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NEAR-DEATH EXPERIENCES AND PSYCHOTHERAPY

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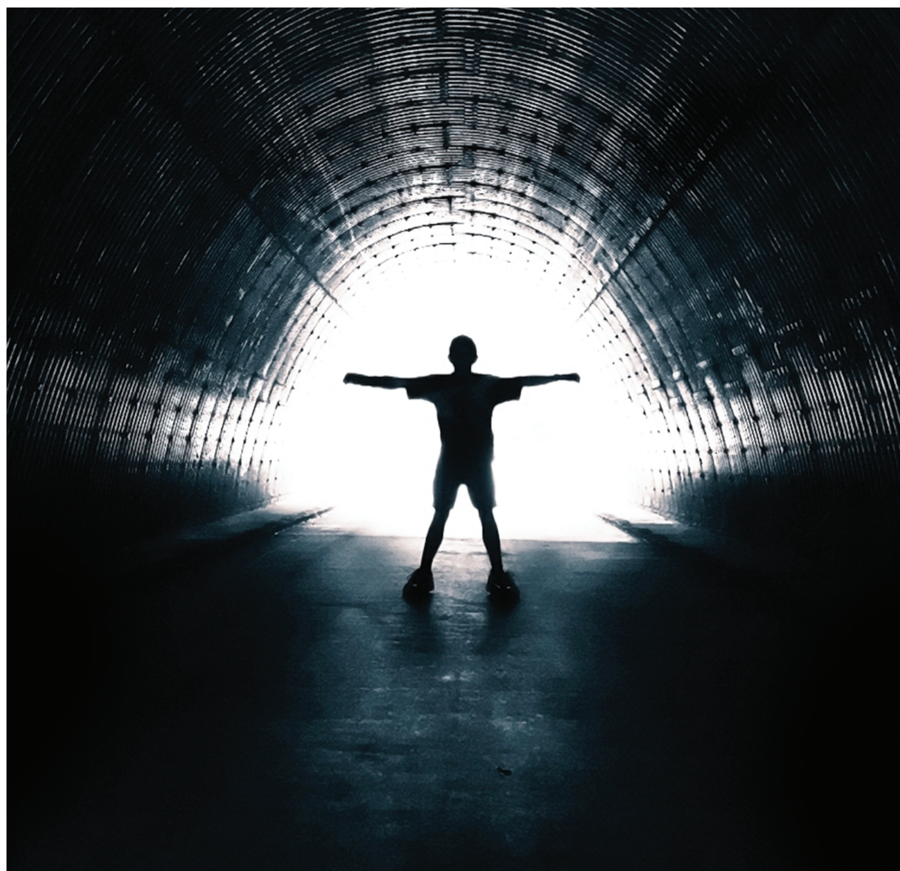
ABSTRACT

Psychiatrists are likely to come into contact with patients who have had near-death experiences, who may have a variety of reactions to the experience, and who may benefit from psychotherapy. We may also have opportunities to work with individuals who are reacting to others who have had such experiences. There is much a psychiatrist can offer to these people, including listening respectfully, being nonjudgemental, normalizing the experience, providing education, and assisting with integrating the experience into their lives to develop or maintain the best possible functioning.

INTRODUCTION

Psychiatrists have played a role in the recognition of the "near-death" phenomenon as well as popularization of the subject and subsequent research.[1] Even before the term *near-death experience* (NDE) was brought to the public eye by a nascent psychiatrist, Raymond Moody, in his book *Life after Life*,[2] another psychiatrist, Russell Noyes, wrote journal articles on the subject.[3] Elisabeth Kubler-Ross expanded our interest into the arena of death and dying and was also very interested in NDEs.[4] More recently, psychiatrist Bruce Greyson has been prominent



EDITOR'S NOTE: All cases presented in the series "Psychotherapy Rounds" are composites constructed to illustrate teaching and learning points and are not meant to represent actual persons in treatment.

