Near-Death Experiences and Transpersonal Psychology

Focus on Helping Near-Death Experiencers

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The transpersonal nature of the near-death experience (NDE) challenges the limitations of mainstream psychology and supports the need for transpersonal psychology. Raymond Moody (1975) is credited with coining the term NDE, while noting several predominant characteristics that challenge what Westerners are socialized into believing is “reality.” Some of these include seeing a bright light, floating through a tunnel, having an out-of-body experience with vivid sensory awareness, telepathic communications with spiritual beings and deceased relatives, family, and friends, having a life review (i.e., recalling the highlights of one’s life)—and all of these can occur when a person is deemed clinically, as well as nearly, dead. In addition, occurring after these unusual experiences are many profound aftereffects that can dramatically and permanently change the lives of NDE experiencers (NDErs). NDEs may result in post-integration issues, such as psychospiritual crises that may require therapeutic intervention to resolve.

Whether or not the aftereffects cause significant adjustment problems, the transpersonal realms experienced starkly contrast with ordinary consensual reality, and therefore can potentially disrupt NDErs’ worldviews as they try to make sense out of the profound state they have experienced. The ineffability of the experience only adds to the confusion, since many struggle with the inadequacy of words when trying to communicate their experience to others. To compound the issue, the past 37 years of research have indicated that a large percentage may initially question their own sanity due to having experienced a different state of awareness that does not conform to three-dimensional space–time rules—which only reinforces ambivalence to share their experience with others (Duffy & Olsen, 2007; Greyson, 1997, 2005, 2010; James, 2004; Simpson, 2001). However it is not just NDErs who are often left confused, but scientists who study this phenomenon with open minds are also left wondering, as it contradicts so much of the prevailing materialistic perspective.
Whether these experiences are real or some confabulation of the brain is not the issue at hand for transpersonal psychologists to decide. Rather, it is important to keep in mind that it is real in the mind of the experiencer. The fact that millions of people have reported NDEs with consistent characteristics in all ages, genders, and cultures is simply not something that can be easily ignored. While many theories have been proposed over the past few decades to try to explain NDEs, or perhaps better yet “explain them away,” each has fallen short of being able to adequately account for all characteristics reported, let alone why these consistent characteristics have prevailed for centuries, regardless of religion or prior personal or spiritual beliefs. (For an overview of these theories and their limitations, see Greyson, 2009, 2010.) This makes the NDE a unique phenomenon in a class of its own that is different from other transpersonal experiences, and therefore, deserves to be recognized as such. The aim of this chapter is to present information on what is known about NDEs, as well as common aftereffects, to better inform transpersonal psychologists and those interested in transpersonal phenomena, about the NDE and its implications for working with NDErs.

Incidence: How Common are NDEs?

Over the past 37 years, it has been estimated that as many as 10–40% of those who survive a clinical crisis are reporting NDEs and that, due to improved techniques of resuscitation, these numbers are expected to increase (Parnia, Spearpoint, & Fenwick, 2007; van Lommel, van Wees, Meyers, & Elfferich, 2001). In a recent analysis, Nancy Zingrone and Carlos Alvarado (2009) found that the incidence rate in “retrospective studies combined is 35 percent, whereas that of prospective studies combined is 17 percent” (p. 34). However, Suzanne Simpson (2001) and many others (e.g., Duffy & Olsen, 2007; James, 2004) highlighted that the actual occurrence of NDEs may be significantly higher, since many NDErs may be reluctant to talk about their experience post-NDE due to fears of being labeled as “crazy.”

Noting these limitations in obtaining accurate incidence rates of NDEs, earlier studies showed slightly higher occurrences prior to when Bruce Greyson’s (1983) NDE Scale was developed to screen for the validity of NDEs using clear criteria. For example, a prospective study by Kenneth Ring (1980) found that 40% out of 102 individuals who came close to death and/or were resuscitated reported a NDE, while a Gallup Poll conducted in 1982 (Gallup & Proctor, 1982) revealed that nearly 8 million people reported a NDE (which equates to nearly 35% reported by those who presumably came close to death). In another prospective study, Greyson (1986) assessed 61 patients who were admitted to the hospital for a suicide attempt and found that 16 reported a NDE. It seems likely that these numbers will continue to rise as medical advances enable the resuscitation of more and more people from the brink of death.

