Editor's Foreword • Bruce Greyson, M.D.

A Comparative Study of Near-Death Experience and Non-Near-Death Experience Outcomes in 56 Survivors of Clinical Death • Richard J. Bonenfant, Ph.D.

The Deconstruction of Death: Postmodernism and Near-Death • Raymond L. M. Lee, Ph.D.

Silent Journey: The Discovery of the Near-Death Experience of a Nonverbal Adolescent • Rick Enright, M.S.W.


Book Review: Religion, Spirituality and the Near-Death Experience, by Mark Fox • Susan C. Gunn, Ph.D.
Editor's Foreword 153

Bruce Greyson, M.D.

ARTICLES

A Comparative Study of Near-Death Experience and Non-Near-Death Experience Outcomes in 56 Survivors of Clinical Death 155

Richard J. Bonenfant, Ph.D.

The Deconstruction of Death: Postmodernism and Near-Death 179

Raymond L. M. Lee, Ph.D.

Silent Journey: The Discovery of the Near-Death Experience of a Nonverbal Adolescent 195

Rick Enright, M.S.W., RSW

BOOK REVIEWS

Life After Death: A Study of the Afterlife in World Religions, by Farnáz Ma’súmián 209

Reviewed by Ken R. Vincent, Ed.D.

Religion, Spirituality and the Near-Death Experience, by Mark Fox 213

Reviewed by Susan C. Gunn, Ph.D.
Editor’s Foreword

This issue’s lead article is an empirical study of transformational changes and aftereffects in people who have survived clinical death. Medical scientist Richard Bonenfant compared survivors who reported near-death experiences (NDEs) with those who did not. He found that these two groups surprisingly shared a number of aftereffects that previously were thought to be limited to near-death experiencers. However, the NDErs reported more of the spiritual and paranormal aftereffects than did the nonexperiencers, and reported that their aftereffects not only persisted but increased over time. Bonenfant discusses some implications of these findings for the mechanisms by which clinical death with and without NDEs may bring about different types of transformational change and aftereffects.

In a theoretical essay, Malaysian sociologist Raymond Lee continues his exploration of the social context of NDE accounts by focusing on their role in challenging contemporary assumptions about the meaning of reality. Lee argues that NDE narratives deconstruct the modern concept of death, and therefore that discourse on NDEs can be understood best within the context of postmodernism.

Next, Canadian social worker Rick Enright presents the unique story of an adolescent who had been left brain-damaged from surgery at age 8, quadriplegic and unable to speak. In the course of his therapy with this client, Enright discovered serendipitously that the boy had had an NDE during that operation, and over time he painstakingly elicited the inspiring account of the boy’s NDE and how that experience influenced his attitudes toward his medical treatment and his eventual death.

We end this issue of the Journal with two book reviews. Psychologist Ken Vincent reviews religious scholar Farnáž Ma’súmián’s Life After Death, a panoramic survey of afterlife concepts from the sacred texts of various ancient and modern religions. And English language scholar Susan Gunn reviews British religious philosopher Mark Fox’s Religion, Spirituality and the Near-Death Experience, an overview of NDEs from the perspective of theology, philosophy, and the humanities.

Bruce Greyson, M.D.
A Comparative Study of Near-Death Experience and Non-Near-Death Experience Outcomes in 56 Survivors of Clinical Death

Richard J. Bonenfant, Ph.D.

Malcolm Randall Veterans Administration Medical Center, Gainesville, FL

ABSTRACT: The objective of the study was to determine whether non-near-death experiencers (nonNDErs) expressed aftereffects similar to those reported by near-death experiencers (NDErs). I divided 56 survivors of near-death events into two groups. The first group, consisting of 40 persons (71 percent) who reported extraordinary experiences during their near-death events, I designated the near-death experiencers (NDErs). The second group, consisting of 16 persons who retained no recall of what transpired during their near-death events, I designated the nonNDErs. I administered to both groups a questionnaire designed to identify behavioral changes and aftereffects commonly reported by NDErs, and subjected the findings to chi-square analyses to determine whether observed differences between the two groups were statistically significant. Results indicated that nonNDErs do report some NDE-like changes and aftereffects following their near-death events. However, I found these effects to be less prevalent in nonNDErs, and found statistically significant differences between the two groups in spiritual and paranormal measures. I also found a significant positive correlation between duration of near-death event and sensory confusion in NDErs. In addition, I found a new physiological effect, spine tingling, to be significantly associated with NDEs. Finally, NDErs reported that behavioral changes and aftereffects initiated by their near-death experiences not only were persistent but often increased with the passage of time.

KEY WORDS: near-death experience, synesthesia, kundalini, aftereffects, duration of effects.

Richard J. Bonenfant, Ph.D., is a retired research scientist who is currently affiliated with the Psychiatry Service of the Malcolm Randall Veterans Administration Medical Center in Gainesville, FL. Reprint requests should be addressed to Dr. Bonenfant at the Psychiatry Service, 116A, Malcolm Randall VA Medical Center, 1601 Southwest Archer Road, Gainesville, FL 32608-1197; e-mail: Richard.Bonenfant@med.va.gov.
Individuals who survive a clinical death event can be divided into two groups: those who retain memories of extraordinary experiences, commonly called near-death experiencers (NDErs), and those who have no recall of what transpired during the event, the non-near-death experiencers (nonNDErs).

In the past, great attention has been given to the study of NDErs. Initially, interest in NDErs was based upon their testimonial support of the survival hypothesis, the hypothesis that some aspect of humans can survive death of the body. Later, professional attention focused on a consistent pattern of behavioral changes that appeared to result from these experiences. NDE-related changes in behavior have been investigated by a number of researchers, including Russell Noyes (1980), Martin Bauer (1985), Cheri Sutherland (1990), and Gary Groth-Marnat and Roger Summer (1998). Commonly referred to as transformational changes, these alterations in belief, attitude, and behavior generally produced a transition from self-oriented behavior towards greater social benevolence. Specifically, the attributes of transformational change included a reduction in death anxiety, increased appreciation for the value of life, greater benevolence towards others, reduction in materialistic concerns, renewed interest in learning, development of latent skills and talent, a newfound concern for the environment, and a strong commitment to unconditional love.

In addition to these value changes, a number of unusual aftereffects have been reported by NDErs. These aftereffects encompass a wide range of physiological, neurological, electromagnetic, and paranormal abnormalities. Some of the specific anomalies reported by NDErs include hypersensitivity to light; development of a host of allergies, skin rashes, and sudden dietary food preferences; adverse interaction with sensitive electronic devices, particularly wristwatches; occult awareness of electrical fields such as underground power lines; and increased psychic experiences. These effects were identified by P. M. H. Atwater (1988, 1994, 1996) and later corroborated by Sutherland (1989).

NonNDErs, by contrast, have been relegated to a subsidiary role in near-death research. Since nonNDErs do not recall extraordinary experiences, they were presumed not to undergo transformational changes or experience aftereffects. When incorporated into studies, nonNDErs usually serve as control subjects. If transformational changes and aftereffects are present in NDErs but not in nonNDErs, then the current status of nonNDErs is entirely valid. However, a careful study should be conducted to rule out two possibilities relating to nonNDErs. First, it is possible that some people designated as
nonNDErs may actually have had NDEs but are unable to recall the experience. This possibility is particularly appealing to researchers who hypothesize that frightening NDEs may be repressed in some survivors of clinical death. It certainly is conceivable that subjects who have repressed their NDEs may be buried in the nonNDE population. A variation on this hypothesis is that some people who recall extraordinary experiences near death may nevertheless identify themselves as nonNDErs because they do not wish to acknowledge these experiences as NDEs (Greyson, in press).

