Near-Death Experiences: Perception *is* Reality

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ABSTRACT: The authors propose three etiologies responsible for the near-death experience, which they refer to as an altered state of consciousness: physiologic, pharmacologic, and psychologic. They recommend research to determine what developmental factors influence the emotionality of the experience and how in-depth understanding can be used to provide better patient care.

Perception *is* reality. There are no different types of realities, only that which is perceived by the perceiver. The near-death, or, rather, "deathlike" experience is, like religion, politics, beauty, and sex, in the eye of the beholder.

Harry Stack Sullivan used the term "consensual validation" in referring to the efforts of psychiatrists to find "factors that will prove to be of *real moment* [italics added] in understanding our intuition of psychopathological situations–and living generally–and in understanding our ubiquitous errors in both of these" (Sullivan, 1962, pp. 258–259). Lewis B. Hill used the term "consensual validation" to mean a shared reality. He suggested that schizophrenics attempt consensual validation in an effort to experience reality (Hill, personal communication, 1951).

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Mary Baker Eddy, founder of the Christian Science movement, did away with death and thus defined reality: "There is no life, truth, intelligence, nor substance in matter. . . . Spirit is immortal Truth; matter is mortal error. Spirit is the *real* [italics added] and eternal; matter is the unreal and temporal" (Eddy, 1934, p. 468).

The point of these examples is that, to the experiencer, the experience is real, very real. Our position is that there is a scientific explanation for near-death phenomena and that open-minded, not mind-set, research to demonstrate etiology is possible. Currently, experiencers and researchers have offered anecdotal material to make their cases.

Study Method

The emotional aftereffects of unconsciousness in physically traumatized patients was a focus for our study. These patients were unconscious as the result of vehicular accidents, suicide attempts, gunshots, stabbings, falls, and other injuries. The period of unconsciousness lasted from days to many weeks, necessitating artificial life-support systems (Schnaper, 1975).

Over a one-year period, we examined 68 patients after they attained their capacity to verbalize following their recovery from unconsciousness. We told them that the reason for the interview was "Shock-Trauma's interest in your experience while you were unconscious on the Unit." For some it was necessary to ask directly, "Were there any fantasies or dreams?" or "Was there ever any thought or feeling you might be dead?"

Results

Of the 68 patients interviewed, 43 (63 percent) claimed amnesia for the period of unconsciousness; included in this group were six (9 percent) who were vehement in expressing their amnesia.

The remaining 25 patients (37 percent) described their experience using their own verbal constructions; included in this group were 17 (25 percent) who were able to relate their experience retrospectively, and eight (12 percent) who pleaded amnesia but subsequently were able to recall the experience.

It was the rule that patients were hesitant in presenting their fantasies, fearing they would be labeled "crazy." The interviewer had to be nonjudgmental and allow time for trust to develop. Three themes

prevailed: being held prisoner; wrongdoing to justify imprisonment; and death. It is interesting that no patient expressed ideas or feelings pertaining to dying, but rather made reference to the *state* of death.

Illustrative Vignettes

Case 1

Mrs. A., a widow in her late 40s, drove over an embankment and was unconscious for three days. She was on a stretcher in a corridor near an elevator and began to see "transparent" images of many people of all ages, in all sorts of garb. Regularly, groups would get on the elevator and leave, "like it was this day's toll of death." She concluded that these people were dying and that because she was not put on the elevator, "my time had not come."

Mrs. A. felt incarcerated and was "always trying to escape" by pulling the needles out of her arms. She denied she did so to gain attention but admitted that she disconnected the ventilator tubing, which set off an alarm in the nurses' station, in order to get the nurses to come to her. She tried in vain, by moving her lips, to get her daughter to take her away, and was very depressed when the visiting medic from the helicopter did not "save" her.

Mrs. A. thought the nurses were very cruel to hold her prisoner but, in the last two days, realized they were there to help her and that it was unnecessary to escape.

Case 2

Mr. B., a man in his 30s, suffered a crushed chest while working on his parked truck. He was unconscious for almost two weeks. He said that since he was a truck driver, the mention of the word "accident" produced a fear of hurting someone with his big equipment. All he could see was running the truck into a school bus full of children or running over a car full of pregnant women. He denied the reality that his truck was parked during his accidental injury.