More recently, Pim van Lommel and colleagues (2001) conducted an 8-year prospective study on 344 survivors of cardiac arrest in 10 Dutch hospitals and found that 18% reported an NDE and, out of these, 12% reported a core experience with several features originally noted by Moody (1975). While these rates are considerably lower than those reported in earlier findings, van Lommel and colleagues found that the occurrence of NDEs was not associated with fear of death prior to the cardiac
arrest, medication, duration of unconsciousness, or length of cardiac arrest. Another prospective study conducted by Parnia, Waller, Yeates, and Fenwick (2001) examined 63 consecutive survivors of cardiac arrest in a British cardiac care unit and found that 11% reported a NDE. Likewise, Schwaninger, Eisenberg, Schechtman, and Weiss (2002) assessed 174 consecutive survivors of cardiac arrest over a four-year period and found that 23% reported a NDE. Similarly, Greyson (2003) conducted a prospective study in which he examined 1,595 patients consecutively admitted to a tertiary cardiac care inpatient unit over a period of thirty months. Greyson found that 10% of the patients who survived cardiac arrest reported a NDE.

**Demographics**

NDEs have been reported in a broad array of populations and circumstances. There has been no differential prevalence found for religion (McClenon, 2006a), race (Greyson, 2003; McClenon, 2005), age (Britton & Bootzin, 2004; van Lommel et al., 2001), gender (Audain, 1999; Greyson, 1997, 2001, 2003; Parnia et al., 2007), or education and socioeconomic status (Greyson, 1997). Furthermore, NDEs have been shown to be psychologically healthy using various measures (Greyson, 2007, 2009; Parnia et al., 2007; Wren-Lewis, 2004), and do not meet clinical criteria for post-traumatic stress disorder (PTSD) or dissociative disorders as outlined in the *DSM-IV-TR* (American Psychiatric Association (APA), 2000; Christian, 2006; Greyson, 2001, 2007; Morris & Knafl, 2003; Wren-Lewis, 2004).

Likewise, NDEs are reported in a wide variety of medical crises, such as surgery, cardiac arrest, accidents/injuries, childbirth, allergic reactions, acute and/or terminal illness, drowning, military combat, and extreme emotional stress, to name a few (Britton & Bootzin, 2004; Greyson, 1997, 2001, 2003, 2009; Moody, 1975; Parnia et al., 2001, 2007; Ring, 1980; van Lommel et al., 2001). Morse, Conner, and Tyler (1985) found gender differences between the types of clinical crises that provoked a NDE, as well as differences in children, but overall, reports by children and adults generally consisted of the same key characteristics.

**Cross-Cultural Research**

Rich data have been gleaned from cross-cultural research, which strongly suggest that many characteristics of NDEs appear to be a universal phenomenon. While research has shown that cultures may interpret the meaning of the NDE differently (i.e., attributing the light or spiritual beings to their specific religious/spiritual ideology), Greyson (2009) pointed out that the essential characteristics appear to remain the same (i.e., seeing a light, out-of-body experience [OBE], life review, seeing deceased spirits/relatives/loved ones, enhanced telepathic/psychic abilities, etc.).

For example, a recent study conducted in Iran found that Muslim NDErs reported similar criteria to Western accounts (Fracasso, Aleyasin, Friedman, & Young, 2010). Out of 19 participants, 62% reported encountering a light, 53% reported coming to a border or boundary and said they were “sent back,” 42% reported hearing an
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unidentifiable voice, 41% reported a life review, 37% reported seeing scenes from the future, 32% reported OBEs, 26% reported seeing deceased relatives or religious (holy) spirits, and 21% reported sensing the presence of deceased relatives and/or religious (holy) spirits. Likewise, 53% reported they were able to communicate and receive information telepathically in this state of consciousness, and 74% reported enhanced psychic abilities post-NDE.

Other researchers have found similar results. Allan Kellehear (2008) conducted a cross-cultural comparison of data through 2005 and found that non-Western NDEs had many similarities to Western accounts, with only a few minor differences. Cultures examined were China, India, New Zealand, Hawaii, Western New Britain, Native America, Tibet, Guam, and Africa. Kellehear found that all non-Western NDEs included reports of meeting/seeing deceased relatives or supernatural beings and experiencing other realms of pure, unlimited knowledge, as commonly reported in Western NDEs. In contrast, Kellehear found that reports of the tunnel experience were not described in most non-Western accounts, although reports of floating through darkness were common, which appears to resemble the tunnel experience. Belanti, Perera, and Jagadheesan (2008) suggested these differences may be due to sociocultural influences surrounding how one interprets the meaning of the experience, language barriers, and/or religious beliefs.

