving forms of sleep paralysis may last, where the loss of physical control can generate anxiety (61.6% of all 1004 respondents were not frightened during temporary partial paralysis, see [3], p. 14). However, this fear is mostly transitory or even combined at the time with positive feelings. When we analyze the repercussions of the phenomenon, it will be confirmed that people maintain a positive or very positive perception of their experience.

11 Sharing experiences

The survey asks participants to find out who they shared their experiences with. One would expect such frightening and destabilizing experiences to lead to a demand for care and, consequently, to the solicitation of health professionals. Analysis of the 88 responses to open-ended questions Q140 and Q141 makes it possible to distinguish six categories, answering two questions: with whom did they share their experience? And how were they received?

Experience shared… :

- With everyone: 6 persons (7%)

Example:

(F001, Female, 49 years old): “I even testified at the time in an issue of INREES[4]! I recounted my experience in one of my books, and the whole family knows it. I am not afraid to tell about it to anyone who becomes familiar to me. No one has ever made fun of me. As I am a very serious person (former university professor in comparative literature), I benefit from a kind of credibility!”

- With a few selected people: 79 persons (90%)

Example:
(F095, Female, 48 years old): “Friends who are like me open to energy and who think that the soul or the consciousness outlives matter.”

- With nobody: 3 persons (3 %)

Example:
(F366, Female, 44 years old): “I myself am in doubt ... so how can I tackle this question with others?”

Reception of experience:

- Positive reception : 45 persons (51 %)

Example:
(F116, Female, 36 years old): “With close family and friends. Very well received, I was never passed off as crazy. I had a hard time talking to my dad about it, I didn't know how to approach the subject but finally this also contributed to his appeasement.”

- Mixed reception: 28 persons (32 %)

Examples:
(F364, Female, 33 years old): “Close friends, many of them were amused...”
(F416, Female, 34 years old): “Some understood, reassured me, others listened without conviction.”

- Negative reception: 15 persons (17 %)

Examples:
(F020, Female, 45): “My husband: he tells me it's my brain playing tricks on me. My sister: she is afraid of this experience.”
(F351, Female, 70 years old): “I was treated with anti-depressants, Imovane for sleeping and Solian for my visions and the voices I heard. People did not understand these experiences (family and colleagues).”

These testimonies tell us that people prefer to talk about these experiences to people who are close to them, friends, or people they know are sensitive to these issues (79 out of 88 persons, 90%). Few people say they can talk to everyone about it or get their message out publicly (6 of 88 persons, 7%). Others prefer not to talk about it, or wait until they find the right people to

[4] The magazine *Inexploré* published by the company “Institute for Research on Extraordinary Experiences” (INREES) has been on newsstands since 2008 and deals with themes like psychology, spirituality and the paranormal.

do so (3 of 88 persons, 3%). One person claims to have spoken about it to a psychologist who did not express an opinion, another spoke about it to their mourning counsellor, and another was treated with psychiatric drugs for their experiences. It therefore appears that healthcare professionals rarely seem to be informed of these experiences.
People often have concerns about how these experiences will be received. Many have faced disbelief experienced as rejection, indifference, or mockery. Sometimes they have managed to get more nuanced feedback, or through individuals who are more open. In total, 15 persons (17%) had an exclusively negative reception; 28 persons (32%) had a mixed reception; and 45 persons (51%) said they have received supportive listening from the (rare) people they have confided in.

12 Implications of the experience

Exceptional experiences have a reputation for having a big impact on an individual's life trajectory. Prospective studies examining the repercussions of near-death experiences seem to point in this direction [107], but still face methodological criticism [108]. What about necrophanies?
In item Q137, 36% of people say that the after-death communication has changed their life, 49% that it is important, 7% considers it moderately important, 3% not very important and 2% not at all important. Overall, therefore, this is a milestone in their existence.
Specifically, near-death experiences are known to lessen the fear of physical death by assuming it is not the end of everything [107]. Item Q132 assesses the change in fear of death following the necrophany. In all, 25% say that their fear of death has disappeared, 34% decreased, 34% remained the same, and 1% increased. Necrophanies therefore have a similar impact to NDEs with regard to fear of death [108].
Behind this modified representation of death, several interpretations can emerge. Items passed before the description of the necrophany ask about the degree of religiosity (Q11 and Q12) and spirituality (Q13 and Q14) with which the person identified *before* and *after* their experience.

