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CHAPTER 7

Near-Death Narratives

Bruce Greyson

Many people, when they come close to death, go through a profound experience in which they feel they leave their bodies and enter some other realm or dimension, transcending the boundaries of the ego and the ordinary confines of time and space. Such experiences are partially or totally disconnected from the mainstream of the individual's conscious awareness. Raymond Moody, the psychiatrist who named this phenomenon the "near-death experience," (NDE) (Moody, 1975), described it as an ineffable experience that may include: feelings of peace, unusual noises, sensations of being out of the physical body, movement through a dark tunnel, meeting other spiritual beings, a life review, a border or point of no return, a return to the physical body, and profound changes in attitudes and values. Once thought to be rare, the NDE is now acknowledged to be reported by at least a third of people who come close to death (Ring, 1980; Sabom, 1982). A Gallup Poll (Gallup & Proctor, 1982) estimated that about 5 percent of the American population, or about 13.6 million Americans in 1996, have had NDEs.

Although the term "near-death experience," was not coined until 1975, the phenomenon had been described as a clinical syndrome in 1892, when Swiss geology professor Albert von St. Gallen Heim published a collection of the subjective observations of mountain climbers who had fallen in the Alps (as he himself had done), soldiers wounded in war, masons and roofers who had fallen from scaffolds, and individuals who had nearly died in construction or railway accidents and near-drownings.

The following two accounts of NDEs were provided to me by two experiencers who had heard of my research interest in these events. While the first is predominantly blissful and the second terrifying, both illustrate the breadth of phenomena encountered in the NDE and the characteristic shifting of attention from the physical environment to an alternate reality and back again.

The first account was related to me by a fellow physician who had heard me speak about my research, about five years after his pulmonary arrest from a viral pneumonia:

> The near-death experience that I experienced was . . . during my first year of medical school. I had been feeling quite ill for several days, with what appeared to be a viral illness, had been planning to attend a party with several friends with whom I had attended college who were also in medical school, but realized that I did not feel "up to par." Regardless, I did attend the party after I had assured myself that I was no longer running a "temp" nor feeling as congested as previously, although I am sure this was due to antipyretic medications and decongestants that I had been taking.
>
> I attended the party; everything seemed to go well at that time. However, upon returning home, I began to experience severe difficulty with my breathing. The congestion was present, but more obvious than that was the extreme difficulty that I was experiencing in exchanging oxygen. I realized that I was not oxygenating myself effectively, commented to [my wife] regarding such, subsequently began to have more extreme difficulty, and told her that I felt that "something needed to be done."
>
> About that time, I began to experience severe difficulty; (my wife) became very frightened, contacted a friend, and took me to the emergency room immediately. I vaguely re-

member entering the emergency room, do not remember actually entering the room in the emergency room. Shortly thereafter, while I was apparently unconscious, I heard the physician say, "He's gone." I had experienced a pulmonary arrest, my temperature was greater than 105° F . . . .

[C]ardiopulmonary resuscitation was begun with an unconscious awareness on my part of such; subsequently I observed the entire process myself, was "met" by my maternal grandfather during this process, and had a direct association with several other close relatives.

I did indeed observe my body as the physicians were working with me. At this point, I "left" the room, traveled through the tunnel at a rapid speed, although time was totally irrelevant, and had multiple subsequent experiences. There was a travel through a misty area, hearing voices and sounds, not seeing anyone at this time, but being acutely aware of both positive and negative forces.

It seems as though there was a period of time in which I was in "a room" with a solitary lightbulb with no shade, several doors, heard sounds that I do not currently remember, went through a door, and progressed through the mist. There was a distinct awareness of illumination in the distance, becoming brighter progressively, subsequently experiencing a direct contact with what I currently term "the Being of Light," with extreme verbal and emotional interaction. I experienced a panoramic review of my entire life, had glimpses into the "future" regarding not only myself but of other possible events, saw in the distance beautiful palaces and areas which I presumed represented "knowledge."