Interestingly, James McClenon (2005) analyzed 28 African-American narratives from 1,832 anomalous experiences collected in North Carolina to compare elements of the NDE with ritual healing ceremonies. McClenon reported that a majority of the NDE narratives revealed more negative emotions than the rituals. Following this, McClenon (2006b) analyzed eight Kongo NDEs from Central Africa and found that they all reported out-of-body experiences, “other realms” of pure knowledge, and communication with supernatural beings, which lends further support to the universality of this experience. In Satwant Pasricha’s (2008) survey of 60 villages in India (36,100 people), she found that four individuals out of every 10,000 reported a NDE. As in Western NDEs, Pasricha found the most commonly reported elements were seeing a bright light, a sensation of a “cave” (commonly referred to as a tunnel in Western accounts), extrasensory experience as well as extreme feelings of peace. Australian reports of NDEs have also suggested that approximately 8% of the population reported NDEs, with a 36% prevalence rate reported among those who had a close brush with death (Perera, Padmasekara, & Belanti, 2005).

NDE Aftereffects

It is also well documented that there are several profound aftereffects commonly associated with NDEs, including both positive as well as negative post-integration issues that appear to occur over a period of 15 years or more (Bush, 1991; Christian, 2006; Groth-Marnat & Summers, 1998; Insinger, 1981; Noyes, Fenwick, Holden, & Christian, 2009; Sutherland, 1992). Research has shown that in a substantial number of cases, clinical intervention may be needed to help NDErs integrate their NDE into their daily lives—although many researchers view even these difficult aftereffects as positive post-integration growth opportunities in which shallow parts of the old
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self are left behind as NDErs seek to integrate deeper values (Holden, 2009). Many researchers have found high rates of divorce due to radical changes in lifestyle values (Christian, 2006), some became suicidal during certain phases (longing to return to the peaceful realm experienced during their NDE), while others struggled with depression, perhaps due to not having the experience validated by friends, family, and/or practitioners (Bush, 1991; Groth-Marnat & Summers, 1998; Noyes et al., 2009).

Positive Long-Term Aftereffects

Positive long-term effects of NDEs commonly cited in the literature include an increased sense of purpose and meaning in life (Britton & Bootzin, 2004; Greyson, 1996, 1997, 2009; Moody, 1975; Noyes et al., 2009; Ring, 1980; van Lommel et al., 2001; Zingrone & Alvarado, 2009), feelings of unity, love, and compassion towards all of life (Greyson, 2001; Holden, Long, & MacLurg, 2006; James, 2004; Parnia et al., 2001), a decreased interest in obtaining material wealth (Stout, Jacquin, & Atwater, 2006), a desire to eat healthier (many reported eating more vegetables and desiring less red meat), a decreased fear of death, and an increased desire to be of service to others (Brumm, 2006; Christian, 2006; Kinnier, Tribbensee, Rose, & Vaughan, 2001; Moody, 1975; Morris & Knafl, 2003; Ring, 1980; Sabom, 1982; Wren-Lewis, 2004). Many NDErs also reported a decreased desire to consume certain chemicals found in some foods and/or addictive type of substances, such as caffeine, alcohol, and nicotine (James, 2004; Ring, 1992).