Another possibility is that some behavioral changes and aftereffects are brought about by an agency related to the close brush with death itself rather than to NDEs. Should this be the case, survivors in both groups would be expected to display similar changes and aftereffects. Another possibility is that NDEs themselves, as well as transformational changes and aftereffects, are dependent upon a certain threshold of stress associated with physical death. In such cases, the duration of a clinical death event or some other measure of its severity should produce similar effects in both groups of survivors. In view of these possibilities, it would appear prudent to investigate whether transformational changes and aftereffects are in fact limited to NDErs, or whether they are continuously expressed in all survivors of clinical death.

This investigation attempted to address this issue by questioning nonNDErs about the presence or absence of NDE-related transformational changes and commonly reported aftereffects following their clinical death event. The study was intended to clarify three questions: (1) whether differences between NDErs and nonNDErs are discrete or continuous in nature; (2) whether differences between NDErs and nonNDErs vary by type of effect, that is, psychological, physiological, neurological, electromagnetic, or paranormal; and (3) whether duration of clinical death is significantly associated with NDEs. A secondary objective of the study was to add new information concerning NDEs to the existing commonwealth of data.

Method

Subjects

Subjects were sought who had survived clinical death in a medical setting. To meet this requirement, subjects were recruited from three
health facilities in New York State: the cardiology unit of St. Peter's Hospital in Albany, NY; Community Hospice of Schenectady, NY; and the Long Island Head Injury Association in Commack, NY. The Traumatic Brain Injury unit of the New York State Department of Health declined direct participation, but agreed to provide referrals to the study. In addition, local health professionals who were acquainted with the study also referred subjects.

During a six-month period beginning in November 1998 and ending in May 1999, 136 packets were distributed to survivors of clinical death. Of these, 56 packets (41 percent) were returned.

**Instruments**

A new instrument, the *Death Event Questionnaire*, was designed to measure participants' responses. The questionnaire consisted of six sections. Section I recorded demographic data, such as gender, age, education, income, and other socioeconomic variables. Section II recorded data related to the clinical death event, such as date, cause, and duration. Section III contained an inventory checklist of 37 reported NDE elements and was completed only by subjects who reported NDEs. Section IV consisted of 13 multiple-choice questions relating to changes in belief, attitude, and behavior following the clinical death event. Section V contained 18 Likert-scale questions on physiological, neurological, paranormal, and electromagnetic after-effects. Section VI invited subjects' comments, questions, and personal descriptions of their clinical death event.

A second instrument, the NDE Scale (Greyson, 1983, 1985, 1990), was administered to subjects who reported NDEs in order to validate and categorize their NDEs. The NDE Scale is a 16-item instrument that is widely used in the field of near-death studies to discriminate between different types of NDEs. According to Bruce Greyson (1993a), NDEs are composed of elements that broadly fall into four distinct categories. The *cognitive component* is dominated by features relating to changes in thought process: distortion of one's sense of time, acceleration of thoughts, panoramic life review, and a sense of sudden understanding. The *affective component* includes elements related to changes in emotional state: feelings of overwhelming peace, painlessness, well-being, joy, cosmic unity, and an apparent encounter with a loving being of light. The *paranormal component* is made up of features related to what appear to be psychic phenomena: hyperacute physical senses, apparent extrasensory perception and precognitive
visions, and a sense of being out of the body. The final *transcendental component* is identified by mystical elements: apparent travel to an unearthly realm, encounters with a mystical being, visible spirits of deceased or religious figures, and a barrier beyond which one cannot return to earthly life.

**Procedure**

Patients who were resuscitated from clinical death, or otherwise experienced a clinical death crisis, were informed of the study after their condition had stabilized. Patients who agreed to participate in the study were provided with a packet containing: (a) a formal description of the study and its objectives, (b) an informed consent form, (c) the Death Event Questionnaire, (d) the NDE Scale, and (e) a stamped, return envelope pre-addressed to a local post office box in the Albany area. The consent form was the only document that contained identifiable personal information. To ensure confidentiality, each instrument was linked to an individual consent form by a randomly generated three-digit code.

Specific protocols varied by institution, in keeping with the organization's institutional review board for research. At St. Peter's Hospital, subjects were solicited who had received cardiac defibrillation in response to a medical emergency. These individuals were judged by medical staff to have been clinically dead for a period of at least 30 seconds. Twenty-five individuals meeting this criterion were selected by the cardiac unit staff from a list of patients who had been defibrillated during the previous six-month period. Hospital staff telephoned these individuals and asked if they would be willing to participate in the study; 23 patients agreed to do so and two abstained. Patients who agreed to participate were mailed packets. Fifteen of the 23 packets were completed and returned. Of these, six were from NDErs and nine were from nonNDErs.

Community Hospice provides clergy and nursing support for various hospice facilities located in the Albany and Schenectady regions of Upstate New York. Patients in these centers are terminally ill from acquired immune deficiency syndrome (AIDS), cancer, and diseases of advanced age. In the protocol used by Community Hospice, 15 volunteer clergy and nurses asked patients who had undergone emergency resuscitation to participate in the study. Each of the 15 clergy and nurses who assisted in the study was given study packets to be provided to clinical death survivors who expressed interest in the
study. Nine of the 45 study packets were returned. All nine were from patients who had experienced NDEs.

At the Long Island Head Injury Association, potential subjects were selected from a review of medical records for patients who recovered from comas associated with traumatic brain injuries. All selected patients were judged to have been severely injured and on the verge of death. The institutional review board of this organization requested that 35 packets be sent to their organization. Eligible patients were told of the study and invited to participate by staff personnel. In some cases hospital staff assisted patients in completing the study forms. A total of 12 packets were returned: ten from NDErs and two from non-NDErs. The Long Island Head Injury Association retained all consent forms and forwarded only the study instruments back to the investigator.

The largest number of participants came from referrals from the New York State Traumatic Brain Injury program and from medical professionals familiar with the study. I requested that referred subjects initiate the request for participation. Most referrals contacted me by telephone, but a few did so by letter. Each qualified referral was sent a packet to complete. Forty-three packets were distributed in this manner and 19 were returned; 15 from NDErs and four from non-NDErs.

Upon receipt of the completed packet, consent forms were secured and data from the two instruments were encoded for processing. Statistical analyses were carried out on demographic variables, cause of clinical death, duration of clinical death, and NDE scale classification. Associations between NDE status and specific behavioral changes and aftereffects were tested by chi-square analyses. Potential relationships were tested for statistical significance using an alpha level of .05. The strength of relationship was indexed with Cramer’s Statistic. Small cell values were further evaluated with Fisher’s exact test after responses had been reduced to meaningful 2 x 2 table formats.