Throughout this experience, there was no fear whatsoever, I felt totally warm and comforted, enveloped by compassion and love. There was a specific verbalization that I indeed heard . . . it was apparent that "it was not my time" and the next thing that I remember was awakening in the Intensive Care Unit where I had apparently been for two days. I do remember experiencing some degree of fear during the subsequent two days, primarily related to intense physical discomfort, multiple monitors, continuing with an endotracheal tube, intravenous fluids running continuously at two locations, and quite frankly there appeared to be some sort

> of tube within every orifice of my body excepting my ears. I responded rapidly over the next several days, and after much discussion with my attending physician, was discharged directly from the ICU to my own home for recuperation.
>
> The first direct communication that I had with (my wife) regarding such was in the car on the way home. She was in no way shocked by my discussion regarding such, apparently had a realization as she related that some such experience had occurred with me. In recollecting the experience, the primary theme that recurs is that love is the most important aspect of life, is obviously necessary, has something to do with why I did not die at that time although technically I was "pronounced dead for a period of time," and seems to be the essence of existence and being. It was obvious to me that I had "unfinished business" here, certainly with my family but extending beyond my family.

The second account was provided to me by the editor of a medical journal, who had read of my work, about 10 years after his cardiac arrest:

> A minute or two passed and suddenly I began to lose my vision—first on my left side and then the nurse's face over me began fluttering. I couldn't tell if it was my eyelids or my vision causing it, but she was like a T.V. screen going awry. I can still remember clearly the last glimpse of the nurse's face as she announced in a strong voice, "We have a code here." And I saw the heel of her hand come down on my chest and begin to pump. I lost all vision as the movement of others approaching me blurred and disappeared. I thought to myself, "Well, there's no doubt now. I've seen it on T.V., I was recently trained in CPR, and here I am receiving it. This is a heart arrest." For the first time I realized that I was indeed in a life-threatening situation. My prayer was simple: "Dear God, let them do a good job."
>
> Although I couldn't see or feel very much, I could still hear some bits of conversation and some movements around me. There was a discussion of bicarbonate of soda somewhere in the background. However, I clearly heard a doctor order 100 mg of lidocaine.

I slipped into another level of consciousness at about this time. It was as if I were sitting in the pilot seat of a glass-enclosed space ship. But the glass of the space ship was my own skin. It was like I was sitting inside my own body, but I had absolutely no control over the speed or direction it was taking. I could see various shapes and events of my life suspended out in space as I hurtled headlong toward them.

I wanted to slow down so I could see the shapes and understand the events and I wanted to avoid crashing into them, but I was completely out of control. I felt absolutely helpless as I plunged through the shapes at incredible speed. I remember the shape of the long-ago destroyed house where I was born and reared came into view, but as I crashed into it and other shapes and events, they dissolved without tearing through the surface and without hurting as much as I expected. But the cumulative effect was beginning to hurt very much. I'm not sure whether the pain was physical or the effect of the desperate internal struggle to get control of myself with no success at all.

This experience did not seem like a dream—it seemed to be an extension of reality, but somehow my consciousness remained aware that what was happening was taking place in the life-or-death atmosphere of the emergency room. And occasionally, some words of the doctors or nurses got through. I heard the second order for 100 mg of lidocaine. And I remember thinking, "I hope it works; I have to get out of this stupid situation." This wild ride seemed very real, but it was unscheduled and unwanted. It was simply wrong to be so out of control and I was trying to fight it. I heard an order from a doctor, "Charge it again—and keep it charged." Then I realized that a defibrillator was being used on me.

Instead of reviving, I was plunged deeper into pain and darkness in this incredible journey. Now my mind was spinning, tumbling, and twisting so there was no up or down, forward or backward, right or left. Then it seemed I suddenly crashed into a solid, black wall with tremendous force. I felt total, excruciating pain. There was nothing left in my consciousness but total blackness and intolerable pain. I felt I was disintegrating—like being at the center of

a powerful explosion that wouldn't stop. The pain was so complete and so intense that I had nothing to fight back with. I just had to accept it. "This has to be what death is," I thought. "I guess I'm not going to make it."