Long-Term Post-Integration Issues

Some of the commonly cited long-term, post-integration issues include frustration with finding one’s purpose in life, confusion about the true meaning of life, high rates of depression, anxiety, anger, as well as problems integrating the experience into his or her daily life (Christian, 2006; Duffy & Olsen, 2007; Greyson, 2001, 2007; James, 2004; Morris & Knafl, 2003; Olsen & Dulaney, 1993; Simpson, 2001; Wren-Lewis, 2004). Furthermore, NDErs commonly report a growing sense of isolation from others due to feeling different, and/or being reluctant to talk about the experience out of fears of being rejected or ridiculed (Greyson, 2009). Mori Insinger (1981) suggested this sense of isolation may lead to higher rates of depression, and these findings are consistent with subsequent studies (Christian, 2006; Greyson, 2007; Greyson & Harris, 1987; Morris & Knafl, 2003; Wren-Lewis, 2004). However, it should be noted that depression and anxiety are normal responses to a NDE and the profound aftereffects often take years to integrate; therefore, pathological conditions need to be differentiated from the normal course and outcome of the NDE. Again, research has shown that NDErs have a significantly high rate of divorce post-NDE, perhaps due to drastic changes in lifestyle values, which may place strain on interpersonal relationships (Christian, 2006; Greyson, 2009; Morris & Knafl, 2003; Wren-Lewis, 2004). Whether this is a sign of pathology or one of moving toward healthier and more fulfilling relationships has not been determined. Likewise, John Wren-Lewis (2004) found that positive life changes also co-existed with higher rates of personal distress, making this picture confusing.
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In a study conducted by Stout, et al. (2006), participants were asked what their main struggles and challenges were post-NDE. Stout and colleagues found six key themes consistently reported: (1) difficulty processing a radical shift in reality, (2) difficulty accepting their return back to this life, (3) difficulties sharing their experience with others and/or lack of validation or understanding from family and/or friends, (4) a growing sense of isolation due to the inability to talk about the experience with others, (5) challenges adjusting to heightened chemical sensitivities and intuitive gifts, and (6) difficulty finding/living their life purpose and integrating new spiritual values into daily life.

Other integration issues include a lack of boundaries post-NDE. Greyson (2007) suggested this may be due to the state of unconditional love and “Oneness” that was experienced during the NDE, and that many struggle with integrating back into a society that predominantly lives by the belief that individuals are separate from each other. In fact, Greyson noted many are not able go back to that prior way of living and thinking, which may present several adjustment issues, especially because family or friends may not understand their new values. Moreover, it is important to note that this sense of unity and oneness is not just an intellectual belief for many, but rather, becomes a central part of their new reality.

Other issues surround responses from family and/or friends. In addition to lack of validation and sometimes being disbelieved, Greyson (1997, 2007) suggested some may put the NDEr up on a pedestal expecting superhuman powers from them. The extreme of either of these responses can put immense pressure on NDErs, leading them to not feel understood, while reinforcing a desire to suppress the experience.

Mental Health Studies

Over the past few decades, several studies have been conducted to assess NDErs’ mental health. While many may experience higher rates of depression and anxiety, it is important to note that this may be a normal reaction to an extraordinary event, and that the profound changes that often accompany a NDE that may take several years to successfully integrate. Therefore, we highly encourage practitioners to take this into consideration, and discourage the use of diagnostic labels that may not be appropriate and applicable to many in the NDE population. The APA’s (2000) Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-TR-IV) has created a specific diagnostic label under V Code 62.89 for “Spiritual or Religious Problem” for issues that do not qualify as a pathological disorder, which may more succinctly represent the NDE and its normal aftereffects than other psychodiagnostic labels (see Lukoff, Lu, & Turner, 1998).

Dissociative and Post-Traumatic Stress Disorders

Researchers have found some NDErs report recurring auditory hallucinations that they describe as “internal voices” (Bentall, 2000). However, Richard Bentall found that 97% who reported recurrent hallucinations found these experiences to be positive, and that NDErs did not meet clinical criteria for dissociation, schizophrenia,
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or post-traumatic stress disorder as outlined in the *DSM-IV-TR* (APA, 2000). Subsequent studies conducted by Greyson and Mitchell Liester (2004) found the same results, indicating that NDErs highly valued these experiences and functioned better psychologically as a result.

Other studies have focused on post-traumatic stress disorder (PTSD) and dissociative symptoms following a NDE. Out of 194 NDErs, Greyson (2001) did find higher rates of intrusive PTSD symptoms compared to non-experiencers, but not more avoidance symptoms. Greyson suggested that avoidant-type behavior may be more related to feelings of being different than others and not gaining validation, versus related to trauma caused by the NDE. These findings are consistent with earlier findings from Glen Gabbard and Stuart Twemlow (1984), who found that NDErs were psychologically healthy and did not differ from normal controls. More recently, Parnia et al. (2007) confirmed these findings and also reported that NDErs did not score significantly higher than normal controls for PTSD or dissociative disorders. However, more research is needed on those who report distressing NDEs. Richard Bonenfant (2001) reported one case of a six-year-old boy who suffered PTSD following a distressing NDE during a car accident. Bonenfant stated, “The boy’s parents reported that their son suffered from restlessness, anxiety, and nightmares for months following his NDE” (p. 93). While in this case it is difficult to determine whether the symptoms were the result of the car accident or the NDE, distressing NDEs need to be explored further to determine if the aftereffects present psychological challenges that differ from pleasurable NDE accounts.