Results

Demographic Description of Sample

Table 1 presents demographic variables ascertained to determine the nature of the NDEr sample. As shown in the table, gender was nearly equally distributed between males and females, but the racial composition was overwhelmingly Caucasian. The ages of subjects approximated a normal distribution with a mean of 48 years. The
Table 1  
Demographic Characteristics of 40 NDErs

<table>
<thead>
<tr>
<th>Variable</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>21 (52.5%)</td>
</tr>
<tr>
<td>female</td>
<td>19 (47.5%)</td>
</tr>
<tr>
<td>Race:</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>38 (95.0%)</td>
</tr>
<tr>
<td>African-American</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Asian</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Mean = 48.0 yrs</td>
<td></td>
</tr>
<tr>
<td>Median = 45.5 yrs</td>
<td></td>
</tr>
<tr>
<td>Range = 10–76 yrs</td>
<td></td>
</tr>
<tr>
<td>Religious preference:</td>
<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>Mainstream Protestant</td>
<td>9 (23%)</td>
</tr>
<tr>
<td>Born Again Christian</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Jewish</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>other preference</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>no preference</td>
<td>11 (28%)</td>
</tr>
<tr>
<td>Education:</td>
<td></td>
</tr>
<tr>
<td>postgraduate degree</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>undergraduate degree</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>high school degree</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>unknown</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Marital status:</td>
<td></td>
</tr>
<tr>
<td>married</td>
<td>19 (48%)</td>
</tr>
<tr>
<td>single</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>separated/divorced</td>
<td>8 (20%)</td>
</tr>
<tr>
<td>Financial status:</td>
<td></td>
</tr>
<tr>
<td>secure</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>middle class</td>
<td>17 (43%)</td>
</tr>
<tr>
<td>working class</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>disadvantaged</td>
<td>8 (20%)</td>
</tr>
</tbody>
</table>
majority of NDErs reported their religious preference as some form of Christianity, and no subjects described themselves as atheists. The majority of NDErs had a college degree, and almost half were married. Five subjects were defined as financially secure, meaning that they would be able to survive loss of income for an extended period of time; 17 were described as middle class, defined as having dual income plus savings and assets; 10 subjects were defined as working class, that is, being entirely dependent upon a weekly salary; and 8 were described as disadvantaged, defined as requiring social assistance.

Source of Subjects

Data describing the source of referral to the study and characteristics of the death event for all 56 subjects are presented in Table 2. The source distributions of NDErs and nonNDErs were significantly different, with St. Peter's hospital referring the smallest number of NDErs but more than half the nonNDErs.

Cause of Death

Cause of the death event was also different for the NDErs and nonNDErs. NDErs described a variety of causes of death, including multiple NDErs reporting heart attacks, automobile accidents, near-drownings, accidental falls, electrocutions, and surgeries; whereas 61 percent of the nonNDErs reported having had a heart attack, and only 1 nonNDEr reported each of the other causes listed. Because heart attack was the only cause of clinical death reported by more than one nonNDEr, the chi-square test was performed on cause of clinical death with responses dichotomized as heart attack or other cause, and the difference between the two groups was statistically significant.

There were no significant associations between cause of clinical death and selected behavioral changes and aftereffects.

Duration of Clinical Death

Duration of clinical death, in minutes, was solicited from both groups of survivors in order to determine if a relationship existed between this variable and selected behavioral changes and aftereffects in either group. However, the inability of many nonNDErs to report their duration of clinical death limited testing of this variable to NDErs. The majority of NDErs reported that their death events lasted from 1 to 5
Table 2
Referral and Death Event Characteristics of NDErs and NonNDErs

<table>
<thead>
<tr>
<th>Variable</th>
<th>NDErs</th>
<th>nonNDErs</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of referral:</td>
<td></td>
<td></td>
<td>$\chi^2 = 14.39$, df = 4, p &lt; .01</td>
</tr>
<tr>
<td>NYSDH TBI* or local referral</td>
<td>15 (38%)</td>
<td>4 (25%)</td>
<td></td>
</tr>
<tr>
<td>St. Peter's Hospital</td>
<td>6 (15%)</td>
<td>9 (56%)</td>
<td></td>
</tr>
<tr>
<td>Long Island Head Injury</td>
<td>10 (25%)</td>
<td>2 (13%)</td>
<td></td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Hospice</td>
<td>9 (23%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>unspecified</td>
<td>0 (0%)</td>
<td>1 (6%)</td>
<td></td>
</tr>
<tr>
<td>Cause of death event:</td>
<td></td>
<td></td>
<td>$\chi^2 = 8.31$, df = 1, p &lt; .01</td>
</tr>
<tr>
<td>heart attack</td>
<td>6 (15%)</td>
<td>10 (63%)</td>
<td></td>
</tr>
<tr>
<td>other**</td>
<td>24 (85%)</td>
<td>6 (37%)</td>
<td></td>
</tr>
<tr>
<td>Duration of clinical death:</td>
<td></td>
<td></td>
<td>***</td>
</tr>
<tr>
<td>&lt;1 minute</td>
<td>3 (8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–2 minutes</td>
<td>11 (27%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3–5 minutes</td>
<td>10 (25%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6–10 minutes</td>
<td>7 (18%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10 minutes</td>
<td>6 (15%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unknown</td>
<td>3 (8%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* New York State Department of Health Traumatic Brain Injury unit.
** Among NDErs, 10 auto accidents, 5 near-drownings, 4 accidental falls, 1 surgery, 1 electrocution, and 3 unspecified; among nonNDErs, 1 in each of these categories.
*** As reported by NDErs; nonNDErs could not estimate duration of clinical death.

minutes. The study protocol did not permit access to medical records to corroborate subjects’ reported duration of clinical death.

Duration of clinical death event was tested against 10 behavioral changes and 16 aftereffects in NDErs. Only one aftereffect was found to be associated with this variable: sensory confusion, defined as a fusion of two different modes of perception, such as feeling colors, tasting words, or smelling sounds. This effect is characteristic of a rare phenomenon known as synesthesia, an involuntary crossmodal association in perception in which stimulation of one sensory modality
reliably causes perception in one or more different senses. Although sensory confusion was statistically associated with duration of clinical death ($\chi^2 = 21.07$, df = 16, $p = .05$, Cramer's $V = .47$), one such statistical association at this level of significance would be expected purely by chance among 26 simultaneous statistical tests. In this study, 21 of the NDErs who responded to the question about sensory confusion (64 percent) reported experiencing the effect. Furthermore, 3 nonNDErs (19 percent) reported some degree of sensory confusion, although among that group it was not significantly associated with duration of clinical death.

**NDE Element Inventory**

Section III of the Death Event Questionnaire contained a 37-item inventory of commonly reported NDE elements. Table 3 presents the number and percent of NDErs who endorsed each of these items, in order of frequency.

Eight of the nine least reported elements (struggling to escape, being terrified, being in a dreary environment, seeing demons, being taunted, seeing others tortured, being assaulted, and smelling foul odors) were those associated with frightening NDEs. Only three subjects (8 percent) reported NDEs that could be characterized as frightening, and they tended to contain a mosaic of blissful and frightening elements. For example, one subject, a 7-year-old boy who survived a near fatal automobile accident, wrote the following account of his experience for his classmates:

One summer day, me and my parents went to the ice cream truck for ice cream. Like always, I got excited and ran across the street. I didn't quite make it. I closed my eyes hoping to beat the car. All of a sudden, I felt something metal punch me. Everything went black. Then I find myself in this tunnel. As I floated through it, I found two doors to my right. So, however curious I was I opened one of them. I saw something. It didn't take long to find out I was talking to the Devil. We had a short conversation, then I sadly walked out of that room. Then in front of me, I saw a light brighter than the sun, but it did not hurt my eyes. It said, "Do not be afraid." It put me in a dungeon. Everything went blurry. I had to clear my eyes but before I could I woke up in the emergency room.