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TABLE 1. Elements of near-death experiences

COGNITIVE ELEMENTS
Altered sense of time
Accelerated thought processes
Life review
Sudden understanding
AFFECTIVE ELEMENTS
Feeling of peace
Surrounded with light
Feeling joy
Feeling cosmic unity/oneness
PARANORMAL ELEMENTS
Out of physical body
Senses more vivid than usual
Extra sensory perception (ESP)
Visions of the future
TRANSCENDENTAL ELEMENTS
Another world
Encountered beings
Mystical being
Point of no return
Adapted from Zingrone NL, Alvarado CS. Pleasurable Western adult near-death experiences: features, circumstances, and incidence. In Holden JM, Greyson B, James D, eds. *The Handbook of Near-Death Experiences*. Santa Barbara, CA: Praeger Publishers; 2009:20.

in NDE-related research and was the editor of the *Journal of Near-Death Studies* from 1982 until 2007.[5] One of our most prominent contemporary psychiatrists, Glen Gabbard, has also studied aspects of the phenomenon.[6] Researchers in other disciplines, including nonpsychiatric physicians, psychologists, nurses, social workers, and chaplains, have researched and written on the subject of NDEs and have brought the breadth of their training to this fascinating field as well.

It is not surprising that psychiatrists are interested in the subject of NDEs, given our curiosity about the mind and brain. NDEs are reported to affect nearly one-third of individuals having a close brush with death, representing about five percent of all Americans.[7,8] The number of individuals reporting NDEs is greater than the number of patients with schizophrenia and bipolar disorder combined, making it probable that psychiatrists will encounter those known in the field as "experiencers," or NDEers for short, at some point in their careers.

So what is an NDE? NDEs are not a new phenomenon. Plato, in *The Republic*, recounted a story of a soldier who appeared dead, but returned to life to tell about another world he visited.[9] Although subsequent reports appeared over the years about people's death-bed experiences, it was psychologist Kenneth Ring who began researching them.[10] He developed a peer-reviewed journal, *Anabiosis*, which ultimately became the *Journal of Near-Death Studies* now published under the auspices of the International Association for Near-Death Studies. (IANDS)[11,12]

It has been difficult to develop an operational definition of an NDE, given that NDEers find it difficult to put their experiences into words, placing them in the realm of the ineffable. Ring developed the Weighted Core Experience Index,[10] and subsequently Greyson developed the NDE Scale,[13] both of which have improved consistency in a field fraught with anecdotes and retrospective analyses (Table 1).[14] According to the IANDS website, an NDE is as follows:

"… a profound psychological event that may occur to a person close to death or who is not near death but in a situation of physical or emotional crisis… An NDE typically includes a sense of moving, often at great speed and usually through a dark space, into a fantastic landscape and encountering beings that may be perceived as sacred figures, deceased family members or friends, or unknown entities. A pinpoint of indescribable light may grow to surround the person in brilliant but not painful radiance; unlike physical light, it is not merely visual but is sensed as being an all-loving presence that many people define as the Supreme Being of their religious faith… The emotions of an NDE are intense and most commonly include peace, love, and bliss, although a substantial minority of these experiences is marked by terror, anxiety, or despair. Most people come away from the experience with an unshakable belief that they have learned something of immeasurable importance about the purpose of life."[15]

CASE EXAMPLE 1

Psychiatrist: I always find it helpful when a new patient comes in for an evaluation to find out what it is that made you decide to come in now, and what you are hoping I can help you with.

Patient: I died.

Psychiatrist: Oh!? How about if you tell me something about what happened.

Patient: Well, I had a heart attack. (hesitates)

Psychiatrist: I'm sorry to hear that. What happened after that?

Patient: Well my heart started fimbrilating (sic).

Psychiatrist: (waiting attentively, nodding with concern)

Patient: That was when it happened.