Again, I heard an order for another 100 mg of lidocaine. Someone else said, "He's already had 200 mg." But the first person repeated, "Prepare 100 mg and inject 50. Hold for a reaction."

I gradually became aware of some light at the edges of the darkness and I could begin to feel parts of my body distinct from the total consciousness of pain I had been experiencing. I knew my legs were still intact and my right side was without pain. I knew I had made it because the pain, while just as intense, was now localized—in my left side, my chest, my throat, and my mouth. At least, I had not disintegrated.

Then, I heard some welcome words, "He's back with us." I opened my eyes and saw the doctor who said it looking down at me. I wanted to talk but couldn't. The oxygen mask was over my face, an airway was plunged into my throat, and my tongue was pinned to the floor of my mouth. It was very uncomfortable, but the rest of the pain had subsided to a marked degree. I recalled the first injection, the I.V.s, the EKG monitor, the nurse calling the code, her quick resuscitative response, the physician's orders.

DISSOCIATION UNDER STRESS

Dissociation is the process by which certain experiences or behaviors are disconnected or established separately from the mainstream of one's conscious awareness. For example, most dissociated behavior is experienced as not under conscious control, while dissociated memories are not available to consciousness, although both may still influence conscious thought and behavior. An example of nonpathological dissociation is the common experience of driving a car with no reflective awareness while carrying on a conversation (Spiegel & Cardeña, 1991).

Janet (1889) and Prince (1900–1901) both proposed that an individual might dissociate in response to trauma. However, dissociation is not necessarily a pathological state, as Janet thought, but can be a

normal phylogenetically developed response to intolerable physical or emotional trauma (Ludwig, 1983). It is common in people who have undergone the stress of trauma, but otherwise exhibit no abnormal characteristics (Putnam, 1989).

The current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders—Fourth Editon* (DSM-IV) (1994) cautions that "Dissociation should not be considered inherently pathological and often does not lead to significant distress, impairment, or help-seeking behavior" (p. 477). The DSM-IV recognizes that dissociative symptoms occur in contexts other than dissociative *disorders*, but offers no diagnostic category for a dissociative state that lasts only for the duration of a life-threatening crisis.

The dissociative phenomena of depersonalization, a sense of detachment from the physical or psychological self, and derealization, a sense of detachment from the environment, are common under stress (Horowitz, 1976). Prisoners report feeling detached from their physical surroundings and reliving their preconfinement lives (Frankenthal, 1969); rape victims commonly report dissociative symptoms, including a sense of leaving the physical body (Rose, 1986); correctional officers being beaten by rioting prisoners report anesthesia, time distortion, and being at a distance from their bodies (Hillman, 1981); and hostages report numbness, dissociation, and out-of-body experiences (Siegel, 1984). Summarizing a wide variety of studies in varying contexts, Spiegel and Cardeña (1991) concluded that between 25 and 50 percent of survivors of traumatic events experience a sense of detachment from their physical or psychological self or from their physical surroundings.

This dissociated perception of traumatic experiences may lead to amnesia or distorted recall of the experience. Some of this memory impairment results from the cognitive disorganization fostered by intense anxiety. However, in addition, a narrowing of attentional focus on the trauma itself, while ignoring peripheral and contextual aspects, may impair memory by disembedding the perception from its context, making the traumatic event much more unusual, salient, and therefore difficult to integrate within the person's repertoire of experiences (Spiegel & Cardeña, 1991). This narrowing of focus is a primary feature of absorption (Tellegan & Atkinson, 1974), which complements and facilitates dissociation by taking out of conscious awareness peripheral events and focusing so narrowly on the experi-

ence that reflection becomes difficult. The disconnection of reflection, including self-awareness, from ongoing experience results in dissociative identity and memory disturbances.

NEAR-DEATH EXPERIENCES AS DISSOCIATIVE STATES

Although clinical descriptions of NDEs abound in the literature of most ancient cultures, their psychological analysis was rare until Oskar Pfister's 1930 article was translated into English a half century later (Kletti & Noyes, 1981). Pfister's interpretation of the NDE as a defense against the threat of death has been elaborated by Noyes and Kletti (1976, 1977), who conceived of the NDE as a type of depersonalization. Pfister proposed that persons faced with potentially inescapable danger attempt to exclude this unpleasant reality from perception and replace it with pleasurable fantasies, which protect the individual from being paralyzed by emotional shock. To the extent that a state of depersonalization mimics a state of death, this mechanism may also serve as a sacrifice of a part of the self in order to avoid actual death.