Chi-square testing revealed no significant association between duration of death and the intensity of NDEs as measured by the total number of reported elements. Data used in determining this finding are presented in Table 4.
### Table 3
Number and Percent of 40 NDErs Reporting NDE Elements

<table>
<thead>
<tr>
<th>NDE Element</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling quiet, peaceful and secure</td>
<td>27 (68%)</td>
</tr>
<tr>
<td>2. Being drawn to a bright light</td>
<td>24 (60%)</td>
</tr>
<tr>
<td>3. Sensing the presence of others</td>
<td>21 (53%)</td>
</tr>
<tr>
<td>4. Being in the presence of a spiritual being of light</td>
<td>21 (53%)</td>
</tr>
<tr>
<td>5. Being in the presence of a light that created a state of love, peace, and happiness</td>
<td>19 (48%)</td>
</tr>
<tr>
<td>6. Feeling completely and unconditionally loved</td>
<td>19 (48%)</td>
</tr>
<tr>
<td>7. Being instructed to return</td>
<td>18 (45%)</td>
</tr>
<tr>
<td>8. Being in an environment that transcends space and time</td>
<td>17 (43%)</td>
</tr>
<tr>
<td>9. Engaging in telepathic communication with other being(s)</td>
<td>16 (40%)</td>
</tr>
<tr>
<td>10. Leaving the body and seeing yourself from a different vantage point</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>11. Being escorted by friendly beings</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>12. Experiencing a sense of enlightenment</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>13. Perceiving an alternate reality</td>
<td>13 (33%)</td>
</tr>
<tr>
<td>14. Being in a dark place</td>
<td>11 (28%)</td>
</tr>
<tr>
<td>15. Seeing your life pass in review</td>
<td>11 (28%)</td>
</tr>
<tr>
<td>16. Meeting deceased relatives and friends</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>17. Seeing past or future events</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>18. Experiencing desperation to return</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>19. Seeing beings dressed in white robes</td>
<td>9 (23%)</td>
</tr>
<tr>
<td>20. Traveling through space at a high rate of speed</td>
<td>9 (23%)</td>
</tr>
<tr>
<td>21. Seeing a boundary (door, bridge, gate, river, etc.) which marked the boundary between life and death</td>
<td>7 (16%)</td>
</tr>
<tr>
<td>22. Other visions or experiences not noted in this inventory</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>23. Smelling fragrant scents</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>24. Being drawn into a dark hole, pit, or void</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>25. Seeing others performing various tasks</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>26. Being in a beautiful garden or natural landscape</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>27. Hearing beautiful singing or music</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>28. Seeing angels, saints, or lesser deities</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>29. Struggling desperately to escape</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>30. Being terrified or fearful</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>31. Being in a gray and dreary environment</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>32. Seeing demons, ogres, or the devil</td>
<td>3 (8%)</td>
</tr>
</tbody>
</table>

(Continued)
Table 3  
(Continued)

<table>
<thead>
<tr>
<th>NDE Element</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Being taunted or attacked</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>34. Seeing others being terrified or tortured</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>35. Seeing buildings, artificial structures, or cities of light</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>36. Being bitten, scratched, kicked, beaten, or otherwise assaulted</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>37. Smelling foul odors</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Classification of NDE

On the basis of NDE Scale scores, 11 NDEs in the present study (28 percent) were classified as cognitive, 11 (28 percent) as affective, 10 (25 percent) as transcendental, 4 (10 percent) and paranormal, and 4 (10 percent) as unclassifiable. There was no significant difference between the NDE type distribution of men and of women ($\chi^2 = 6.55$, df = 4, $p = .20$).

Attempts to correlate type of NDE with known behavioral changes and aftereffects revealed no statistically significant associations.

Table 4
Duration of Clinical Death and Number of Reported NDE Elements

<table>
<thead>
<tr>
<th>Duration of Clinical Death</th>
<th>Total Number of Reported NDE Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;5</td>
</tr>
<tr>
<td>&lt;1 min</td>
<td>0</td>
</tr>
<tr>
<td>1–2 min</td>
<td>3</td>
</tr>
<tr>
<td>3–5 min</td>
<td>3</td>
</tr>
<tr>
<td>6–10 min</td>
<td>3</td>
</tr>
<tr>
<td>&gt;10 min</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
</tbody>
</table>

$\chi^2 = 24.177$, df = 16, $p = .086$.

Note: Duration of death could not be calculated for 6 NDE cases.
Table 5
Transformational Changes Reported by NDErs and NonNDErs

<table>
<thead>
<tr>
<th>Transformational Change</th>
<th>NDErs</th>
<th>nonNDErs</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical death event significant</td>
<td>38/40 (95%)</td>
<td>1/16 (6%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Death event impacted life</td>
<td>40/40 (100%)</td>
<td>12/16 (75%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Fearful of dying</td>
<td>8/40 (20%)</td>
<td>9/15 (60%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Believe in afterlife</td>
<td>34/40 (76%)</td>
<td>8/15 (53%)</td>
<td>.029</td>
</tr>
<tr>
<td>Believe in reincarnation</td>
<td>26/40 (65%)</td>
<td>7/15 (47%)</td>
<td>NS**</td>
</tr>
<tr>
<td>Believe in God/supreme being</td>
<td>38/38 (100%)</td>
<td>13/16 (81%)</td>
<td>.023</td>
</tr>
<tr>
<td>Religious beliefs changed</td>
<td>33/40 (83%)</td>
<td>8/15 (53%)</td>
<td>.039</td>
</tr>
<tr>
<td>Think about death event often</td>
<td>15/40 (38%)</td>
<td>3/16 (19%)</td>
<td>NS</td>
</tr>
<tr>
<td>Attitude toward others changed</td>
<td>28/38 (74%)</td>
<td>9/16 (56%)</td>
<td>NS</td>
</tr>
<tr>
<td>Relationships with loved ones changed</td>
<td>17/38 (45%)</td>
<td>5/16 (31%)</td>
<td>NS</td>
</tr>
<tr>
<td>Friends chosen based on death event</td>
<td>0/40 (0%)</td>
<td>1/16 (6%)</td>
<td>NS</td>
</tr>
<tr>
<td>Attitude toward materialism/popularity changed</td>
<td>16/40 (40%)</td>
<td>6/16 (38%)</td>
<td>NS</td>
</tr>
<tr>
<td>Participate in volunteer/service activities</td>
<td>34/39 (87%)</td>
<td>13/16 (81%)</td>
<td>NS</td>
</tr>
<tr>
<td>Participate in learning/teaching activities</td>
<td>35/40 (88%)</td>
<td>11/16 (69%)</td>
<td>NS</td>
</tr>
<tr>
<td>Ever contemplated suicide</td>
<td>13/37 (35%)</td>
<td>3/16 (19%)</td>
<td>NS</td>
</tr>
<tr>
<td>Changes persist to present day</td>
<td>36/40 (90%)</td>
<td>6/16 (38%)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

* Calculated by Fisher's exact test after data were reduced to dichotomous (yes/no) data.
** Not significant.

Behavioral Changes and Aftereffects

One of the main objectives of this study was to investigate differences between NDErs and nonNDErs with regards to transformational changes and aftereffects. Both groups of survivors were asked a series of questions regarding attributes commonly associated with each effect category. NDErs and nonNDErs differed significantly on 7 of 16 measures of transformational changes, and 5 of 10 measures relating to aftereffects. Data on transformation changes reduced to dichotomous (yes/no) questions are presented in Table 5, and data on aftereffects reduced to dichotomous (yes/no) questions are presented in Table 6.

