

Near-Death Experiences in Suicide Attempters in Sri Lanka

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ABSTRACT: Previous studies of suicide attempters have revealed near-death experiences (NDEs) in this group in varying proportions. We studied such a group in Sri Lanka in order to extend these findings. We prospectively interviewed 77 consecutive suicide attempters admitted to a tertiary teaching hospital in Sri Lanka, using the translated modified NDE Scale, and noted biopsychosocial information and medications used. The majority of the population were 18 to 25 years old and had attempted suicide by drug overdose. Seven percent had loss of consciousness. Contrary to expectation, none reported an NDE. This absence of NDE reports may have been due in part of in combination to the effects of pharmacologic agents, the relative lack of loss of consciousness, the lack of serious intend to die, and the in-hospital location of the interviews.

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Near-death experiences (NDEs) have been reported to have occurred under a variety of different circumstances, including attempted suicide. However, there have been relatively few published studies among this particular group, when compared with serious medical or surgical problems. David Rosen (1975) interviewed seven people who had survived the jump from the Golden Gate and San Francisco-Oakland Bay Bridges, all of whom reported near-death experiences. Kenneth Ring and Stephen Franklin (1981) interviewed 36 suicide attempters in the community and noted that 47 percent had NDEs. Bruce Greyson (1991) studied 61 patients who had attempted suicide in a hospital setting and noted that 26 percent had NDEs. The present study was an attempt to explore the phenomenon further in a larger study population.

Methods

Patients

We included patients who had attempted suicide and required inpatient admission for more than 24 hours in Ragama Hospital in Colombo, Sri Lanka, which is a tertiary teaching hospital. We interviewed participants at least 24 hours after hospital admission in order to limit the sample to patients who attempted suicide with serious sequelae. The patients had to be in the hospital at the time of the interview and they had to speak fluent Sinhalese. We excluded patients who had any past or current history of major psychotic condition with thought disorder or related hallucinatory phenomena. We performed the study over an 8-month period. We obtained written informed consent from all patients and approval from the local ethics committee.

Questionnaire

We translated Bruce Greyson's (1983) NDE Scale into Sinhalese to assess the prevalence of NDEs among the patient population. We modified the scale by adding a third positive response option to the choice of answers to account for any variations in education levels in a

developing country or any cultural or language differences. This third positive response option detected if the participants had experienced an aspect of the elements of a NDE that was not accounted for by the two positive response options included in the original English version. After the initial translation, we reviewed the questionnaire multiple times and drafted the final version on a consensus basis. An independent party then translated this Sinhalese questionnaire back into English to assess its similarity to the original version. We then used the questionnaire in a pilot study where we assessed its usefulness in a clinical setting. After this pilot study with ten participants, we further modified the instrument before using it in the main study. A translated copy of the questionnaire is available from the authors. We defined an NDE as endorsement of two or more elements on the translated NDE Scale.

Procedures

We recruited as research assistants two recent medical school graduates who were awaiting their internship appointments. The first author (K.A.L.A.K.) trained these research assistants to administer the questionnaires to the study participants and randomly assessed their administration of the questionnaires to study participants.

The study involved a short, standardized questionnaire that was completed during a one-on-one interview with sufficiently recovered patients during their inpatient hospitalization. The researchers coded each element on the NDE Scale with a score of 0 to 3. The researchers also recorded data on the date of the interview; age; gender; religion; education; details of the suicide attempt, including any loss of consciousness either experienced by the patient or observed by a bystander or by a clinician; current or past psychiatric history; history of seizures in the past or during the current suicide attempt; medications used by the patient currently or within the previous 2 weeks; and a history of previous suicide attempts. A copy of the data recording sheet questionnaire is available from the authors.