Mr. B. felt at one time that all the doctors and nurses were against him because he had wronged them. In a "dream" he had urinated in bed and believed this was the reason people disliked him. He was not aware that a catheter was in place the entire time he was on the Unit.

In one of Mr. B.'s dreams he had two brothers, Hercules and Colossus, who wore armor and protected him. When he was to be transferred from University Hospital, he heard the word "university" and thought of plans to play football with his brothers, perhaps on some other college team. In reality, he had no brothers and his education was limited to the eleventh grade. Questioned, he admitted his difficulty in distinguishing reality from dreams, vehemently giving more credence to the fantasies.

Mr. B. became very upset and sobbed when queried about a "dream" of a tombstone that his wife had mentioned to the interviewer. In his dream it was as if he were looking at a television screen. There he saw his wife wearing a black veil, and his children standing in a cemetery. He could see the headstone in front of them; on it was engraved his name. Recalling the dream was still tearfully painful to Mr. B. even at this later date.

Discussion

Interviewing more than 100 post-cardiac arrest patients soon after the experience yielded results similar to those described above: two-thirds were amnestic; one-third had distorted recall, each of which reported unpleasant feelings (Schnaper, 1980).

Denial is an unconscious defense that prevents one from seeing that which is unpleasant, particularly about oneself. In the critically ill patient there are the following specific threats that mobilize various other defenses, such as regression, magical thinking, and suppression (Schnaper and Cowley, 1976):

(a) *helplessness:* In any illness one becomes dependent on someone else for healing and comfort. The defense of regression follows dependency. The caretakers are viewed as protecting or parental figures. The more severe the physical injury, the more intense are the feelings of separation from family and abandonment. The amount of regression is proportionate to the severity of the injury and intensifies the patient's magical expectations of his or her helpers.

(b) *humiliation:* Injury and hospitalization also engender desperate feelings of indignity in reaction to hospital procedures, such as the bedpan, catheters, and taking blood. Severely traumatized patients are necessarily exposed to these procedures in the admission area and throughout their hospitalization. If they are unconscious when admitted, they experience this humiliation retrospectively when they wake up. If they are semiconscious when admitted, they might view their

clothing being cut off and the other procedures as assault and battery, especially if they have been under the influence of alcohol or other drugs.

(c) *body image:* One's body image is one's conscious and unconscious concept of the physical appearance of the body. Body image can also include one's car and clothing or one's perception of one's environment, all of which contribute to a sense of identity (Schnaper, 1970). Emotional investment in a particular body organ compounds the threat, such as a woman's attitude toward the removal of a breast. In the severely traumatized patient, the threat of mutilation of the body is often overwhelming.

(d) *mental symptoms:* The implied threat here is the experiencing of unconsciousness. The etiology may be physical or emotional. Emotional causes are usually a defensive dissociation or blacking out to avoid an emotionally painful situation.

The state of death is impossible to conceptualize, and the thought of dying is terrifying. Since "being dead" cannot even be imagined, a void evolves, only to be filled with superstitions, fantasies, and poetic creations. When a void in consciousness occurs, it must be filled with retrospective fantasies (Schnaper, 1977). The cases described above demonstrate the need patients have to fill that void of consciousness that so frequently occurs in critical illness and injury.

We maintain that all of the anecdotes about life after death can be explained phenomenologically as altered states of consciousness. There are three primary etiologies: physiological, including hypoxia, anoxia, hepatic delirium, uremia, and Meduna's carbon dioxide therapy; pharmacological, including "mindbenders," narcotics, steroids, pentylenetetrazol, insulin, barbiturates, and other psychotherapeutic medications; and psychological, including dissociative reactions, panic, and psychoses. Hypnagogic states and eidetic images can claim any of these three etiologies.

Edwin Shneidman's (1974) study of the general population's concern for death and life after death revealed some interesting responses to his questionnaires. He found that roughly 23 percent strongly believe in life after death, 20 percent tend to believe, and 22 percent doubt life after death. As to a *wish* for life after death, 55 percent strongly wish for it and 34 percent are indifferent; and as to the *meaning* of death, 35 percent think it is the end or final, 13 percent a transition or new beginning, and 17 percent a termination of life but a survival of the spirit.