In terms of transformational changes, NDErs were found to differ from nonNDErs on questions relating the impact of the clinical death event in their lives, and to questions relating to religious or spiritual issues. As shown in Table 5, Fisher's exact test revealed that NDErs
### Table 6
**Aftereffects Reported by in NDErs and NonNDErs**

<table>
<thead>
<tr>
<th>Aftereffect</th>
<th>NDErs</th>
<th>NonNDErs</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physiological:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequent minor ailments/illnesses</td>
<td>16/40 (40%)</td>
<td>6/16 (38%)</td>
<td>NS**</td>
</tr>
<tr>
<td><strong>Neurological:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sensory confusion/synesthesia</td>
<td>23/36 (64%)</td>
<td>3/15 (20%)</td>
<td>.001</td>
</tr>
<tr>
<td>spine tingling</td>
<td>30/39 (77%)</td>
<td>4/15 (27%)</td>
<td>.001</td>
</tr>
<tr>
<td>eyes sensitive to sun/fluorescent light</td>
<td>30/40 (75%)</td>
<td>7/16 (44%)</td>
<td>.033</td>
</tr>
<tr>
<td><strong>Electromagnetic:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>wristwatch runs fast/slow</td>
<td>14/40 (35%)</td>
<td>4/16 (47%)</td>
<td>NS</td>
</tr>
<tr>
<td>lights often burn out in your presence</td>
<td>14/38 (35%)</td>
<td>2/14 (14%)</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Paranormal:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dreams often come true</td>
<td>7/37 (19%)</td>
<td>1/15 (7%)</td>
<td>NS</td>
</tr>
<tr>
<td>out-of-body experiences</td>
<td>20/37 (54%)</td>
<td>1/15 (7%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>demonic/hellish nightmares</td>
<td>21/38 (55%)</td>
<td>3/15 (20%)</td>
<td>.031</td>
</tr>
<tr>
<td>inexplicable/paranormal experiences</td>
<td>36/38 (95%)</td>
<td>9/15 (60%)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

* Calculated by Fisher's exact test after data were reduced to dichotomous (yes/no) data.

** Not significant.

felt that their clinical death events were more significant ($\chi^2 = 42.90$, df = 5, p = .001) and had a greater impact on their lives ($\chi^2 = 13.42$, df = 3, p = .004) than did nonNDErs. They also reported that they were less fearful of dying ($\chi^2 = 8.42$, df = 3, p = .038) than were nonNDErs. NDErs more positively affirmed belief in the existence of an afterlife ($\chi^2 = 16.58$, df = 4, p = .002) and in the existence of God or a supreme deity than did nonNDErs, although the latter difference did not reach statistical significance when broken down into 5 levels of belief and evaluated by the chi-square test ($\chi^2 = 8.64$, df = 4, p = .07). NDErs reported greater changes in religious beliefs than did nonNDErs, although that difference also failed to produce a significant chi-square test on 4 levels of belief ($\chi^2 = 5.39$, df = 3, p = .151), and they were more likely than nonNDErs to report that changes in belief, attitude, and behavior were still in effect, even years after their death events ($\chi^2 = 21.98$, df = 3, p = .001).

On the other hand, Fisher's exact test revealed no significant differences between the NDErs and nonNDErs in their belief in
reincarnation ($\chi^2 = 1.68$, df = 3, $p = .64$), frequency of thinking about the clinical death event ($\chi^2 = 6.20$, df = 3, $p = .10$), attitude toward others ($\chi^2 = 2.35$, df = 2, $p = .31$), relationships with loved ones ($\chi^2 = 1.04$, df = 3, $p = .79$), role of the clinical death event in choice of friends ($\chi^2 = 1.55$, df = 3, $p = .67$), attitude toward materialism or popularity ($\chi^2 = 4.63$, df = 3, $p = .20$), participation in volunteer or service activities (although this difference was significant when broken down into 4 levels of participation and assessed by the chi-square test: $\chi^2 = 15.76$, df = 3, $p = .003$) or in educational or teaching activities ($\chi^2 = 2.73$, df = 4, $p = .61$), or contemplation of suicide ($\chi^2 = 4.69$, df = 3, $p = .20$).

In terms of aftereffects, Fisher's exact test showed that NDErs were more prone than were nonNDErs to experience sensory confusion or synesthesia ($\chi^2 = 9.59$, df = 2, $p = .022$), a tingling sensation in their spines ($\chi^2 = 12.44$, df = 3, $p = .006$), and sensitivity to direct sunlight or fluorescent lights, although the latter difference was not significant as measured by the chi-square test of 5 levels of sensitivity ($\chi^2 = 6.26$, df = 4, $p = .13$). They also reported more frequently than did nonNDErs having out-of-body experiences ($\chi^2 = 10.07$, df = 2, $p = .007$), nightmares with demonic themes (although this difference did not reach statistical significance when evaluated by a chi-square test of 5 levels of frequency: $\chi^2 = 14.56$, df = 4, $p = .07$), and paranormal experiences in general ($\chi^2 = 14.46$, df = 4, $p = .006$). There were no significant differences on Fisher's exact tests between NDErs and nonNDErs in their reports of minor ailments ($\chi^2 = 2.18$, df = 3, $p = .54$), wristwatches running fast or slow ($\chi^2 = 4.00$, df = 4, $p = .41$), light bulbs burning out when in close proximity ($\chi^2 = 3.46$, df = 3, $p = .48$), or precognitive dreams, although this last phenomenon was significantly more common among NDErs when broken down into 5 levels of frequency and evaluated with chi-square ($\chi^2 = 13.66$, df = 4, $p = .005$).

### Duration of Effects

It is widely assumed among near-death researchers that both transformational changes and aftereffects are long-lasting in duration, if not permanent. The current study attempted to examine this issue by asking death survivors whether the changes and aftereffects they reported were still in effect, and revealed a significant difference in response between the two groups. A majority of nonNDErs, 9 patients (56 percent), reported that their clinical death event had had no effect on their lives; 5 nonNDErs (31 percent) indicated that resulting effects had not changed with the passage of time; 1 nonNDER
(6 percent) reported that the aftereffects were ongoing and increasing with time; and 1 (6 percent) reported that the aftereffects had decreased over time. By contrast, the majority of NDErs, 22 patients (55 percent), reported that NDE-related effects were ongoing and had increased over time; 14 NDErs (35 percent) reported that these effects had not changed with the passage of time; 2 NDErs (5 percent) reported that the aftereffects had decreased over time; and 2 (5 percent) reported that their NDE had had no effect on their lives. These differences between NDErs and nonNDErs were statistically significant ($\chi^2 = 21.98, \text{df} = 3, p = .001; \text{Cramer's V} = .63$).

**Discussion**

**Demographics and Clinical Death Events**

This study did not discern any difference between NDErs and nonNDErs on socioeconomic variables or cause of death. Furthermore, among NDErs, I did not find any significant association between type of NDE and selected transformational changes and aftereffects, nor between duration of clinical death and NDE intensity as measured by the total number of reported NDE elements. The finding that number of NDE elements reported was not associated with duration of clinical death concurs with that of a recently published study by Pim van Lommel, Ruud van Wees, Vincent Meyers, and Ingrid Elfferich (2001) which found that the seriousness of a death event did not appear to influence the depth of the associated NDE.

**NDE Elements**

Two inferences can be drawn from the 37-item NDE element inventory. First, 18 of the 20 most frequently reported elements relate to spiritual aspects of the NDE. These attributes have been reported throughout the world in both Western and nonWestern societies (Carr, 1998; Counts, 1985; Zhi-ying and Jian-xun, 1992; Gómez-Jeria, 1993; Murphy, 2001; Pasricha, 1992, 1993; Pasricha and Stevenson, 1988), and they appear to maintain a consistent structure and sequence. Most NDErs claim that their experience was spiritual in nature, and the pattern of reported attributes tends to support this viewpoint. These findings are in agreement with of those Noyes (1980), Bauer (1985), and Sutherland (1990).