Results

We studied 77 suicide attempters. Their mean age was 30.5 years (S.D. = 11.3 years). Demographic data are provided in Table 1. The majority were between 18 and 25 years of age. Seven patients (9

Table 1
Demographics of the Study Population

Variable	Number of participants (Percent)
Age:	
18–25	33 (43%)
26–35	23 (30%)
36–45	14 (18%)
46–55	3 (4%)
56 and older	3(4%)
Gender:	
male	39 (51%)
female	38 (49%)
Education:	
none	2 (3%)
primary school	38 (49%)
secondary school	35 (45%)
tertiary/graduate school	2 (3%)
Religion:	
Buddhist	55 (71%)
Christian	19 (25%)
Hindu	1 (1%)
Muslim	1 (1%)
Loss of consciousness:	7 (9%)
History of psychiatric illness:	15 (19%)
Suicide method:	
drug overdose	38 (49%)
poisoning	29 (38%)
drowning	4 (5%)
hanging	3 (4%)
setting fire to self	2 (3%)

percent) had loss of consciousness. Three of those (4 percent of the total sample) had loss of consciousness verified independently, and the other four only by self-report.

Seventy-three patients (95 percent) were not on any routine medication at the time of the attempt. Medications used by the others were chlopromazine, sodium valproate, and atenolol.

The attempted methods of suicide were drug overdoses, especially with paracetamol; poisonings with a variety of commercially available chemical substances; hangings; attempted drowning; and attempts at setting fire to themselves. Drug overdoses were the most common method used, accounting for 49 percent of the attempts. An additional 38 percent had attempted poisoning; 5 percent drowning; 4 percent hanging; and 3 percent setting fire.

The participants were questioned at least 24 hours after their suicide attempt. The mean interval between the attempt and the interview was 3.2 days (SD = 4.5 days). Fifty-seven participants (74 percent) were interviewed within 72 hours after their suicide attempt. The longest period between the suicide attempt and the interview was 28 days.

None of these patients reported an NDE as we have defined it, that is, as the endorsement of two or more items. However, there were 5 respondents who said they recollected past events.

Discussion

The methods of deliberate self-harm in this study were similar to those reported in other studies from Sri Lanka (De Silva and Seneviratne, 2003; Kuruppuarachchi, Rajakaruna, Dassanayake, Ratnayake, Gunawardana, and Fernando, 1998).

One item was endorsed by five attempters who endorsed no other elements of NDEs: "Did scenes from your past come back to you?" We suspect that this item may have been interpreted as reminiscence prior to the suicide attempt itself rather than a true NDE-related life review, as it was the only element endorsed by these participants.

The negative result was surprising, given that in all of the previous reports there were NDEs among suicide attempters. There are a number of possible explanations for this discrepancy.

It is possible that the subjects may not have reported NDE elements for fear of ridicule. However, some respondents when being questioned had mentioned that these items are usually reported by dying people, and beliefs of the afterlife are common in the Sri Lankan community. Greyson (1998) suggested the inhibiting influence of a hospital psychiatrist as a possible reason that he found fewer NDEs among suicide attempters than did Ring. Even though there are strong cultural beliefs in the afterlife in Sri Lanka, it is possible that the respondents may not have acknowledged these elements in a hospital

that is managed on a “nonindigenous” or Western European medical model. The interviewers themselves had been well trained, and the study participants were not aware that the interviewers were physicians.

Although routine medications were unlikely to have influenced participants’ recall of their experiences, it may be that the effects of the drugs they had ingested in overdose quantities could have clouded their sensorium to the extent that they did not remember NDEs. Ring (1980) discussed the fact that drugs may indeed hamper recall of NDEs.

A large proportion of our sample group of suicide attempters were young persons. It is known that young people may have made parasuicidal gestures to signal psychosocial distress rather than a genuine attempt at self-harm (Anonymous, 2003; De Silva and Seneviratne, 2003). However, even if these patients had not intended to harm themselves seriously, the effects of their attempts had necessitated them being admitted to the hospital and detained for more than 24 hours. Only a few reported loss of consciousness, and we wondered whether that fact had any bearing on our negative result.

Finally, since negative results are less likely to be published (Rockwell, Kimler, and Moulder, 2006), we may not be aware of previous studies that failed to find NDEs among suicide attempters.

Contrary to our expectation, suicide attempters did not report near-death experiences in the present study. The facts that participants were questioned in a hospital managed on a Western European medical model, that few had loss of consciousness, and that their recollections may have been clouded by medications on which they had overdosed, acting singly or in combination, may have influenced these unexpected results. Further research into NDEs among suicide attempters should include a measure of suicidal intent.

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