Schizotypal Personality Disorder and Psychotic Disorders

As for schizotypal personality disorder and other brief psychotic disorders, studies have shown that NDErs differ in a number of ways. Schizotypal personality disorder consists of perceptual and cognitive deficits that include pervasive interpersonal deficits that are not seen in NDErs (Gabbard & Twemlow, 1984; Irwin, 1993; Locke & Shontz, 1983). David Lukoff, Lu, and Turner (1995) suggested that NDEs can be differentiated from brief psychotic disorders by their acute onset following a stressful event, in addition to their good premorbid functioning and positive attitude post-NDE.

To our knowledge, there are no studies in the academic databases presently that have shown NDErs to meet criteria for any of the psychotic disorders. This is not to say that this diagnostic category might not be applicable to some (perhaps pertaining to those who had a mental health disorder prior to their NDE); however, as of this date, those who had prior mental health disorders (especially of a psychotic nature) have not been adequately studied to compare psychological functioning pre- and post-NDE. Moreover, previous psychological diagnoses of any such psychotic disorders would need to be differentiated from the NDE itself, as it is not common for NDEs to present with psychotic aftereffects.

Childhood Antecedents & Personality Characteristics

Gabbard and Twemlow (1984) proposed NDEs are more likely to occur in individuals who have personality characteristics prone to dissociation, absorption, or
fantasy-proneness. According to Gabbard and Twemlow, traits such as absorption allow an individual to screen out the external world and focus on internal characteristics, which make it more likely to experience a NDE under states of stress or trauma. Furthermore, this theory proposed that individuals who report NDEs may be more prone to fantasizing or daydreaming, and that the NDE is simply a psychological defense that may occur under a high state of stress or trauma. However, several studies show contradictory results and do not reveal significant relationships between NDEs and fantasy-proneness personality traits (Britton & Bootzin, 2004; Brumm, 2006; Greyson, 2003; Wren-Lewis, 2004).

In addition, Ring (1992) compared 74 NDErs and 54 controls and found several childhood antecedents in NDErs that he called the encounter-prone personality (p. 145). While Ring found no statistical differences between the groups on fantasy-proneness, a higher percentage of NDErs reported a sensitivity to alternate realities (p. 127), and reported more psychic experiences as a child. Examples included awakening in the night and seeing nonphysical beings, telepathic communication, premonitions, and other psi-related activity. Ring also found a higher percentage of NDErs reported childhood abuse or trauma, and/or reported a stressful childhood due to severe illness. Ring suggested that experiencing prior trauma or a stressful childhood may foster the development of dissociative type of symptoms, leading to a sense of depersonalization and absorption proneness, thus making some more susceptible to having a NDE. To our knowledge, findings of this have not been researched further, so remain an area that needs to be explored to assess whether these childhood antecedents are consistent in larger samples.

Therapeutic Challenges

Research has indicated that there are both interpersonal and intrapersonal NDE aftereffects that may occur in various stages, and about which mental health practitioners could benefit from being aware. Some of the main issues involve disclosure barriers and various integration issues that range from grief work, depression, divorce, career changes, addressing any anomalous aftereffects (electrical sensitivity and/or ongoing psi-related phenomena), and addressing distressing NDEs (Foster, James, & Holden, 2009).

Disclosure Barriers

Some initial barriers to working with a NDE client may surround reluctance to talk about the experience due to fears of being labeled as mentally ill, as well as many questioning their own sanity (Duffy & Olsen, 2007; Greyson, 1997; James, 2004; Simpson, 2001). Cassandra Musgrave (1997) explored 51 NDErs’ attitudes post-NDE and, among many positive aftereffects, found that 76% reported a reluctance to disclose their experience due to fears of being ridiculed or rejected. Moreover, Regina Hoffman (1995a, 1995b) explored disclosure tendencies and needs in 50 NDEs and found these tended to occur in stages. The first stage entailed a sense of shock and surprise in trying to make sense out of the NDE. Once the initial shock was handled,
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a need to have the experience validated tended to occur. Following this, the impact
the NDE had on their lives started to become apparent, accompanied by the need
to actively explore spiritual and psychological implications of their experience. The
final stage entailed how to integrate this experience into their lives which, as Cherie
Sutherland (1992) and many other researchers have noted (e.g., Greyson, 2007;
Greyson & Harris, 1987), can take years.