Human nature being what it is, many of us will continue to deny the unknown, romanticizing it as is done so frequently in the operatic

Liebestod and in stories of "lovers' leap" and "going to his or her reward." Of course, there are the old, the tired, and the religious who look forward to "going home again, to the arms of Jesus."

Out-of-body experiences have been prevalent for years. An example is a Rosicrucian lecture by H. Spencer Lewis (1950) in which "so-called death" became "transition." His description of transition shifts the more recent portrayals of death from something novel to what might be considered old wine in new bottles:

> There is just a great lightening of the body. . . . They see themselves lying on the bed. . . . They say they seem to be six or seven feet away and above themselves, looking down on their own physical bodies . . . the sense of great peace . . . of music . . . freedom from all suffering. (Lewis, 1950, pp. 12–13)

The following is a counter-anecdote to the out-of-body experience, personally observed by one of us (N.S.). After resuscitation and a period of confusion, the patient related a distorted account of the experience, while insisting he "saw everything." He was most grateful to the team leader who was now standing at the foot of the bed. He gave the physician rave reviews for the skill with which that doctor had orchestrated the resuscitating group. There was only one problem: the physician team leader was nine hospital floors away during the experience.

Conclusion

The direction near-death researchers must take in their studies of the phenomenon is to define the importance of psychological development as an influence on the emotionality of the experience. A particularly clear example of this is the woman in her 40s, dying of Hodgkin's disease, who had a deathlike experience three weeks prior to her actual death. After the 48-hour episode she made much of the unpleasantness and feelings of abandonment, although she had called out repeatedly during the experience, "I'm coming, Jesus Christ! I'm dead, dear Jesus!" She subsequently related how she was raised by her mother's "silent treatment" and her need to be loved and to be touched (Schnaper and Wiernik, 1979).

This patient was carefully and thoroughly studied by the most modern of medical technologies. The conclusion, supported by the patient, was that she was so frightened of imminently dying and of death that she "flipped" into a dissociative reaction or altered state of consciousness.

Another and more immediate positive contribution by the researchers should be on behalf of those who do experience what is in essence a deathlike experience: when their caretakers are informed and understand, the patients will be the beneficiaries. There are some suggestions emanating from our study of these 68 patients. When the patient is unconscious, or seemingly so, as with stroke, he or she needs to be spoken to, called by name, touched and handled as gently as possible. Listening calms the patient's fears. Listening is the art that complements the science of medicine and can be gratifying. Ominous prognostic and other medical discussions within earshot of the patient should be avoided. These are obvious caveats, but perhaps require restatement (Schnaper, 1977).

As to the patient's "crazy idea," Mrs. A.'s response is relevant and succinct:

> To the patient these ideas are very real, I'm afraid. I think perhaps if the staff were told that people have these feelings, are going to say strange things, they will be able to talk with the patient in a different tone of voice and reassure them.

We all dream during a significant part of our sleep period. Sleep is a void in our waking state. This is so in illness, injury, anesthesia, hypnosis, and even in severe emotional trauma. When we awaken from our normal sleep pattern, we can be dream amnestic; recall a "crazy" dream; or, upon hearing or seeing something we associate to, recall that we did indeed dream. How *normal* it is to fill in a void in consciousness, be it sleep, injury, or emotional shock.

As to near-death experiences, it is more appropriate to refer to them as "deathlike" experiences. We have no intent to malign those who have had or support the "pleasant" deathlike experience. We would conjecture that temporal distance converts the unpleasant to the pleasant. We are all familiar with a widow who hated her husband, yet years after his death tells how wonderful he and the marriage were.

Denial, retrospectively, is the predominant defense mechanism used to deal with the possibility of being dead. The pleasant near-death experience denies the concern for what death might engender: a day of judgment, worms or other processes to make us biodegradable, the fear of loneliness, or separation from family and friends. There are those of us who do fear the reality of death and the dying that precede it. Then we join some death awareness movement to deny death intellectually. We cope by "finding the inner peace of death," "life after death," and so on. Thus we maintain a facade of courage to deny that we are *really* afraid.

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