Psychiatrist: (after a pause) Yes, go on…

Patient: Ahh, I don't know if you'd believe it if I told you…

Psychiatrist: I'd be very interested to hear.

PRACTICE POINT

Not all NDEers are immediately forthcoming about their experience, as many have received reactions bordering on catastrophic from healthcare providers, family members, friends, and clergy. Often some sense of trust needs to be developed before they will privilege you with the details of their experiences. Showing that you are someone who can respectfully listen does much to allow disclosure.

It has been reported in virtually every demographic category imaginable that NDEers are not different in any substantial way from nonexperiencers.[16] People of all ages, from the young to the very old, have

reported NDEs, as have both women and men, including heterosexuals and members of the gay, lesbian, bisexual, and transgender community.[17] All varieties of religious affiliation and lack of affiliation from agnostics and atheists to Buddhists, Christians, Hindus, indigenous-religion participants, Jews, and Muslims are among the ranks of NDEers. All races and numerous cultures have been represented. Near-suicide completers who have an NDE during their foray are very similar to those near-suicide completers who do not have an NDE, both demographically and psychologically.[18] Individuals with disabilities, including blindness and quadriplegia, have reported NDEs. As an interesting aside, individuals who are blind from birth have reported visual experiences during their NDEs.[19] Even when one takes into account whether NDEers had prior knowledge of the phenomenon of NDEs or not, there is no difference in incidence.

Having an NDE in and of itself should not be viewed as evidence of psychopathology. It has been shown that individuals who have had such an experience are similar in psychological profile to those who nearly died but did not experience an NDE. Interestingly, of patients studied who had psychiatric diagnoses and an NDE, there was a trend toward the mentally ill NDEers actually having less elaborate NDEs.[16]

Various associations with psychological states have been explored. Gabbard and Twemlow reported that NDEs are distinctly different subjective experiences than depersonalization, with NDEs being marked by their pleasurable quality and their sense of being more real than usual daytime alertness versus the unreal quality of depersonalization.[20] Ring and Greyson both reported that while NDEers did in fact score somewhat higher on a dissociation scale, it was not into the range of psychopathology.[21,22] The proviso is also given that, with retrospective research, it cannot be determined if the increase in dissociation is a result of the NDE or if it preceded it. Even with something as potentially indicative of psychopathology as auditory hallucinations, those reported by NDEers were found to express largely positive content, containing inspirational themes that contributed to their lives rather than causing dysfunction.[23] Nonpathological characteristics include fantasy-proneness and psychological absorption but are of insufficient degree to explain the phenomenon.[24,25]

CASE EXAMPLE 2

Psychiatrist: How have you been doing?

Patient: (with apparent indignation) I am allowed to practice religion however I want to!

Psychiatrist: (waiting)

Patient: (appearing irritable and speaking rapidly with a slight sing-song quality) My family is all freaked out now with my beliefs, but they make sense to me and explain things in a way that fits with what I think.

Psychiatrist: What happened that brought this up?

Patient: Well, they called the police.

Psychiatrist: About your religious beliefs…

Patient: Well they said I was freaking them out.

Psychiatrist: Do you think you were manic at the time?

Patient: Well yeah, maybe, but that doesn't mean I can't have my beliefs.

Psychiatrist: Would it be okay with you if I tell you something about how I decide if behavior is healthy spiritual behavior or if it is mania?

Patient: (chewing gum loudly) Yeah, sure.

Psychiatrist: It has a lot to do with how you are functioning. Becoming preoccupied with religion can sometimes be a marker for someone becoming manic, if it is not your usual behavior. Of course, religion and spiritual beliefs can also be an important part of your recovery from mental illness.

Patient: (nodding, grinning more broadly than usual)

Psychiatrist: So tell me a bit about how you have been doing outside of your religious beliefs, like how you are sleeping, for example.

Patient: Well, I haven't been sleeping much.

Psychiatrist: How is your energy level?