Other researchers have suggested the initial reaction to a NDE plays a critical role
in the course and outcome of its aftereffects, which may require a team-oriented
approach to client care from the moment the NDE occurs (James, 2004). Because
NDEs are commonly happening in medical care facilities, there have been widespread
training efforts in this last decade focused on educating medical practitioners about
NDEs, and how to help a client who may have experienced one (Duffy & Olsen, 2007;
James, 2004; Simpson, 2001). Mental health practitioners can benefit from learning
about some of the guidelines medical practitioners have implemented in an effort to
increase communication among professionals, and to deliver proper treatment and
referrals to the NDE population.

In order to break through client reluctance to discuss their NDE and any aftereffects,
mental health practitioners can begin the dialogue by asking clients who have survived
a medical crisis if they remember anything during their period of unconsciousness, and
then assess client openness from there. Additionally, it is recommended that clients
be assured that many others have reported similar experiences (while not discounting
the uniqueness of their experience), and to educate them about the nature of this
phenomenon in order to reduce fears they may have about discussing their experience.

Psychotherapeutic Strategies

Several treatment approaches have been recommended by practitioners who have
worked with the NDE population, which are predominantly focused on helping clients
integrate this experience into their daily lives. Although empirical research needs to be
done to test the efficacy of these methods, the below strategies were put together by
a panel of NDE researchers who have spent years working with the NDE population
(Greyson & Harris, 1985). The following is a recent list of strategies outlined by

Therapeutic Approaches Immediately Following a NDE

*Appreciate unexpectedness.* Because clients have not had time to prepare (due to not
expecting a traumatic experience to happen), a key to working with NDErs is an
appreciation of the unexpectedness of the experience.

*Reorientation.* Immediately following the NDE, clients may be extremely confused
and disoriented. Researchers suggest that grounding techniques geared towards stim-
ulating tactile senses may help them become more aware of body consciousness.

*Clarify and reflect.* Avoid interpreting the meaning or reason the NDE occurred, and
instead listen attentively and help the client clarify and reflect on the experience.
Diagnostic labels. Immediately following a NDE, if clients do have another psychological disorder make sure they understand the NDE is a distinct phenomenon not related to their other diagnoses.

Education. Provide NDErs and their family and friends literature on NDEs to ensure them many others have reported this experience, and that the experience is not abnormal. However, ensure that “normalizing” the experience does not discount the uniqueness of their experience.

Avoid victimization. Avoid a sense of victimization by encouraging the client to grieve for the loss of the ego (or shallower parts of the old self that they may choose to leave behind).

Expression of ineffable. Help clients try to express the ineffability of the experience through non-verbal therapies, such as hypnosis, guided imagery, or art therapy.

Here and now approach to therapy. Using a here-and-now approach to therapy may help clients integrate the experience into their daily lives. Helping them realize what the experience means, and how this impacts daily living can help them make sense out of the experience and facilitate growth.

Couples or family counseling. Because of the high divorce rate among the NDE population, it is important to offer couples or family counseling early on to help family members understand the dramatic lifestyle changes that NDErs may undergo. This can help the client gain validation and support from family and/or friends, and may reduce the later onset of feelings of alienation and isolation, which can result in changes such as divorce.

Support groups. Refer the NDEr to support groups such as the International Association for Near-Death Studies (IANDS: www.iands.org) so that they can explore problems and solutions with other NDErs. Researchers suggest this may help reduce the sense of bizarreness about the experience.

Spiritual crisis. For those who present with psychospiritual crisis, grounding techniques such as mindfulness meditation or yoga have been found to be effective in helping clients get reoriented to the here-and-now. Additionally, meditation may help clients relive the experience and gain new insights into how to integrate the experience into daily living.