However, as Noyes and his colleagues have indicated, this model can accommodate only some of the phenomena common to NDEs. Noyes and Kletti (1977) found that survivors of life-threatening danger reported depersonalization, derealization, time distortion, lack of emotion, and a sense of detachment from their bodies. However, in a factor analysis of responses to life-threatening danger, Noyes and Slymen (1978–1979) identified in addition to depersonalization a "hyperalertness" factor, diametrically opposed to depersonalization, and a "mystical consciousness" factor not addressed by the depersonalization model.

The DSM-IV characterizes depersonalization disorder as a type of dissociative disorder that includes a feeling of detachment or estrangement from one's self, as if living in a dream; a sensation of being an outside observer of one's mental processes or of one's body, sensory anesthesia, lack of affective response, and a sensation of lacking control of one's actions. It notes, however, that "Depersonalization is a common experience, and this diagnosis should be made only if the symptoms are sufficiently severe to cause marked distress or impairment in functioning" (American Psychiatric Association, 1994, p. 488). Depersonalization *disorder* is characterized by its persistent, recurrent, or chronic nature and consequent dysfunction. These factors differentiate it from the transient depersonalization that is

reported by about half of the normal population, occurs spontaneously under conditions of fatigue, and brings about only very transitory distress (Spiegel & Cardeña, 1991).

Gabbard and Twemlow (1984) differentiated between depersonalization and NDEs on a number of parameters. They pointed out that depersonalization involves the observing self watching the functioning self; usually does not include a sense of being out of the body; is experienced as dreamlike; is typically unpleasant; is characterized affectively by anxiety, panic, and emptiness; is experienced as pathological and strange; typically occurs in persons between 15 and 30 years of age, and rarely over 40; and occurs twice as often to women as to men. Near-death experiences, by contrast, involve the observing and functioning self being experienced as one while the physical body is inactive; often include a sense of being out of the body; are not experienced as dreamlike; are typically pleasant; are characterized affectively by joy, ecstasy, and feelings of calm, peace, and quiet; are experienced as religious, spiritual, and noetic; have no characteristic age group; and have an even gender distribution.

Irwin (1993) also argued against viewing the NDE as a type of depersonalization. He wrote that the NDEr's sense of identity is not altered, but is in fact unusually lucid; what is altered is the association with bodily sensation. Thus, he argued that the NDE is not an example of depersonalization but rather of dissociation of one's self-identity from bodily sensation and emotions. Irwin emphasized that dissociation is not in itself pathological, but develops spontaneously in childhood as a normal process related to fantasy and imagination and decreases in frequency with age. Traumatic experiences, Irwin wrote, teach children to use this normal dissociative ability defensively.

He studied dissociative coping style among near-death experiencers and a control sample, both self-selected from a population of college students. He found no significant difference between the two groups on dissociative style, but a significantly higher rate of childhood trauma among the NDErs. Thus, despite reporting a greater number of episodic and unpredictable traumatic events in childhood, NDErs did not develop a proneness to dissociation. Irwin speculated that NDErs may have developed a tendency to dissociate in response to highly stressful unforeseen events, but *not* a general dissociative defense style used to cope with everyday stressors.

Serdahely (1993) discussed NDEs as a type of dissociation, focusing on a separation of the person or personality from the physical body. Serdahely saw the NDE as a dissociation from the physical

and/or psychological pain mediated by the nervous system. He described a continuum of stages of dissociation, ranging from feeling fragmented and not totally present in the moment, through a split in consciousness with or without coconsciousness with other (alter) personalities, as in dissociative identity disorder (DID, previously known as multiple personality disorder), to a frank out-of-body experience as seen in NDEs.

