How Not to Panic When Your Client Talks to Dead People

Contributed by Michael Sanger, MSW, Ph.D.

Imagine you are a relatively new social worker interviewing a woman in her late seventies. You might be working in a hospital, an assisted living facility, or a social service agency. The interview is progressing nicely, and the two of you are bonding. Then the woman sitting across from you starts telling you how just the other night she was talking with her mother, who died two years ago. Or perhaps she mentions glimpsing her deceased husband standing by the kitchen window. Or that every time she sees the vapor trail of a jet in the sky, she knows it’s her brother sending her a message. {mosgoogle right}

What do you do? Do you panic and get flustered and change to a more comfortable topic? Do you decide she’s probably crazy and needs some serious medication? Or do you listen to her, let her share her thoughts, and perhaps ask a few probing questions about her experience?

I know what you would do, even if you don’t. And in a minute I’ll share that with you. But first, let me tell you a story.

Introduction

I became a social worker shortly after my wife died. Anne had been diagnosed with stomach cancer a few years after we were married, and she died less than two years later. While her dying was painful for both of us, that pain was eased through the assistance we received from our local hospice.

At the time, Anne and I had owned a blue four-door Toyota Corolla, and a few days after her death, a drawing appeared traced in grime inside the back seat window, on the driver’s side. It was a silhouette of Anne’s face just after she died, lying on the hospice bed. I assumed that somehow Anne’s spirit had made the drawing as a final message. I didn’t particularly believe in that kind of thing—messages from beyond the grave—but there was the picture staring me in the face.

I gradually got used to the idea that this was a final message from Anne, letting me know that she was okay. I told a few of my friends about it, and they looked at the car window, agreed it was probably Anne, and that was that.

Then, after getting my MSW, I entered a PhD program. My dissertation explored how social workers worked with clients who felt they had been in contact with deceased loved ones—like I had been, with Anne. That research tells me how you’ll react if a client ever tells you she was talking with her dead mother.

Do clients really talk to dead people?

In this study, I interviewed twenty-one social workers about how they dealt with clients who felt they’d had what the literature called an “ideonecrophic experience (IE).” Three of these social workers were still in school, and the others averaged 12 and a half years of experience in the field. The responses shared by the students were almost identical to those shared by the MSWs. These social workers had worked with IEs experienced by:

- schoolchildren,
- people in both individual and group therapy,
- people in therapy for grief-related issues,
- people who were not particularly addressing grief-related issues,
- people who were in the process of dying, and
- clients who were seen in private practice, medical settings, and social service agencies.

These clients shared the following kinds of experiences:

- Felt Presence. By far the most frequent experience reported by social workers was the felt presence of the deceased. “...she absolutely felt her daughter's presence right there in the room.”
- Feeling watched over. This is a variation on felt presence, in that it includes a sense of the deceased being concerned about the client.
- Physically feeling the deceased. This is different from feeling the presence, in which the feeling is more an emotional or cognitive sensing than an actual physical sensation. In the case of physically feeling the deceased, there is the actual physical sensation of the deceased touching the client. Two gentlemen in a bereavement group, for example, reported feeling their deceased wives next to them in bed, and they were referring to the actual physical sensation of touch.
- Hearing the deceased. One client heard her deceased husband’s voice and “…his voice was so real to her that she needed to open her eyes and look over, and didn’t see him there.”
- Seeing the deceased. Clients often caught a glimpse of the deceased in places like the kitchen or bedroom.
- Other people seeing the deceased. One client, for example, was talking about her deceased daughter at a school assembly, and one of the students in the audience reported seeing her daughter on the stage.
- Dreams in which the deceased is really present. On awakening, the dreamer believes the deceased was really present in the dream and not just a dream image.
- Messages from objects. Events in the physical world interpreted as containing messages from the deceased. For example, clocks chiming on the deceased’s birthday, memorial candles burning twice as long as they should have, and a balloon stuck in a tree on the deceased’s birthday, were all taken as messages from the deceased.
- Found possessions. This is a variation on messages from objects, in which the object appears mysteriously, and the

appearance is imbued with meaning. “I have had other people say that they have found a piece of jewelry that their husband or wife or whatever had given them, and it had been lost for years,” said one social worker. “And, suddenly, it was on the sidewalk in front of them.”

How the social workers reacted to these clients

When I began this research, I thought that some of the social workers would tell me they thought their clients were crazy, or at least not grieving very well—and that some social workers would try to convince the clients they had been hallucinating, or that they should forget about the deceased and get on with their lives.