Table 1: Perceived changes in religiosity and spirituality, as a percentage of opinions expressed

	Totally agree	Agree	Neutral	Disagree	Totally disagree
Religiosity before	4	17	39	21	18
Religiosity after	10	20	30	30	10
Spirituality before	28	29	22	17	4
Spirituality after	60	26	13	2	0

These retrospective data do not necessarily rigorously reflect the situation before the necrophany, but they do give an indication of how people perceive or rather claim a change in their beliefs associated with their experience. We can see a slight increase in religiosity (from 21% to 30% in agreement) and continued disagreement with religion (39-40% disagree), often seen as a source of dogmatism. The variations are obviously due to rather neutral people who

will polarize slightly. On the other hand, we note a very strong increase in spirituality (from 57% to 86%), with a minimal number of people who do not identify with it. In the overall sample, we see very similar numbers ([3], p. 5).
Specifically, items Q130 and Q131 assess (retrospectively) the belief in the existence of an afterlife *before* and *after* the necrophany. We thus go from 51% of people who believed in life after death *before* to 89% who believe in it *after* the necrophany (+ 38%). The initial 19% skeptics drop to just 1% in the aftermath, while the uncertain drop from 28% to 9%. One can imagine that this massive conversion to the conviction of continuity of consciousness after physical death comes to question the whole social relationship. Indeed, the participants in the survey come from cultures where death remains perceived as a total discontinuity, except within the framework of religious beliefs, whose authority has diminished with the secularization of Western societies. How could a clinician position himself/herself vis-à-vis an individual investing in such a belief?
It turns out that clinical interest could primarily focus on the well-being of the patient. Some items assess also the perceived impact of necrophanies on the grieving process, with question Q170 on the contribution of necrophanies in terms of comfort and emotional healing. In all, 55% of participants claim to have benefited in this respect from their necrophanies, against 19% answering "no" to this question and 11% saying they are uncertain. This question was not appropriate for all contexts since 14% explained that they had never been in mourning for the perceived deceased.

In the following open-ended question (Q171), people describe in what ways necrophanies had a **specific effect on the grieving process**:

Examples:
(F132, Female, 30 years old): "This 'apparition' appeased me. I told myself that she was watching over me, that I had the ability to bounce back. I later managed to forgive myself completely."
(F308, Female, 36 years old, who lost her daughter a few hours after giving birth): "When I was sure that it was real and that I received the certainties, it calmed my sorrow. I did not shut myself up and feel sorry for my fate... other questions arose... since after death it is not nothingness... who takes care of her? How does it work? etc. This opened up another form of concern. The message on my husband's answering machine then reassured me as well... "Everything is fine"... I know that I will meet her again when it will be time... I am a special mom with one foot in heaven and the other on earth because we must... continue and move forward (I am currently pregnant with her little sister, 6 months pregnant)."
(F365, Female, 63 years old): "Before this contact, I was in survival mode."

Some accommodate **changes in the relationship with the deceased**:

(F153, Female, 48 years old): 'I did not understand why I was so upset by the death of my director (fast spreading cancer) and why I was experiencing these contacts and then having listened to him and helped him relieve me of this upheaval.'

Some even say that it **prepares them better for the next bereavements** to come:

(F158, Female, 39 years old): "Mourning is about the physical person and all the moments that will never exist again. Having said that, I think I will not go through the next griefs quite the same. But losing a loved one in our daily life has nothing to do with maintaining a

"relationship" beyond. We no longer share the daily grind; there is no longer a presence in the physical world."

Others make of the necrophany a **crucial step in their mourning**:

Examples:
(F068, Female, 23 years old): "I couldn't mourn until the ADC [necrophany] occurred."
(E145, Female, 50 years old): "I'm really not sure how my bereavement process would have been if I had not experienced the communication with the deceased."

Item Q185 analyzes the centrality of the necrophany in the grieving process. 43% of participants attribute a major role to necrophanies, 26% are not sure, and 14% think that the bereavement would have gone the same way without this experience. Here again, we can see the importance given to this experience by those who have it. In the total population, 68.4% find the experience important, 11.4% are uncertain and 20.2% do not find it important in relation to the grieving process ([3], p. 22). There is a significant difference in the centrality of the experience between all the necrophanic experiences and those that were frightening.
All this suggests that necrophanies in the context of mourning could correspond, for some people, to a necessary phase of the mourning process, described by Freud [1] as an over-investment in the lost object – in this case by a quasi-hallucination – after which the detachment of the libido is accomplished.
Item 177 asks the question differently: "Do you have a strong desire for a new contact with the deceased or are the perceived contact(s) sufficient for you?" One would expect so-called frightening necrophanies to be a deterrent experience. However, 36% would like to repeat the experience (against 26% who would not, and 6% uncertain). These figures are lower than those for the overall sample (46.9 % would like a new contact, compared with 33.3 % for whom the perceived contacts are sufficient and 7.5 % who are unsure) ([3], p. 22). When we examine the "Other" answers (13%), we find a majority desire to continue the experience, but with certain nuances, due in particular to the specific wording of the item :