Ring (1992) suggested that dissociation might account for what he called NDErs' sensitivity to alternate realities. As reasons for suspecting dissociation to be part of NDErs' psychological profile, he cited anecdotal evidence that NDErs are more likely than others to have suffered childhood abuse and trauma. Ring studied dissociative tendencies of NDErs and a control sample of people who were interested in NDEs but had never had one themselves; he found the NDErs' mean score to be significantly higher than that of the control group and of a reference sample of unselected undergraduates.

Ring argued that NDErs have dissociative *tendencies* but not dissociative *disorders*. He proposed a developmental theory of sensitivity to extraordinary experiences such as NDEs: Childhood abuse or trauma stimulates the development of a dissociative response style as a means of psychological defense. As dissociating allows the child to "tune out" threatening aspects of the physical and social environment by splitting off from the sources of those threats, it also allows the child to "tune into" alternate realities where, by virtue of the dissociated state, he or she can feel safe regardless of what is happening to the body. By "alternate realities," Ring meant dimensions or realms of existence distinct from, but as objectively real as, the world of ordinary waking consciousness.

Evans (1989) has also argued that it is the ability to dissociate that governs access to alternate realities. But Ring argued that attunement to alternate realities is not a result of dissociation itself, which only *allows* it, but of psychological absorption, the ability to concentrate and focus one's attention on inner reality to the exclusion of events in the external environment. One must transcend the sensory world (dissociation) *and* attend to internal states (absorption) to register and recall alternate realities.

Ring summarized the development of what he called the "encounter-prone personality." This individual has a traumatic childhood history and has developed dissociative tendencies to cope with

adverse circumstances. The encounter-prone personality becomes something of an expert at becoming deeply absorbed in alternate realities. This expertise then comes into play when the person is exposed to the shock of a near-death incident; the repertoire of dissociative skills allows the person to enter a state of consciousness that renders a view of nonordinary realities. According to Ring (1992):

> NDErs are actually unwitting beneficiaries of a kind of compensatory gift in return for the wounds they have incurred in growing up. That is, through the exigencies of their difficult and in some cases even tormented childhoods, they also come to develop an extended range of human perception beyond normally recognized limits. (p. 146)

Ring noted that childhood abuse and trauma made up only one route that leads to the propensity to undergo extraordinary encounters such as NDEs. He assumed that some people are born more psychologically sensitive, while others may be nurtured through positive means to cultivate sensitivity or nonordinary realities, such as by having imaginative involvement encouraged in childhood.

Other researchers' preliminary data support Ring's notion of an "encounter-prone" personality, in which childhood trauma leads to tendencies toward dissociation and absorption, and in turn to vulnerability to NDEs under life-threatening conditions. Irwin (1985) has documented that out-of-body experiences are in fact related to absorption abilities; while Council and Greyson (1985) and Council et al. (1986) found greater tendencies toward absorption among NDErs than among control groups, as well as a positive correlation between absorption tendency and "depth" of NDE among those who reported an experience.

Examples of dissociation and absorption are evident in the NDE accounts presented at the beginning of this chapter. Progressive disconnections of perceptual experiences were described by the first NDEr at the start of his experience:

> [C]ardiopulmonary resuscitation was begun with an unconscious awareness on my part of such; subsequently I observed the entire process myself. . . .
>
> I did indeed observe my body as the physicians were working on me. At this point, I "left" the room. . . .

and a reconnection at its termination:

> There was a specific verbalization that I indeed heard, . . . it was apparent that "it was not my time" and the next thing I remember was awakening in the Intensive Care Unit. . . .

The second NDEr described this sensory disconnection more graphically:

> Suddenly I began to lose my vision—first on my left side and then the nurse's face over me began fluttering. I couldn't tell if it was my eyelids or my vision causing it, but she was like a T.V. screen going awry. . . . I lost all vision as the movement of others approaching me blurred and disappeared.

This experiencer remained only partially disconnected from his mainstream sensory experience:

> This experience did not seem like a dream—it seemed to be an extension of reality, but somehow my consciousness remained aware that what was happening was taking place in the life-or-death atmosphere of the emergency room.