But none of them reacted that way. They all reported that when a client brought up one of these experiences, they:

- Respected the client’s experience, maintaining a nonjudgmental stance.
- Normalized the experience—letting the client know that this is a relatively common occurrence, experienced by more than 40% of adults (Davis & Smith, 1997).
- Explored the meaning the experience had for the client.
- Acknowledged the importance of the experience for the client.
- Used the experience as a stepping stone to work with other issues that were important to the client’s well-being, for instance, processing a troubled relationship with the deceased.

Although these social workers generally agreed in how they would work with clients, they differed over how they viewed the experience. Some thought it was actually the deceased, others thought it was a biologically-based memory of the deceased, and still others just thought of it as a normal part of the human experience. They all accepted it as a common part of grieving, and none of them thought that it was a sign of any kind of pathology or improper mourning.

I found this amazing, since I had expected some of the social workers to view the contacts as signs of pathology, or at least as signs that their client needed to do some grief work. But that was not the case, at least for the social workers who took part in this study.

Why the social workers reacted as they did

Two sets of factors helped explain why these social workers were so accepting of the client’s experience. The first set was based on having a non-pathologizing view of IEs, while the second set was based on adhering to basic social work values.

Many of the social workers had either experienced the presence of a deceased loved one themselves, or knew close friends or family members who had had such visits. Those social workers who did not have a personal history with this kind of experience were familiar with the experience either from talking with people about it, or reading the literature on continued bonds with the deceased (Stroebe, Stroebe, Gergen, & Gergen, 1992). This literature points out that, contrary to the Freudian “mandate” to break bonds with the deceased as part of the mourning process, in most cultures throughout history, it is normal for survivors to stay connected to the deceased. Boelen et al. (2006) discussed three types of continued bonds: (1) thinking about the deceased, (2) keeping reminders of the deceased, and (3) sensing the presence of the deceased. Recognizing that IEs are one type of continuing bond with the deceased helped social workers who had not experienced IEs directly accept them as a normal and non-pathological part of the human experience.

All the social workers, even those who had neither personal experience of IEs nor a conceptual framework in which to place the phenomena, relied on basic social work values to help them work with clients around IEs. These basic values are summarized in the Code of Ethics. The overriding factor influencing how social workers dealt with clients around this issue was a world view that included:

respect for client self-determination,
respect for the dignity and worth of the client, and
client-centered practice.

That is to say, when faced with an unexpected revelation from a client, the social workers relied on good basic social work practice, and listened to what the client had to say.

In closing

When this issue comes up in your own practice, you might think it is a little weird, or even be taken completely off-guard. But then you will remember these social workers, and how they worked with their clients. You’ll remember that 40% of adults reported this experience, that it is a common aspect of mourning, and that it is nothing to worry about. You might check to make sure the client is doing okay otherwise, but then you can work with them just as you work with any other client.

Although some of us may feel ill-prepared to deal with clients around IEs, the interviews with these twenty-one social workers show that we can take heart in our ability to comfort and assist clients by relying on the basic principles of starting where the client is, and respecting the client and the client’s experience. Beyond that, you may find it useful to recall the following:

Social workers in a wide range of settings can expect to have clients who bring IEs into the client–social worker relationship.
Social workers can realize there is nothing inherently abnormal about IEs.

Social workers can base their responses to these clients on the fundamental social work value of respecting the dignity of the client and of the client’s experience.

Basic competence in this area does not require extensive training specific to the topic, but simply following the basic norms of social work. Whereas knowledge of topics particularly related to IEs can be helpful, the lack of deep knowledge around this topic need not lead us to believe we are inadequately prepared to address it. The experiences, views, and techniques used by the social workers in this study to address their clients’ IEs provide guidance for any social worker who encounters this situation in his or her practice.

References

Boelen, P. A., Stroebe, M. S., Schut, H. A. W., & Zijerveld, A. M. (2006). Continuing bonds and grief: A prospective analysis. Death Studies, 30 (8): 767-776.

Davis, J. A., & Smith, T. (1997). General social surveys, 1972–1996: Chicago, IL: National Opinion Research Center [producer], 1996. Ann Arbor, MI: Inter–university Consortium for Political and Social Research [distributor], 1997.

Stroebe, M. S., Stroebe, W., Gergen, M. M., & Gergen, K. J. (1992). Broken hearts or broken bonds. American Psychologist, 47 (10), 1205–1212.

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