Examples:
(F308, Female, 36 years old): "I would like regular contacts with my little girl, but I know that she must also 'make her life' ... what I have received is so incredible that I could be satisfied with it until the moment when we will meet again."
(F300, Female, 35 years old): "I do not wish it intensely, but some days I hope for it."
(F119, Female, 40 years old): "The perceived contact is sufficient in its essence and its intention but it is true that I would not say no to another contact if there were to be one."
(E094, Male, 22 years old): "I want to contact but not in dreams but in a controlled way or in a conscious state."

Through the multiple windows through which the repercussions of necrophanies are observed, we see changes claimed as important, of a general nature in religiosity and spirituality, more specifically in the development of a belief in the continuity of life after death, reducing or eliminating the fear of the latter. Whether this is the result of the experience or the interpretation associated with it, or a combination of the two, the majority of participants claim a crucial overall impact on the favourable development of their grieving process.
If we had to compare classic mourning and mourning with necrophanies, the question would arise of the place to assign to this belief in the continuity of life. Indeed, many classic bereavements lead to a reconstruction of the philosophy of life, bringing appeasement and serenity.

Here, the post-mourning seems to have as its base, for a majority of the participants, an articulation between experience and belief in afterlife which ends with a **paradoxical form of mourning** (cf. supra): mourning is accomplished at the cost of always maintaining open and lively the relationship with the deceased. This contradicts the rational norm of death as discontinuity, but is it ultimately a cultural horizon towards which the clinician should guide his/her patient (cf. infra)? This assumption of continuity seems to be able to generalize to other losses and other bereavements, developing a protective effect. The salience and centrality of the necrophanies in this montage can be read in the answers given when the conjecture of a life where such an experience would not have taken place is raised.

13 Testimonies

To get a more complete picture of the trajectory of a person living with necrophany, we have selected three cases that exemplify the phenomenological diversity of these experiences and the support issues they raise. These data are extracted from the parts of the questionnaire accepting free responses and allowing a qualitative analysis.
Participant F132 is a 30-year-old female, childless, working full time. At 19, she had an abortion that she found it hard to forgive herself:

> "One night I dreamed that I was standing still, in the middle of a church, as if I was about to get married, with many people that I could not recognize and who were busy around me. Further away, also motionless, stood my grandmother, who had died 5 years earlier (a difficult loss for me). We were facing each other, with about ten meters between us. She looked fit, calm, and was looking at me. She began to smile at me with that smile that I will never forget, that I always adored as a child, and that has always reassured me. That smile seemed to tell me 'everything is fine and everything will be fine, I'm with you'. This dream was so strong and changed so much from all the dreams that I had until then (in particular in intensity, in feeling that it was "more than real"), that when I woke up, I was afraid ! Afraid of going back to sleep the next night and having the same kind of dream. I was not afraid of my grandmother but I had never experienced this, I really felt like I had experienced something supernatural. As I had no explanation, I opted for the one that I liked the most: this dream was a kind of "making contact" of my grandma, at a difficult moment in my life, to remind me of her benevolent presence by my side."

This dream is identified as having facilitated the acceptance of this "traumatic episode" that the abortion constituted for her. It has produced a certain appeasement, while complete forgiveness will only be possible later. The experience was shared with her mother and some friends "chosen for their openness". Spirituality then assumed on a more important place in her life, with the new conviction of a connection beyond death. It is interesting in this experience that there is no representation of the foetus or the unborn child, just a bodily attitude associated with reassurance.

