Guest Editorial

The Examination of Labels– A Beginning

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ABSTRACT: Unclear terminology is a major problem for the study of anomalies, and ambiguous definitions of reality and consciousness make it particularly difficult to discuss anomalous phenomena. Researchers have used the term "near-death experience" to describe four different kinds of incidents. To avoid confusion, we need new labels for experiences that differ in their relationship to death and near-death and in their transformative potential.

I'd been writing about anomalies, those occurrences we have or read about that generally are out of phase with our experience. I wondered, as have others recently, whether these last years of the twentieth century parallel the mid-sixteenth century. Copernicus's ideas suggested that the Ptolemaic paradigm was wrong. Did some scientists who followed him consider anomalies and choose to see the world differently? Did anomalies play a part in Galileo's choice a hundred years later? Galileo was imprisoned by the Inquisition for his ideas about the outer world. Is today's inquisition our unwillingness to see the similarities that exist in the anomalies that disparate disciplines encounter when examining our inner world?

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It was with this in mind that I attended last year's conference of the International Association for Near-Death Studies (IANDS) at Georgetown University. For, after all, isn't the near-death experience (NDE) one of the best researched anomalies? At that conference I learned about the degree of discussion between various groups and conferences on the subject of consciousness, and I also saw that even within IANDS communication is hampered by a less than clear understanding of many of the terms we so easily use. If we are to engage in dialogue outside the boundaries of our own disciplines, it will be well for us to have our linguistic house in order.

It is my hope that this editorial will start us in the direction of change and clarification. It is not meant to be a finished work, but will be, I hope, the beginning of dialogue.

Reality and Alternate Reality

If we are to deal with anomaly we must have an understanding of reality, not in order to discuss the anomaly, but rather to fix the context of the anomaly. Dictionaries are not much help. They define "reality" as "what is real," while they define "real" in turn as "relating to practical or everyday concerns or activities" and "not artificial, fraudulent, illusory, or apparent."

These statements can be at cross purposes in dealing with the mind, where reality is often defined as "the state that can be experienced by the senses." According to that concept, if we can see, feel, smell, hear, or taste it, then it's real. That definition precludes any reality to internal experience. What then am I to make of the feeling of fear I may experience when I awake at 3am? or the feeling of love and longing I may have for my wife when I'm away on a business trip? These experiences are real to me. Must we label these "alternate reality"? I think not. So I must accept that there is reality that is internally generated.

Another part of this puzzle is the reports of individuals that they have, for example, seen ghosts or been apprehended by UFOs. While these are clearly anomalies, are they reality? It may be that these individuals believe their experiences to be real; or they may also believe them to be hallucination. It would seem that reality is in the eye of the person having the experience. It is the judgment of an experience or object that creates the reality.

Conscious and Unconscious

We, as researchers, seem to have a facile understanding of levels of consciousness. We quite easily judge individuals as either conscious, semiconscious, unconscious, or dead. Emergency medical technicians (EMTs) are taught that patients may be either alert (with differing levels of orientation), responsive to voice, responsive only to pain, unresponsive, or without pulse and respiration.

These categories substitute our experience for our judgment. When the EMT cannot get you to respond, it is the EMT's experience that you are unresponsive. It is not the EMT's place to judge whether you are conscious or even dead, but rather to report his or her experience of you. A dictionary definition of "conscious" is "(a) aware of one's own experience, sensations, and environment," or "(b) capable of thought, will, or perception." Many near-death experiencers and lucid dreamers experience a world that can be called conscious, yet we experience them as unresponsive or asleep.

Alertness can be divided into four clinical levels. A patient who is "alert and oriented times three" knows his or her identity, the location, and the time, with some latitude for error. "I don't know the date, but I know who I am and I think I'm in New Jersey" is "alert and oriented times two." Knowing one's identity, but not the place or approximate time would be classified as "alert and oriented times one." Saying "hello," but not answering questions or responding preferentially to one's name would be alert but not oriented.

This is a subjective scale, and my point in presenting it is that there are gradations of being alert. What they are, however, is open to debate. We consider the fully alert person as normal, but it may be that above "alert and oriented times three" are other levels of alertness: the talented state of the individual with savant syndrome, the many facets of multiple personality, the contact of the channel, the perception of the remote viewer, the autistic, the precognitive, the psychokinetic, the viewer of apparitions, the UFO contractee, and many more. These states, however, like those of the unresponsive patient, are experienced only by the person having the experience and not by the researcher.

By confusing unconsciousness with unresponsiveness and by labelling reality we try to apprehend the experience for ourselves. At the time of Galileo the power brokers of the world, those who could communicate other than verbally, chose to define the world in terms of mathematics. Since that time, if an experience could not be quantified,

it is deemed to be less than authentic. Quantification is from the outside in; it is my judgment of your experience, not your experience of your experience.

The Near-Death Experience

I have sincere misgivings about challenging our use of the term "near-death experience," since it's a title that has served us well and is treasured by experiencers. Yet if we are to examine anomalies we must be clear, and "near-death experience" is not the clearest label. This term that served so well to define our field may now serve to confuse. Do near-death studies include all experiences of clinically dead persons who return to life? all experiences of individuals who are judged to be near death? all experiences that lead to transformation? so-called "near-death experiences" whether or not the individual was near death?

I can understand IANDS embracing all of the above. For all may lead to information that will help us redefine our existence. But to avoid confusion they all cannot be called a near-death experience. We need to find words to define these four different areas of research.

First there is the difference between death and near-death. When circulation and breathing stop, clinical death occurs. Unless resuscitation is begun within four to six minutes, brain cells begin to die. This is considered the onset of biological death. Much of the early near-death research considered the experience of those who were brought back from clinical death. Presumably there will be an increasing number of these individuals as technology, EMT response time, and knowledge of cardiopulmonary resuscitation improve. I suggest that what patients remember upon regaining consciousness be called a "death survival experience."

Near-death on the other hand may include a variety of occurrences of illness or trauma that bring the patient close to death. Often these patients receive intense medical care and experience altered states of consciousness. Investigation of the experiences of these individuals is a fruitful area for study. It may or may not add to our knowledge of consciousness, but it most certainly will enhance patient care. I believe we should refrain from categorizing these experiences until we have accumulated a larger body of detailed anecdotal information.

The words "near-death experience" conjure up in the mind of the knowledgeable scenes of the light, an out-of-body experience, a tunnel, a life review, and so on. These generally form an experience that leads

to a changed life for the experiencer. Theoretically I would like to change this title, but practically I believe that would be impossible. I suggest, therefore, that we use the term "NDE" for this category of incident whether the experiencer was clinically dead, near death, or neither.

With this, we've unfortunately opened up the gates to further confusion. How many elements must an experience include to qualify as an NDE? What are those qualifying elements? What if the experience has none of the classic elements but leads to a transformation? What if all the elements are present, but there is no transformation? What constitutes transformation? I would tentatively suggest that seeing the light, feeling unconditional love, and a life transformation would be the minimum criteria for an incident to be called an NDE.

Next we can confront experiences occurring in individuals who are clinically dead or near death but that cannot be classified as NDEs. I believe we need a great deal more information about these incidents broken down by type of experience, causative factors, and transformative potential before we can make any categorical attribution.

In conclusion I want to emphasize that this is but a beginning. I hope I have given impetus to further musing that may lead to clarification and to other areas where research efforts can be started.