Patient: Well I was so excited in church I couldn't sit still. That is what got my family so mad.

Psychiatrist: I noticed when you came in you had an odd expression, almost silly.

Patient: Yeah? Well, I guess I am a little manic.

Psychiatrist: Do you think perhaps that was what your family was worried about, more than your new beliefs?

Patient: Well I suppose, maybe…

Psychiatrist: Let's talk a bit more about how you are functioning so that we can decide what to do next. I think that if the bipolar symptoms were more under control, your family wouldn't be so worried about your beliefs.

Patient: Maybe.

Psychiatrist: Yes, maybe.

PRACTICE POINT

Often NDEers come to psychiatric attention due to concomitant mental illness. Their newly expanded beliefs may be difficult to sort out from the hyper-religiosity associated with mania. Often, returning to basics and

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TABLE 2. Potential after-effects of NDEs

PERCEPTION OF SELF
• Loss of fear of death • Strengthened belief in life after death • Feeling specially favored by God • New sense of purpose or mission • Heightened self esteem
RELATIONSHIP TO OTHERS
• Increased compassion and love for others • Lessened concern for material gain, recognition, or status • Greater desire to serve others • Increased ability to express feelings
ATTITUDE TOWARD LIFE
• Greater appreciation of and zest for life • Increased focus on the present • Deeper religious faith or heightened spirituality • Search for knowledge • Greater appreciation for nature
PARANORMAL PHENOMENON
• Out-of-body experiences • Apparitions • Extrasensory perception • Precognition • Healing • Spiritual, mystical, or transcendent experiences
ALTERATIONS IN PERCEPTION/ CONSCIOUSNESS
• Heightened sensation • Physiological alterations • Unusual movements, sensations • Unusual stimulation of special senses • Mental changes • Increased energy, decreased need for sleep
Adapted from Noyes R, Fenwick P, Holden JM et al. After-effects of pleasurable Western adult near-death experiences. In: Holden JM, Greyson B, James D (eds). *The Handbook of Near-Death Experiences*. Santa Barbara, CA: Praeger Publishers; 2009: 46-47.

helping the patient recognize manic symptoms (and associated dysfunction) will improve the patient's insight and capacity to monitor for such symptoms in the future. The patient can learn to detect whether his or her religious fervor or elation seems to be a genuine transcendent experience or whether he or she is exhibiting markers of pathology, suggesting an underlying mental illness has gone out of control.

In fact, to a psychiatrist's eye, many of the reported after-effects of NDEs can resemble mania (Table 2).[26] On the other hand, other features reflect a new groundedness suggestive of Erikson's phases of generativity and integrity.[27] In general, studies of NDEs find them to be a compelling force for change, most commonly in a direction suggesting maturation and improved wellbeing. Noyes conducted the first systematic study of after-effects in 1980.[28] Nearly two-thirds of NDEers reported a new attitude toward life or death, including a sense of invulnerability or specialness and a decreased fear of death. This would be in the absence of other markers of mania, such as rapid speech or flight of ideation, however. NDEers report having increased love for and acceptance of others and are, in general, more accepting and tolerant. Such positive after-effects have been corroborated by family members and friends.

Occasionally, individuals who are not near death can have an experience with features similar to those of NDEs. This can be brought about by being in a fear-inducing situation or even by imagining such a situation. A psychiatrist colleague once told me about an experience he had during Gestalt-based group supervision. The subject of fear of death was being discussed, and the supervisor suggested the budding psychiatrist, then a medical student, do an imagery exercise in which he believed himself to be dead, to see what emotions arose. After lying down in the center of the group and settling into the experience, he felt himself leave his body and travel through a tunnel, and then he saw a brilliant light. He returned from the exercise having lost his fear of death. This would be termed a *near-death-like experience* and can be similarly life-enhancing.[29]

CASE EXAMPLE 3

Psychiatrist: (after an interview in a hospital room) It sounds like you had a near-death experience.