Participant F312 is a 57-year-old woman, single and working full time. Without religious conviction, her spirituality leaped from "neutral" to "strongly agree" following her experience 21 years previously. As she sat in bed, "deeply in despair over [her] mother's death" from cancer two weeks earlier, she faced the question, as she had been for days, 'But where is she?' She suddenly sees appearing in front of her 'the face of an elderly lady whom I knew very little (the mother-in-law of one of my friends), who died a few months before my mother'. It was 'like an image projected on a screen', 'it felt like it was speaking to me'. Immediately she heard these words in her mind: 'Your mother cannot appear to you. She is too tired and

doesn't have the strength. That's why I'm coming in her place. The weary soul must go through seven circles of regeneration before it can materialize an image of the one who carried it.'
She completes her description: 'Her words were imposed on me; I don't think they were articulated.' The scene is so out of the ordinary that it arouses dread. The bereaved said: 'I don't want to know!' and those words ended everything, but now she regrets. She says that a few days before, a clear sensation of her mother's presence in front of her had been a prelude to this vision. She says she knew nothing about these phenomena at that time. Now the experience is engraved in her. After the fright, she felt 'relief, gratitude for the message but also a lot of questions about my mental state ...' She waits several years before talking about it and decides to entrust it to a psychologist, who gives no feedback. Her conviction is nevertheless made: 'I have no more doubts that it really happened. I couldn't have fantasized these words, which didn't make sense to me at the time and were far removed from my culture and concerns.'
This explanation is favoured over that of hallucination, as it is a source of greater comfort. This attempted proxy contact of her mother, in response to her call, played a crucial role in the grieving process: 'If this experience hadn't happened, I would have really felt abandoned.'

Participant F020 is a 45-year-old married woman, mother, and working full time. A few years ago, she lost her father to cancer. She had accompanied him until the end and was very close to him. A few days after the ceremony and the cremation, his ashes having been scattered in the sea, she experienced an astonishing phenomenon. In a phone conversation on her cell phone with her aunt, the communication "was interfered" as she entered her father's house. "A very intense whistling sound, with interference on the line for 3-4 minutes. I couldn't hear my aunt anymore. The whistling and interference suddenly stopped as a strong, rapid breath was heard through the phone. I was asking who was on the phone: no answer, just that breath that came back several times during this event. I knew this breathing because my dad had had this strong and rapid jerky breathing a few days before he departed. I was attracted to this breathing, but also scared. I didn't want to hang up although I was shaking, so I opened the blind because the house was in the dark and, then, nothing anymore. The communication with my aunt became fluid again. For her part, my aunt had heard the whistling sound and water running, slapping" (which she associates with the sea where the ashes were dispersed). A few minutes after this communication, she smells the scent of her father's after-shave, and has the impression of having dreamed. She now understands this as a message from him showing him that he was still there, that there was something after death. This did not change her religious or spiritual convictions, which remain neutral, but her life is changed and her fear of death has decreased. Moved and unsettled, she regrets that her action of opening the blinds interrupted the communication which only lasted a few minutes. She did not find people around her to share this experience with. Such experiences appearing to use modern telecommunications routes have been identified by professional and amateur[5] researchers since the 1970s and seem to be increasingly frequent [109-110]. The intrusion of this "technological reality" into the narrative of experience raises many questions about clinical accompaniment [111].

14 Implications for clinical practice

Through the analysis of this data, we find that even necrophanies described as frightening can be considered in retrospect as a positive resource. This conclusion is consistent with that of

[5] Kasprowicz L. *Quand les morts nous contactent. Enquête sur le phénomène des coups de téléphone post-mortem et autres contacts supposés avec les morts*. Self-published ; 2016.

Drewry [112] after his analysis of 40 cases of necrophanies. A similar phenomenon was observed for negative near-death experiences which would have the same protective effects against trauma as so-called pleasant near-death experiences [34].

Two questions will guide our reflections on dealing with these experiences: why do these experiences not more often reach the ears of psychologists and psychiatrists? And what would be the conduct for a clinician faced with such cases?

In England, Elizabeth Roxburgh and Rachel Evenden [113] interviewed eight therapists who had received patients reporting exceptional experiences. According to them, patients are reluctant to reveal their experiences for fear of the interpretation that might be made by society in general and by the clinician in particular. Research shows that patients who testify to such experiences in traditional therapeutic contexts do not feel sufficiently listened to, accepted or understood [114]. They may also receive help that they deem inadequate [115], and fear being ridiculed or pathologized, which is why they approach their experiences in small touches and only reveal the extent of their experience when they feel that the therapist welcomes their story positively [113]. Fear of social stigma is one of the biggest barriers to seeking help [116].