Cognitive functioning also became disconnected from these experiencers' traditional awareness. The first NDEr described a life review that was separate from the rest of his cognitive consciousness:

> I experienced a panoramic review of my entire life, and glimpses into the "future" regarding not only myself but of other possible events, saw in the distance beautiful palaces and areas, which I presumed represented knowledge.

while the second experiencer described "slipping" away from his normal cognitive states:

> I slipped into another level of consciousness at about this time. It was as if I were sitting in the pilot seat of a glass-enclosed space ship. But the glass of the space ship was my own skin. It was like I was sitting inside my own body, but

> I had absolutely no control over the speed or direction it was taking.

Emotional states, as well, became disconnected from the mainstream of these individuals' awareness. The first NDEr, who entered his experience frightened by his inability to breath, noted a paradoxical calmness:

> Throughout this experience, there was no fear whatsoever, I felt totally warm and comforted, enveloped by compassion and love.

While the second NDEr felt pain and despair during his experience, he described it as disconnected from the physical pain his body felt:

> I felt total, excruciating pain. There was nothing left in my consciousness but total blackness and intolerable pain. . . . The pain was so complete and so intense that I had nothing to fight back with. I just had to accept it. "This has to be what death is," I thought. . . .
>
> I gradually . . . could begin to feel parts of my body distinct from the total consciousness of pain I had been experiencing. . . . I knew I had made it because the pain, while just as intense, was localized—in my left side, my chest, my throat, and my mouth.

Even their sense of identity became disconnected from their usual self-concept during their NDEs. The first experiencer, as noted above, watched his body being resuscitated and then left the room, while the second felt his self "disintegrating."

THERAPEUTIC IMPLICATIONS

The NDE is usually regarded as a positive experience, and when it does lead to distress, most NDErs gradually adjust on their own, without any help. However, that adjustment often requires them to adopt new values, attitudes, and interests. Family and friends may then find it difficult to understand the NDEr's new beliefs and behavior.

Emotional problems following NDEs include anger and depression at having been "returned," perhaps against their wills. NDErs may have problems fitting the experience into their traditional religious beliefs, or into their traditional values and lifestyles. Because the experience seems so central to their "core" and seems to set them apart from other people around them, NDErs may identify too strongly with the experience and think of themselves exclusively as NDErs.

On an interpersonal level, NDErs may feel a sense of distance or separation from people who have not had similar experiences. NDErs may find it impossible to communicate to others the meaning and impact of the NDE on their lives. Frequently, having experienced a sense of unconditional love in the NDE, the NDEr cannot accept the conditions and limitations of human relationships.

The way a psychotherapist responds to an NDEr can have a tremendous influence on whether the NDE is accepted and becomes a stimulus for psychospiritual growth, or whether it is hidden away—but not forgotten—as a bizarre experience that must not be shared, for fear of being labeled mentally ill. The approaches outlined below have been developed by a consensus panel of clinicians and NDErs specifically for working with the NDEr (Greyson & Harris, 1987).

Before approaching an NDEr, a therapist should explore his or her own prejudices, both positive and negative, about what NDEs mean and about the people who have such experiences. Regardless of what the therapist believes about the ultimate meaning or cause of the NDE, it must be respected as an extremely powerful catalyst for transformation. When appropriate, the therapist may respectfully share his or her reactions to the experience, without discounting or contradicting the patient's perceptions and interpretation. Individuals who appear agitated by an NDE often feel great pressure to understand it. They usually become *more* frustrated if they are told *not* to talk about it. Allowing NDErs to talk permits them to share and thereby diffuse any negative emotions. Unlike delirious patients, who may become more agitated by verbalizing their own confusion, NDErs will usually be relieved if allowed to struggle until they find the correct words to describe their experiences.

Most NDEs, unlike some other kinds of dissociative experiences, are characterized by very intense emotions, and the individual may still have those unusually intense feelings afterward that need to be shared, vented, or explored. Reflecting back to NDErs their own

descriptions and emotions will help them clarify seemingly ineffable experiences, whereas premature interpretations may heighten the NDEr's fear of being misunderstood or ridiculed. Straightforward factual information about NDEs shared in a nonjudgmental way often alleviates concern about the implications and consequences of the NDE. While patients are usually relieved to learn how common NDEs are, therapists must guard against using the prevalence of NDEs to trivialize any individual's experience or its unique impact on his or her life.