Results of the NDE element inventory are in general accord with the findings of other studies. An early study conducted by Michael Sabom
(1982) reported a generally higher incidence of many NDE elements than those found in subsequent studies. In exception to this generalization, this study found a higher incidence of NDErs encountering a being of light (60 percent compared to 28 percent in Sabom's study), and undergoing a life review (11 percent compared to 3 percent in Sabom's study). The frequencies reported by Sabom have been followed by more conservative figures in recent decades (Zhi-ying and Jian-xun, 1992; van Lommel, van Wees, Meyers, and Elfferich, 2001). However, making comparisons among these studies is hazardous due to differences in the wording of questions, the intent and special circumstances of study, and various characteristics of the sample population being studied. Development of a standard set of elements with consistent wording would facilitate comparisons in the future.

The incidence of frightening NDEs was relatively low in the current study. Only three subjects reported NDEs that could be characterized as frightening. Moreover, these experiences did not conform to the classical definition of frightening NDEs described by Margot Grey (1985), but rather contained a mosaic of blissful and frightening elements. While distressing NDEs are relatively rare, they can produce intense stress, especially in children. In the case quoted above, the adverse effects lasted for several years (Bonenfant, 2001).

**Transformational Changes and Aftereffects**

Almost two-thirds of the NDErs in this study who responded to the question about sensory confusion reported experiencing the effect, defined as a fusion of two different modes of perception, such as feeling colors, tasting words, or smelling sounds. This effect is suggestive of synesthesia, a rare anomaly in sensory perception that has been extensively studied by Richard Cytowic (1989, 1993; Cytowic and Wood, 1982a, 1982b), and it corroborates the earlier report by Atwater (1988) of synesthesia as an aftereffect of NDEs. Synesthesia is not considered to represent a functional deficit and is considered to be an abnormality only because of its rarity. Cytowic (1989) estimated the incidence of synesthesia as about 1 in every 25,000 people in the general population (0.004 percent). Since the incidence of synesthesia is so low, even a single case in a sample of 33 NDErs would be suggestive, but finding that two-thirds of NDErs report some degree of sensory confusion is remarkable.

Sensory confusion was also reported by a smaller percentage of nonNDErs in this study, although among that group it did not appear to
be associated with duration of clinical death. The importance of these observations is limited by the fact that sensory confusion was ascertained only by self report of subjects and not verified by testing or medical records. Furthermore, the number of nonNDErs in this study was relatively small. Nevertheless, the possibility that longer clinical death events lead to sensory confusion could have neurological implications.

Two other findings are noteworthy. Spine tingling, a feeling of a strong electrical current running up and down the spine, was significantly more common in NDErs than in nonNDErs; in fact, more than three-quarters of NDErs in this study reported this effect to some degree. Spine tingling is a symptom commonly reported in association with arousal of kundalini, a form of spiritual energy believed to reside in the base of the spine and to rise from there through the chakras, eventually leading to a state of enlightenment. Greyson (1993b), Yvonne Kason (1994) and Gene Kieffer (1994) have previously reported a possible association between NDEs and kundalini symptoms. Current findings support the existence of such a relationship.

Another interesting finding was that NDErs reported that their transformational changes and aftereffects were long-lasting. The overwhelming majority – 90 percent – of the NDErs expressed the opinion that their NDE-related effects had either remained constant or increased over time, whereas only 5 percent felt that such changes had decreased. NDErs differed significantly from nonNDErs in this regard. These findings indicate that NDEs may provoke enduring neurophysiological states in addition to transformational changes in personality. Duration of effect may vary depending on the specific effect in question, or whether the effect is psychological, physiological, neurological, paranormal, or electromagnetic. Atwater (1994) reported that intuition and other psychic abilities tend to increase over time, especially if they are utilized. Further study will be required to delineate which effects are enduring. If these data are truly representative, NDE-related effects not only persist but tend to increase over time.

One of the main objectives of the current study was to determine whether nonNDErs undergo transformational changes and aftereffects. Data gathered in this investigation suggest that they do, but to a lesser extent than NDErs. These results suggest that both NDErs and nonNDErs who survive clinical death display attributes that have been heretofore regarded as being characteristic of only NDErs. Data collected in this study suggest that both differences and similarities exist among clinical death survivors with regards to transformational
changes and aftereffects. Approximately half of the measures examined were shared to some extent by both groups. This observation implies that the effects in question may arise from multiple agencies rather than solely from NDEs.

Effects that were reported commonly by both NDErs and nonNDErs included increased concern for others, reduction in materialistic ideology, renewed interest in learning, and a proclivity to believe in reincarnation. Surprisingly, nonNDErs also reported a high incidence of two electromagnetic effects: failure of wristwatches to keep accurate time and lights dimming or burning out when in close proximity to the survivors. NonNDErs also complained that their eyes were more sensitive to direct sunlight and fluorescent lighting following their clinical death event. If we assume that these effects would be rare among people who have not had clinical death events, then these findings indicate that nonNDErs appear to be transitional in expressing NDE-related effects between subjects who have not had death events and NDErs. If further testing can confirm these findings, it could be argued that some behavioral changes and aftereffects are discrete while others are continuous in nature.

Some changes in values shared by both groups of clinical death survivors may result simply from a newfound appreciation for the importance of life. Surviving a close encounter with death could well produce a re-evaluation of what is truly important in life, regardless of whether or not the survivor had an NDE. Other transformational changes were reported more vigorously by NDErs. As noted above, the majority of NDE elements reported were spiritual in nature. NDErs' confidence in the validity of their experiences could well account for benevolent changes in behavior that are based upon a belief in the soul, an afterlife, the existence of spiritual being, and the importance of unconditional love. Lacking a moving spiritual event, nonNDErs who express sentiments similar to NDErs may do so more from habituation or desire than from personal experience.

Atwater (1996) has proposed that both transformational changes and aftereffects result from an unspecified "brain shift" that occurs following an NDE. This hypothesis would imply that NDEs trigger the neurological effects that are reported by NDEs. However, the "brain shift" hypothesis does not account for the presence of aftereffects in death survivors who have not experienced NDEs. It is more likely that aftereffects have a different source of origin than transformational changes. Aftereffects may result from neurophysiological agencies that are initiated by the trauma of clinical death. For this hypothesis
to be valid, aftereffects should be expressed equally by both NDErs and nonNDErs. Data from this study suggest that nonNDErs do report many NDE-related aftereffects, but that the aftereffects are less robust among nonNDErs. Certain aftereffects, like sensory confusion and spine tingling, appear to be found predominantly in NDErs, while electromagnetic effects and ocular sensitivity are more equally distributed between the two groups. Unfortunately, the small sample size of nonNDErs in the current study limits further speculation.

Several researchers have proposed that neurophysiological agents are directly responsible for NDEs and other states of mystical consciousness (Jansen, 1990, 1997; Jourdan, 1994; Strassman, 2001). In the context of the current study, these same neurological agents may also share responsibility for some of the aftereffects associated with NDEs. Specifically, sensory confusion, spine tingling, and various electromagnetic effects may be brought about by subtle changes to existing neurological networks.

Other researchers have noted that NDEs share many phenomenological similarities with religious experiences (Perry, 1989) or mystical experiences (Pennachio, 1986). These varied experiences are all spiritual in nature, involve some degree of altered consciousness, refer to nonphysical realms of reality, enhance the experiencers' awareness, and produce long lasting changes in belief, attitude, and behavior. According to these researchers, certain stressful situations trigger an altered state of consciousness, which in turn facilitates interaction with nonphysical realms (Quimby, 1989).