Patient: (looking away and appearing distressed) I've heard of those, light and angels and the face of God and all…mine wasn't anything like that…it was horrible…what is wrong with me? I mean, yeah, I sensed a tunnel, but I felt like it would swallow me up for all time…I've never been so scared in my life!

Psychiatrist: It sounds very distressing.

Patient: (quietly crying)

Psychiatrist: (waiting, offering a tissue after the patient looks up) You wondered what is wrong with you that the experience was frightening.

Patient: (nods, sniffling)

Psychiatrist: Did you know that not all near-death experiences are happiness and light?

Patient: (shakes head)

Psychiatrist: Researchers have found that about 15 percent of people who have them find the experience very distressing.

Patient: (making direct eye contact for the first time)

Psychiatrist: And there is no evidence that the distressing ones happen to bad people or come as a punishment.

Patient: Are you sure about that?

Psychiatrist: From the research that has been done so far, distressing near-death experiences can happen to anyone near death, regardless what their life was like before that.

Patient: I'm just sure it must mean I'm a bad person.

Psychiatrist: I have to respectfully disagree.

Patient: Hmm.

Psychiatrist: All of us, when we're in a difficult situation, can talk to ourselves in such a way that makes us feel even worse…but we can learn to not do that to ourselves.

Patient: (quizzically)

Psychiatrist: You are already feeling upset about the experience, not to mention how unsettling it must feel to have been resuscitated. It may be a little unfair for you to

make the assumption these things happened because you are evil or bad or defective in some way.

Patient: That's how it feels.

Psychiatrist: Sometimes we can learn to coach ourselves. To say something like, 'I don't like what just happened to me, but it did. It doesn't mean I'm a bad person. Maybe I can learn something from it.'

Patient: You don't think I'm crazy?

Psychiatrist: It seems to me that you are a normal person who just experienced something very intense and unusual.

Patient: (sighing)

Psychiatrist: You seem exhausted. How about if I leave and let you rest and come back tomorrow to talk again after you've had more time to rest and recover and think about this?

Patient: So you really don't think it happened because I did something wrong?

Psychiatrist: No, I don't…and I've seen many people who have worked through some very distressing experiences and discovered there was actually something good within the experience from which they could learn.

Patient: Well, OK then, sure. Come back tomorrow.

PRACTICE POINT

Not all NDEs are positive experiences for the NDEers, and some are frankly frightening or even hellish. In our "feel good" society, it has been difficult to get people to even acknowledge this, much less research the topic, but some excellent work has been done.[30] Carol Zaleski, a professor of religion, researched historical near-death accounts and found that, in contrast to the emphasis on moving only toward the light or toward heaven in most modern accounts, historically there were both ascents and descents. She reported on four different types of scenarios, including stories of the miraculous; stories of death, revival, and conversion; journeys of apocalypse and revelation; and accounts of pilgrimage.[31] Subsequently, Greyson and Bush presented a collection of distressing NDEs that seem to fall into three types. The largest group experienced classic NDE features, but found them terrifying, as in the case just described. The second type involved a sense of ceasing to exist or being in a void. The third type, a very small number, reported horrific images, such as demons or a dark pit, suggestive of hell.[32]

Bush later wrote about three ways in which individuals commonly deal with the distressing NDE. The most common mechanism has been termed *conversion response* in which the individual takes the distressing experience as a warning and attempts to redirect his or her life. The second mechanism is the *reductionism response* in which the individual attributes it to a rational explanation, such as hypoxia or a seizure. The third, the *long-haul response,* occurs predominantly after the void type of experience, and leaves the NDEer struggling with existential questions for years afterward wondering, as did the patient just described, "What did I do to deserve this?" This latter group is the most likely to seek therapy.[33] Often there is no formal Axis I diagnosis, and treatment can be carried out under the V-code of Religious or Spiritual Problem, a code that was originally proposed to include the NDE phenomena specifically.[34–36]