Frustration is common when one is trying to communicate the NDE and its aftereffects, and individuals may give up trying if they see the therapist as giving up. Furthermore, NDErs who feel they were "sent back" to life against their will may feel rejected and may be particularly sensitive to further rejection.

Regarding the NDEr as a victim of the experience is countertherapeutic. Conversely, helping the patient to appreciate his or her active role in the creation or unfolding of the NDE may help the individual understand and resolve problems arising from the experience. The therapist should encourage grief work for those parts of the ego that may have died. Unwanted parts of the ego that were abandoned or transcended in the NDE may need to be mourned.

Encouraging the patient to interpret NDE imagery on multiple levels, as one might interpret dream imagery, may yield valuable insights into subsequent difficulties. Techniques for inducing altered states of consciousness may aid in recall of further details of the NDE, and may help train the NDEr to shift voluntarily between different states of consciousness. Guided imagery, projective techniques, and nonverbal expressions such as art and music may be helpful in uncovering and expressing changes that are difficult to describe verbally.

If the NDEr identifies a definite reason for having been "sent back" to life, as in the first NDE account presented above, that "unfinished business" may be related critically to continuing problems. With those NDErs who report having chosen to return to life, that decision should be explored. Continuing problems may be related to regrets or ambivalence over having returned.

Subtle changes in values, beliefs, or attitudes following an NDE may require changes in family interactions that in turn may contribute to ongoing problems. The newness and uniqueness of the experience may lead both the NDEr and the therapist to regard it, or the NDEr, in romanticized terms. Likewise, remarkable physical,

emotional, or mental aftereffects may be endowed with undue importance simply because they are so different from the individual's prior functioning. Apparent paranormal effects are particularly liable by their novelty to capture the interest of both therapist and NDEr, leading to neglect of more important aspects of the experience that may hold greater potential for fostering the individual's psychospiritual growth.

Many cities have near-death support groups, in which NDErs and their significant others regularly discuss issues around the experience. A list of such support groups is available from the International Association for Near-Death Studies (IANDS), P. O. Box 522, East Windsor Hill, CT 06028. However, while talking to other NDErs is very helpful in normalizing the experience, identification only with a cohort of NDErs may lead to alienation from others who have not had similar experiences, to a conviction that worldly matters are not meaningful or important, and to consequent neglect of basic problems not directly related to the NDE.

The timeless quality of the NDE may make it difficult for some survivors to remain grounded in the present once they return. Some individuals may become preoccupied with the past after a profound life review, while others may fixate on the future as a result of profound precognitive visions in the NDE. A firm here-and-now therapeutic focus may be helpful to permit the NDEr to function effectively in the present.

Finally, the therapist's ultimate utility to the NDEr may be in helping to channel those insights and values gained during the experience into constructive action. The same altered attitudes, beliefs, and life goals that can create conflicts in the NDEr's environment can also be instrumental in altering that environment for the better. Having internalized new values, beliefs, and attitudes, the NDEr may feel compelled to externalize them. Perhaps the best way for many NDErs to validate and reconcile internally the experience and its aftereffects is to use what they have learned to help others.

CONCLUSION

Near-death experiences are disconnected from the mainstream of conscious awareness and involve a characteristic shifting of attention from the physical environment to an alternate reality and back again.

As such, they typify a type of dissociation that is a normal response to intolerable trauma. The examples of NDEs cited in this chapter demonstrate partial or complete disconnections of perception, cognitive functioning, emotional states, and sense of identity from normal awareness. Although NDEs are usually regarded as positive experiences, emotional problems may arise from the difficulty integrating them into the individual's usual consciousness. The response of a psychotherapist can exacerbate the disconnection between NDEs and normal awareness or, by helping the individual reconnect the experience to mainstream consciousness, stimulate psychospiritual growth.

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