This "gateway" hypothesis has the potential for accounting for a wider range of NDE-related effects than singular psychological, physiological, or neurological explanations. However, it also involves a greater number of unknowns. Even if viable neurological explanations are able to account for how altered states are invoked during periods of stress, the relationship of these states to paranormal effects and to the existence of nonphysical realms remains speculative. In support of the gateway hypothesis, recent advances in theoretical physics are redefining our concept of reality to integrate paranormal and physical anomalies into the framework of contemporary physics, invoking parallel universes and multidimensional space (Deutsch, 1997; Kaku, 1994; Pitkänen, 2001; Sarfatti, 1987; Talbot, 1991). It remains to be seen whether these new concepts will have a bearing on NDEs, but they do hold promise for reframing investigation of the phenomenon.
Limitations of the Study

A number of limitations are inherent in this study. Foremost is the underrepresentation of nonNDErs. Ideally, it would have been desirable to have equal representation in both groups of survivors. This deficiency was not anticipated and weakens the conclusions drawn about nonNDErs. A possible explanation for the lower number of nonNDErs is that this group of clinical death survivors assumed that they had little to contribute to the study because they lacked any recall of what transpired during their death crisis.

Another potential weakness in this study is that patients’ statements that they had not had NDEs were taken at face value. Because both the inventory checklist of NDE elements in the Death Event Questionnaire and the NDE Scale were administered only to those patients who reported NDEs, we cannot be certain that the nonNDE group excluded persons who did in fact have NDEs. In a recent study, 10 percent of clinical patients who identified themselves as nonNDErs actually did have NDEs as defined by the NDE Scale criterion (Greyson, in press).

Another drawback is that a single consistent methodology could not be applied to the collection of subject responses. Since the collection protocols varied by institution, a degree of variation emerged in the selection of subjects. In addition, staff at some institutions assisted patients in completed their questionnaires. This assistance may have inadvertently introduced some bias in the results. Furthermore, with the exception of cardiac patients from St. Peter’s Hospital, duration of death was not confirmed by documentation from medical records. This deficit weakens the conclusion of a relationship between duration of death and synesthesia.

The wording of questions was still another factor that could affected study results. Several clinical death survivors commented that the wording of some questions in could have been improved upon. For example, “Does your wristwatch run fast or slow?” was made difficult to answer because some clinical death survivors experienced difficulties with their wristwatches before their death events. A more accurate phrasing would have been, “Following your death event, did you observed that your wristwatch failed to keep accurate time (failed to operate, or ran either fast or slow)?” Though difficult to gauge, unclear wording could have had an adverse effect on the study results.

A final drawback was that this study did not include responses from individuals who have not had a clinical death event. In order to
validate the conclusion that nonNDEs are intermediate in the expression of some transformational changes measures and aftereffects, it is necessary to verify that these measures are least frequently experienced in those who have not had a death experience. Until verification can be obtained from this population, statements about the transitional nature of NDE-related effects in nonNDErs must be guarded.

**Conclusion**

The relationship between NDE status and subsequent behavioral changes and aftereffects appears to be both subtle and complex. Some psychological changes in belief and value that appear in both groups of death survivors may result simply from surviving a death event. Prolonged death events appear to produce a synesthesia-like symptom, sensory confusion, in both groups. This particular effect was found to be significantly associated with NDEs, but it was not absent in nonNDErs. Many NDE attributes continue to be explained best by the assumption that they are products of actual spiritual experiences. The lower incidence of the same attributes among nonNDErs may simply reflect a reinforcement of pre-existing values. Brain death, or some synchronic neurological process, may be responsible for spine-tingling and sensory hypersensitivity. Enhanced psychic abilities and electromagnetic effects are speculated to result from secondary neurological events that alter existing neurological networks. These aftereffects are expressed primarily in NDErs and could be products of neurological cascades associated with mental and/or physical stress. Reports by NDErs that these aftereffects are enduring and even increase over time would imply that causal agent has initiated long lasting neurological changes. It is doubtful that any single factor will be able to account for the wide range of effects that have been observed in NDErs. A better understanding of the phenomenon and its consequences await advances in 21st century neurobiology and physics.

**References**


The Deconstruction of Death: Postmodernism and Near-Death

Raymond L. M. Lee, Ph.D.
University of Malaya, Kuala Lumpur, Malaysia

ABSTRACT: The near-death experience (NDE) embodies a range of claims that challenges modern assumptions about the meaning of reality. Major publications on NDEs appeared between the 1970s and 1990s, converging with the debates on postmodernism. These debates turned modern reality on its head to offer alternative perceptions of space/time and subjectivity. By placing the discourse of the NDE within the context of postmodernism, we can address its significance as a deconstruction of the conventional view of death.

KEY WORDS: near-death experience, modernity, postmodernism, deconstruction.

A significant issue raised by Mark Fox (2003) in his insightful survey of the near-death experience (NDE) concerns how the occurrence and accounts of NDEs reflect changing patterns of belief in the West. Rather than “seeing them as windows affording us privileged peeks into our post-mortem destiny” (Fox, 2003, p. 353), NDEs could be construed as mirrors revealing the transformation of social beliefs. This line of inquiry does not address the reality of the afterlife as much as the way in which contemporary realities have been deconstructed to take on other meanings. It is not the claims of the near-death experiencers (NDErs) that are in question but the challenge of the claims to the principles on which contemporary realities are based. In other words, the NDE cannot be seen as occurring independently of the social context in which a crisis of representation has emerged.
The NDE was initially identified and discussed by Raymond Moody (1975, 1977). It has received public and academic attention continuously for almost 30 years. Many empirical and theoretical contributions to the study of the NDE have appeared during this period (Grey, 1984; Morse and Perry, 1990; Ring, 1980, 1984; Sabom, 1982, 1998; Valarino, 1997). This period also witnessed the emergence of three social trends that influenced the perception and interpretation of the NDE: the rise of the New Age movement within a context of reenchantment, the growth of death awareness, and the renewal of religious faith (Lee, 2003b). Concurrent with these trends was the debate on the plausibility of a paradigmatic shift to postmodernism. It was no mere coincidence that the discovery of the NDE occurred at the same time that modern representations of reality were challenged by the protagonists of postmodernism. Discourses on the NDE and postmodernism undermined the meaning of reality as conceived and practiced within the framework of modernity. Apparent glimpses into the afterlife by NDErs and postmodern deconstruction of *in situ* identities converged to suggest the possibility of realities other than the one posed by the mandate of modernity. In a radical sense, NDErs and postmodernists were unwitting allies in the effort to disassemble the ontological scaffolds of modern reality.

This article argues that the NDE should be considered not only a paranormal phenomenon but also an aspect of a broader movement to disengage from the limitations of modernity. The modern outlook is in effect an outlook of certainty determined by the hard-nosed empiricism of science and capitalist-driven technology. Postmodernism represents an attempt at disparaging the outlook of certainty by a discourse of decentering that overturns all assumptions of exactitude and fixity. It maintains a rebellious attitude that does not take for granted the foundation of modern truth. Decentering is the discursive means by which any foundational thought becomes a target of relentless analysis to disclose its fragmented nature. In short, postmodernism thrives on the crisis of foundational knowledge (Docherty, 1993).

Postmodernism is also closely associated with deconstruction, the analytical technique originally introduced by the French philosopher Jacques Derrida (1974, 1978) for probing the meaning of texts within texts. Deconstruction wrecks havoc on truth by demonstrating that truth is contingent on a variety of claims concealed from our eyes. It is in effect a spoiler of truth (Sarup, 1993). In that respect, the NDE can be conceived as a special instance of deconstructing the ramparts of modern existence by adumbrating the richness of postmortem
existence concealed by the apparent certitude of this life. By claiming to glimpse the afterlife, the NDEr is implicitly deconstructing the modern view of death as a nihilistic finale.

To facilitate this argument, it is first necessary to examine the meaning of death in modernity. Only by asking how death is perceived and experienced in modernity can we understand the significance of the NDE as an event that complements the emergence of postmodernism. The NDE in this sense is not just another out-of-body experience but a profound statement disparaging the nihilism of modernity.