Just as individual NDEers attempt to make sense of their NDEs, so have many researchers. Explanatory models abound and can be divided into several broad categories, including the psychological, the physiological, and the transcendental. Psychological theories include expectancy, in which NDEs are simply a product of the imagination; depersonalization, in which feelings of unreality protects one from the threat of death; and personality features, such as having an increased tendency for dissociation, a high capacity for absorption into the moment, and a proneness to fantasy. Physiological theories include altered arterial blood gases with hypoxia; neurochemical theories related to endorphins or endogenous ketamine-like neurotransmitters; intrusion of rapid eye-movement (REM) sleep; or neuroanatomical changes, including temporal lobe dysfunction or seizures. These have been predominantly speculative, with only minimal research support. Parnia and Fenwick have eloquently objected to these reductionistic theories and noted that acute alterations in cerebral physiology, such as those that occur in some of the physiological scenarios noted previously, lead to "disorganized and compromised cerebral function;" whereas, the NDEs noted after cardiac arrest are "clearly not confusional and in fact indicate heightened awareness, attention, and consciousness at a time when consciousness and memory formation would not be expected to occur."[37,38]

Not all NDEs are felt to be positive by the experiencer, and some are frankly frightening or even hellish.

So if psychological, neuroanatomical, and neurophysiological models are reductionistic, what then is the answer? Some NDE researchers would challenge us to conceptualize a transcendental model, a theory big enough to explain apparent consciousness during a period of brain inactivity, including the counterintuitive concept that consciousness could exist somewhere outside the brain. Greyson, Kelly, and Kelly[37] suggest that perhaps "brain activity normally serves as a kind of filter, selecting material that is allowed to emerge into waking consciousness…the 'relaxation' of the filter under certain poorly understood circumstances may lead to drastic alterations of the normal mind-brain relationship and

TABLE 3. General guidelines for psychiatrists working with NDEers

Avoid the assumption that a client's NDEs are symptomatic of pathology, but recognize that individuals with mental illness may also experience NDEs.
Respect the profound nature of these experiences as well as the individuality of each experiencer.
Provide a safe, nonjudgmental environment in which patients can freely discuss their experiences and the emotions surrounding their NDEs.
Avoid projecting your own value system.
Remember most of these individuals have recently nearly died and encourage them to also express the emotions related to the precipitating events.
Normalize the experience for patients without taking away the uniqueness of the NDE.
Assist patients with integrating the NDE into their daily lives to maintain best possible functioning.
Refer patients to local NDE-focused groups, such as IANDS groups.[12]

NDE: near-death experience; NDEers: near-death experiencers
IANDS: International Association for Near-Death Studies, Inc.
Adapted from Foster RD, James D, Holden JM. Practical applications of research on near-death experiences. In: Holden JM, Greyson B, James D (eds). *The Handbook of Near-Death Experiences*. Santa Barbara, CA: Praeger Publishers; 2009: 235–258.

an associated enhancement of consciousness." Think of it as "a kind of filter, selecting material that is allowed to emerge into waking consciousness…" This is reminiscent of what Freud postulated about Thanatos,[39] the drive toward death, with layers of defenses protecting us from full awareness of what Freud would have considered to be our inevitable end.

CASE EXAMPLE 4

Psychiatrist: I understand you have some concerns about your wife.

Patient: Yes, she is acting so differently. I don't like it.

Psychiatrist: What are your concerns?

Patient: She and I used to do so many things together. Now she is always out doing things with her friends.

Psychiatrist: Sounds like that has been a loss for you.

Patient: Not only that…she just isn't the same person.

Psychiatrist: How so?