Keen, Murray and Payne [114], for their part, conducted a meta-analysis of published research on the sensing of a presence and also point to the stigmatizing aspect of the narrative of such experiences, thus confirming what has already been emphasized elsewhere [9-10]. Keen, Murray and Payne [104] report that men are generally more reluctant to discuss the experience of this phenomenon than women [117] and that older people are more reluctant than younger bereaved [10]. Like Roxburgh and Evenden [113], they find that this reluctance to discuss experiences of sensing a presence is due to the fear of being ridiculed or seen as mentally ill. This restraint could impact people's willingness to share this information with grief practitioners and researchers, and suggests that the prevalence of such experiences is underestimated. It is, however, notable that this reluctance is also a cultural effect. Thus, the Japanese and Chinese participants of the studies of Yamamoto and his colleagues [80] and of Chan and his colleagues [81] did not report this embarrassment, and instead declared that the sensing of the presence of the deceased was normal and comforting in their culture. Nowatzki and Kalischuk [22] have even suggested that the influence of more “oriental” theories could contribute to our understanding of the experience of sensing a presence by offering a more balanced view of the normal, healthy and healing effects of those experiences which, according to them, have been neglected by Western models.

The majority of therapists interviewed by Roxburgh and Evenden [113] say it is important to explore the meaning of the experience from the patient's perspective, rather than imposing their own interpretation. This finding validates the results of research with patients who had sought support for their exceptional experiences [118]: it is important to be able to make sense of the experience with an open-minded therapist. It would be legitimate to consider necrophanies as “clinical material” [119], in the same way as for all exceptional experiences [17-18]. In this sense, it is important for professionals to put their own beliefs aside so that they can focus on the therapeutic and curative benefits of these experiences without questioning their validity or attempting to explain them [22].

The studies reviewed by Keen, Murray and Payne [104] also highlight the need for better training of practitioners dealing with bereaved people who experience the sensing of a presence. For example, the ten participants in the research of Taylor [114] all indicated that they had had an unsatisfactory or poor counseling experience, that is, practitioners did not mention or did not ask about an experience of sensing a presence, considered it abnormal, or avoided the topic when the person spoke about it. These participants did not feel accepted or understood. Four of the ten participants then experienced satisfactory support with a different practitioner, who considered the experience to be normal, encouraged them to discuss it

further, and seemed to understand the person and their experiences. The fact remains that some of these participants would have liked to be asked more questions about their culture and beliefs.

This question of training accompanies a debate already present in the literature concerning the term that would be best suited to the description of these experiences. As the term "hallucination of bereavement" has been used in several studies dealing with these experiences, it is not surprising that health professionals associate this phenomenon with mental illness [120-121]. Practitioners are also likely to have differing personal convictions on the issue of sensing a presence. Thus, Sanger [122] interviewed 21 social workers and found that they had a variety of explanations for these experiences, ranging from psychological, biological, spiritual, to paranormal ideas.
Kamp and colleagues ([15], Table 4, p. 6) list a series of clinical recommendations for evaluating and working with necrophanies, summarizing the opinion of several authors [19-22, 122] which we adapt below:

1. Welcome disclosed necrophanies by encouraging a detailed account, indicating the impact and meaning of these experiences from the subject's perspective;
2. Evaluate the links with (pre-existing) mental health problems, taking into account the risks of misdiagnosis, due to the mostly benign content of these experiences;
3. Psycho-educate by normalizing these experiences (demythologize) and by reassuring about the links with mental health (depathologize);
4. Work on the relationship with the deceased, of which the necrophany can be a catalyst. A healthy continuous bond can be built in some cases;
5. Develop the positive aspects of pleasant necrophanies, in relation to the issue of mourning or other aspects of life;
6. In the event of negative or ambivalent necrophanies, it is important to deepen the assessment of the context of the occurrence and the issues associated with the relationship with the deceased. Then explore with the subject different ways of reacting to this experience;
7. It is necessary to confront the issues related to cognitive dissonance and / or the existential crisis associated with this exceptional experience. The subjects can be in difficulty to give them meaning, to integrate them into a conceptual framework and in particular in their religious or spiritual beliefs;
8. Clinicians should approach these experiences by conducting a non-judgmental exploration, which involves openness and respect for the perception and interpretation of the subject;
9. Clinicians should be sensitive to cultural aspects, to the terms used to interpret the experience, and to be generally benevolent vis-à-vis the perspectives envisaged by the subject;
10. 1If appropriate and relevant, clinicians can take a positive stance about the reality and value of necrophanies, help subjects explore its transformative potential, and enhance post-traumatic growth that would occur naturally in the subject anyway in reaction to his experience.