Long-Term Therapeutic Approaches

Before entering into a therapeutic relationship with a client who has undergone a NDE, Greyson (1996, 1997, 2007) pointed out it is important for mental health practitioners to realize that the NDE and its aftereffects may impact the therapist’s own psychospiritual growth. Therefore, Greyson suggested it is important for the therapist and client to both discuss what their expectations are in therapeutic relationship, as well as desired outcomes. Below are some useful techniques (Greyson, 2007).
Limits on therapeutic relationship. Researchers found it is important to clarify at the onset of therapy that the NDE is distinct from other problems and to clarify specific issues resulting from the NDE. If a client presents with various issues, it may be helpful to refer to the client to another therapist to help with non-NDE related problems to avoid a conflict of interest when helping clients integrate the NDE.

Trust. It may take clients a little longer to trust even the most sensitive and compassionate mental health practitioners due to the contrasting difference between experiences encountered during the NDE and consensual reality. Likewise, therapists may struggle with believing things shared by the client and so it is imperative for mental health practitioners to be aware of their own thoughts, feelings, and biases.

Flexibility in frequency and length of sessions. In order to establish rapport with NDErs, rigid adherence to traditional therapeutic approaches that encourage an objective, analytical stance should be avoided. Researchers have found this only serves to distance the client and may interfere with fostering client’s psychospiritual growth. Likewise, length and frequency of sessions should be more flexible to allow clients to explore ineffable concepts and overwhelming emotions that may result.

Encourage grief work. Due to the dramatic impact NDEs commonly have on lifestyle values, beliefs, and attitudes, it is recommended that mental health practitioners should help clients grieve parts of their ego that may been radically transformed, or “died” as a result of the NDE.

Free association of anomalous details. Researchers suggest therapists should encourage clients to explore anomalous details of the experience on numerous levels such as through dream analysis, guided imagery, art therapy, and/or meditation. Encouraging clients to engage both right and left brain hemispheres may help clients describe ineffable experiences and may provide insights into specific problems of integration.

Explore life purpose. Because many clients struggle with being sent back, and question their life purpose, exploring new values can help reveal underlying problems the client may be struggling to integrate. For example, many report they “chose to come back to life,” and it may be helpful to explore why they chose to come back. Additionally, feelings of guilt and remorse may be related to their return, so these are important areas to explore with the client.

Explore fears of unwanted after-effects. It is important to help clients distinguish the NDE versus the aftereffects of the NDE. This can help clients reject or resist negative aftereffects without having to devalue the NDE itself.

Explore family dynamics. Drastic changes in lifestyle, values, and beliefs can often dramatically alter relationships with family and/or friends, and leave clients feeling alienated and isolated. Therefore, some researchers have found it helpful to make home visits and/or encourage family therapy.
Support groups. While it is important for clients to gain validation from other NDErs, because of the transpersonal nature of the NDE one downside to group therapy with other NDErs is that it can sometimes encourage clients to devalue worldly matters, which can lead to further problems. Therefore, therapists can help clients reaffirm the importance of the here-and-now, as well as what can be learned from the NDE.

Encourage constructive action. Once clients have integrated the aftereffects of a NDE and internalized new beliefs, values, and sense of life purpose, it is important to encourage them to help others. Experts who have worked with NDErs suggest the therapeutic work is done when clients have found a way to actualize a sense of unconditional love experienced during the NDE and share it with others. In summary, once NDErs are able to adapt the various stages of integration into their daily lives and reach out and help others, Greyson (1996, 1997, 2007) suggested the therapeutic relationship should potentially come to a close.

Conclusion

NDErs frequently are permanently and powerfully altered by their experience, which can lead to good or challenging short-term outcomes—and even the challenging short-term outcomes are seen by some as part of the post-NDE integration process that can lead to good long-term outcomes. There are no extant scientific theories that sufficiently explain NDEs to discount their veridicality, leaving this one of the most interesting phenomena that calls for the openness inherent in transpersonal, rather than conventional materialistic, perspectives. Regardless of whether NDEs are ontologically real or not, NDErs are affected deeply by their NDEs. For clinicians working with NDErs, we present some guidelines for assessing and treating this population. Likewise, scientists who study NDEs and NDErs are often deeply affected by many aspects of the phenomena, such as their commonality across cultures that provides indirect evidence that NDEs are not just a product of culturally learned expectations. We think studying NDEs provides perhaps the most interesting window to explore the limits of the most basic assumptions of Western materialism, and to build transpersonal understandings that might go beyond these limits.

References

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