Patient: She never wants to take care of stuff around the house any more, or fix dinner, or pay the bills. It's like she can't be bothered. Ever since she had that frickin "near-death experience"… (spoken with great sarcasm)

Psychiatrist: (waiting)

Patient: And she's so perfect (sarcasm continues)…so much "love" for the world. Well, what about me?

Psychiatrist: Since her near-death experience, you two have not been as close.

Patient: She can't be bothered with little old me. I'm much too common. She has to fight hunger and poverty! Well, what about my hunger? What about our home? What about our bank accounts?

Psychiatrist: It makes you pretty angry…

Patient: You are damn right I'm angry!

Psychiatrist: In her newfound desire to show compassion and love to the world you seem to feel you have been left behind.

Patient: Me and everyone else she used to love…or so she said.

Psychiatrist: When someone has a near-death experience it can be a real strain on marriages. Most serious life-changing events can be.

Patient: That's the understatement of the year…

Psychiatrist: How can I be of help to you as you adjust to this change?

Patient: She's the one who needs to change…to change back.

Psychiatrist: It's not surprising you find yourself wishing to get your old wife back.

Patient: Hmf

Psychiatrist: It's also pretty common and normal to wish for the other person to do the changing.

Patient: Well this is all her doing.

Psychiatrist: Now that this has happened to your wife, nearly dying and the associated changes, you are going to have to decide how you want to handle the situation as it is now.

Patient: She's not going to get over it, like a phase?

Psychiatrist: Many near-death experiences are life changing, and NDEers evolve over time in their response. Changes like you are describing may not change back to the way they were.

Patient: (shaking his head in apparent dismay) What am I going to do?

Psychiatrist: Well, if you like, we can establish a goal for your therapy to help you figure out the answer to that question.

Patient: I don't know if I can even stay married to her when she's like this.

Psychiatrist: Some couples do divorce when one of them has a near-death experience. It is a lot to adjust to.

Patient: You're saying you think I should get divorced?

Psychiatrist: No, I'm not saying that you should or shouldn't, just that some people do in this situation…you have a lot of thinking to do first about what you do and don't want from your marriage. You and your wife could even consider couples therapy to try to decide together what would be best for the two of you as individuals and whether divorce needs to be on the table or not.

Patient: Man, I love her so

much…I don't want a divorce…but maybe she does…

Psychiatrist: How about working on how you are reacting to her changes. You need some time to adjust to all of this and decide how you want to respond. Hopefully we can get you to a calmer place inside yourself from which to decide, not so much from the hurt and anger.

Patient: Nothing calm about me now.

Psychiatrist: Accepting how you are feeling right now is a legitimate place from which to begin.

PRACTICE POINT

Another way psychiatrists may work with NDEs is by caring for individuals who are loved ones of the NDEer and who may feel anything from angry to baffled to derisive to hurt. Just as the psychiatrist needs to express respect for the NDEer and to assist him or her with maintaining adequate function in the face of his or her life-altering experience, so too will some family members need to be supported to do the same, both for themselves and their loved ones.[40]

So, how can we as psychiatrists develop a truly helpful therapeutic stance about an experience that may be foreign to us and about which we may have our own sense of skepticism or uncertainty? I would posit that an analogy could be drawn to our work with patients experiencing "functional" conditions. We know that a certain percentage of functional individuals will eventually be diagnosed with a traditional medical condition that failed to manifest sufficiently for diagnosis when symptoms initially began, making it wise to maintain some sense of humility about what condition the patient actually has. We help the functional patient to develop a stance toward his or her symptoms that is helpful and allows for the best possible adaptation until such time as medical science "catches up" with more thorough explanations. A recent article on the functional patient reminds us to "attend more to the person of our patient."[41] So, too, should we get to know the person who has had the NDE, discovering answers to such questions as how the patient frames the experience, how it has affected the patient and his or her loved ones, and how the patient can continue to "live on the planet" as an individual changed by something thus far inexplicable within our traditional medical model. We can be helpful even if the root cause remains a mystery to us (Table 3).

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