With respect to the stated possibility of taking a position on the ontological status of necrophanies, some authors consider it unnecessary to provide a psychological explanation of the experience to patients. Parker [21], for example, argues that if experiences are perceived as “real” by the bereaved, such rationalizing explanations could hinder the integration of the experience into his/her belief system. Likewise, Longman and colleagues [123] argue that, since any experience is unique to everyone, people should be encouraged to seek their own

explanation to find comfort. The relevance of relying on the cultural and religious beliefs of the bereaved to support them is also frequently stressed [39, 115, 122].
Keen, Murray and Payne [104] make other suggestions for supporting bereaved people experiencing the sensing of a presence:

- Prepare the bereaved for the idea that they may meet the deceased in one way or another [100, 117];
- Reassure on the fact that these experiences do not depend on the nature of the relationship with the deceased, in order to reduce the distress of the bereaved who seek this experience but have never had it [101, 122];
- Address the possibility of the experience in early sessions with bereaved people and their families, so as to reduce fear of mental illness and fear of the stigma associated with a "hallucinatory" presence [101].

The value of these recommendations is that they join, beyond the exceptional necrophanic experiences, they join the intercultural clinic in its approach to a symptomatology that deviates from the cultural norms of the clinician. However, they have certain limitations that field studies could refine. These recommendations encourage to separate the pleasant necrophanies from those which are less so, while the psychic dynamics at play seem the same, as our study shows. They consider these experiences mainly in a context of grief, whereas they occur in various contexts. They apply especially to spontaneous necrophanies, marked by a kind of letting go, and less to those that are provoked voluntarily. Finally, the state of consciousness in which the experience is being lived is not yet recorded as a variable that can provide clinical indications. It seems relevant to us to explore the sensory modalities in which necrophanies occur and their links with psychic life, in particular with psychic envelopes and their borders [18]. This article concentrates on the phenomenological description of frightening necrophanies, and calls for further work to deepen the clinical understanding of such experiences [124].

15 Conclusion

We are talking here about a clinician's place, our purpose being by no means to prove the existence of life after death, but to plead for serious engagement with powerful and frequent subjective experiences. It seems to us necessary to stop dismissing necrophanies in general, and frightening experiences or their negative repercussions in particular, whether for the subject himself or his entourage.
Societal evolutions bring their share of mutations in the way of "grieving," as witnessed by online memorial sites [125-126] or even "Facebook altars" [127]. These experiences of subjective contact with the deceased make it possible to observe the evolution of the forms taken by the work of mourning in our contemporaries. They call for an evolution of the theories on the question, and it is in this context that we propose the notion of paradoxical mourning. The central question of the work of mourning is indeed that of remodelling the link to the object: according to psychoanalysis, the lost object, stamped with the seal of loss, must be disinvested in favour of the internal object, with which the link is reinforced. In necrophanic experiences, everything happens as if this intrapsychic process is externalized. The mourning then takes a paradoxical form: the subject fantastically "resurrects" the lost object, to "meet" it (say goodbye, feel forgiven, break the feeling of loneliness...) and move forward in the process of his mourning. In a way, it is a question of being able to find the lost person to better separate from it, or sometimes to keep it "a little present" to live their absence on a daily basis. These considerations, which underline the adaptive dimension of the ongoing

links in mourning, do not however make us forget that certain necrophanies are also the expression of a pathological mourning dominated by a denial of death.
From a methodological point of view, our study is based on testimonies from a very large database that will lead to other specific studies. The questionnaire, which was previously distributed in French, English and Spanish, will be translated into other languages and used on other continents. More longitudinal investigation is needed to confirm or refute the long-term effects of these experiences.
Finally, we would like to re-emphasize the influence of culture in the way of considering death and mourning. As we have outlined, the dominant thinking in our European societies has spread the normative vision of the rupture model. Is this paradigm, historically originating in the West, not showing its limits? In our opinion, it is important that professionals in the field of psychological care do not adhere, explicitly or implicitly, to anthropological predicates or ideological biases. They must "inform themselves" through clinical anthropology of the particularities and evolutions of cultural norms [96]. The function of the clinician is indeed to take into account the uniqueness of each person, and therefore to consider carefully any exceptional experience, to make it a clinical material in its own right. This positioning, sometimes counter-cultural, guarantees an authentic openness to the reception of accounts of necrophanies and exceptional experiences as a whole. In this way, we will be able to rehabilitate a space for the elaboration of these experiences that could act as a bulwark against alternative practices that are less well regulated and more questionable.

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