Modernity and Death

In the film *The Sixth Sense* (Shyamalan, 1999), a murdered psychologist continues to exist in disembodied form without realizing that he no longer possesses a physical body. He exemplifies a modern professional whose very existence is rooted in his grasp of reality in the here and now. Even after a deranged patient shoots him dead, he has no immediate conception of his death. He wanders around imagining he is still alive. Only a psychically gifted child can see and talk to him. Even the child does not realize the psychologist is dead. Their relationship comes to assume a therapeutic routine as though it is transacted in the world of the living. Only at the conclusion of the film does the dead man awaken to the meaning of his mortality. This film provides the ultimate statement on the modern alienation of death. It suggests that modernity is a condition that produces a numbing effect on death consciousness: the dead cannot come to terms with their own demise. What is it about modernity that has produced a consciousness that nullifies death? To answer this question, we need to consider briefly pre-modern notions of death and their transformation in modernity.

In reviewing anthropological writings on death, John Hick (1976) surmised that pre-modern peoples believed in something insubstantial that survived bodily death. This was termed *ghostly survival*, a type of postmortem existence that threatened the living and needed ritual response as symbolic appeasement. To quote Hick:

> Thus the primitive mind was not conscious of a general liability to death such as is expressed by the proposition that all men are mortal. Death was thought of as being due to particular and contingent causes; people did not just die but were killed. Such a view of death in primitive society is not however at all astonishing, since it must so
largely have corresponded with the facts; for it has been estimated that prehistoric man's average life-span was only about eighteen years, death being usually due to violent causes. (1976, p. 57)

The primitive conception of death was one of continuity into the next life characterized by more or less the same inequalities experienced before death. Citing the work of Edward Tylor (1903), Hick concluded that primitive beliefs in the afterlife were not influenced by the hope in compensation or reward. There existed a sense of immortality but it was regarded neither as positive nor desirable.

However, the belief in a desirable afterlife was also evident in pre-modern times, particularly in ancient Egypt, Vedic India, and classical Greece. In those societies, such a belief arose with the "emergence of individual self-consciousness and as a correlate of faith in a higher reality" (Hick, 1976, p. 73). The quest for a better incarnation or reunification with the divine was possible because the idea of a soul surviving death took on the quality of an inner self that possessed moral consciousness. The application of this consciousness to an already existing belief in the afterlife became the condition for envisaging the possibilities of spiritual enhancement after death.

From this brief review, we can see that in pre-modern times there was already a dynamic transition from mere belief in the afterlife to active search for a better afterlife. Fear of death in primitive times, which Hick (1976) addressed as a reaction to an absence of desired immortality, did not disappear but became attenuated because the growth of moral consciousness raised hopes of liberation or escape from suffering. Later developments in pre-modern times invested people with the idea that personal conduct determined individual destiny. One might fear death but possessed the opportunity to rectify earthly existence through moral actions in order to sublimate fear into a higher identity.

Fear of death was not repressed in pre-modern times because of strong beliefs in the afterlife and the overt concern with one's destiny after death. But to meet this fear necessitated the development of a philosophy that anticipated the ascension of being beyond the pains of earthly life. Thus, Plato in *The Republic* (2000/4th century B.C.) and *Phaedo* (1993/4th century B.C.) argued for a fuller existence in a transcendent realm after death. Fear and grief would not affect those who saw death as the ultimate liberation from the bonds of this life. Similarly, in the *Upanishads* (Radhakrishnan, 1969) that formed the concluding portion of the Indian Vedas, the philosophy of the true or transcendent self (*atman*) provided a view of death as a path to divine
union. Such philosophy brought relief to those who did not equate the ego with the self that "is immortal, self-luminous, self-proved and beyond doubts and denials" (Sharma, 1987, p. 21). Death of the ego as a finite entity would not be feared since the transcendent self is never affected by this event.

These philosophical teachings of the pre-modern era exemplified the type of rational confrontation with death that produced panaceas for the fear of death. The afterlife, as a widely accepted belief, was not represented at all as a continuation of mundane existence but as more real and more illuminating than this life. There was no fear of death for those who were philosophically and morally prepared to face death as entry into an afterlife of higher knowledge.

In the modern era, however, the plausibility of the afterlife has receded. Despite the persistence of this idea in religious teachings that have come down to us in modern times, the organization of attitudes and behavior in response to afterlife existence is tenuous. Indeed, the fear of death in modernity has not abated but neither has the cavalier reception of the afterlife. One reason for this skepticism toward the meaning of the afterlife has to do with the predominance of the ego concept. Despite being treated as something finite and enclosed, the ego has come to increase its scope of influence by becoming a knowledge seeking entity destined to understand and master the vicissitudes of this world. The ego overshadowed the transcendent self to assume an exclusive position for dealing with the complexities of this world. As the ego came into its own as the modern self, the transcendent self took on a mythic quality that relegated it to an understated position outside the sphere of empirical reality. Its redemptive value fell and with it the notion of the afterlife became irrelevant. Hence, the modern fear of death is not explicitly concerned with consequences in the afterlife. Rather, it has to do with the termination of the ego and along with it the aspiration to world mastery.

The work of Sigmund Freud on death illustrates the length to which modern thinkers have gone to repress the notion of the afterlife. In positing the concept of the death instinct, Freud (1975) juxtaposed it to the sex instinct that underlay the will to life and survival. The death instinct negated the sex instinct by inculcating in the organism a striving toward a return to inanimate status. Freud's idea of the death instinct was marked by pessimism that resulted in a failed attention to the question of human consciousness in the death process (Clack, 2002). His focus on death as a return to inanimate existence
suggests the total absence of thought given to the meaning of the afterlife. People and living things just died without any trace of consciousness remaining. Upon perishing the ego became lifeless like a doornail, rendering it needless to argue for the possibility of continued existence in the afterlife.

Thus, the modern fear of death is rooted in the embellishment of what Hick (1976, p. 52) called *individual egoity*. The modern self is this ego placed on a pedestal of world mastery, concentrating its energy on the here and now as the definite course to knowledge and control. Distance arises between world mastery and death to produce an attitude that disenchants the self from the belief of existence after death. The disenchanted self finds affinity with the nihilism of death, the very source of its fear of death (Lee, 2002).

The modern conditions of dying have also contributed to a nihilistic attitude that gives no credence to the notion of the afterlife. The impersonal nature of dying in modern institutional settings accentuates the loneliness of exiting the world without any consideration of the person's state of mind or the possibility of its survival after death (Elias, 1985; Kübler-Ross, 1969; Sudnow, 1967). Under these conditions, death becomes a commodity to be processed by bureaucrats, doctors, and undertakers. There is no latitude in this process for taking into account the meaning of a person's consciousness at death. Medical and bureaucratic routines are enacted to ensure an unproblematic transition from the deathbed to the cemetery. Death rituals are performed to fulfill the customary process of bereavement but not necessarily for the enhancement of death consciousness.

Yet within this modern approach to death and dying, it is advanced medical technology that has made possible the resuscitation of patients some of whom were discovered to be NDErs. Indeed, the NDE as a return-from-death discourse can be construed as an unanticipated outcome of modern medical developments intended to save and prolong lives. The NDE itself is paradoxically a denial of what modern medicine cannot do: to raise the consciousness of the dead. But the modern context in which the NDE became known is not particularly receptive to the ironies of technological advancement in medicine. It has not facilitated a full acceptance of such technology to be a means for reaching beyond the limits of this life. If modern medicine is concerned mainly with saving and preserving lives in the here and now, which implies delaying death, then the NDE is merely considered a sideshow occurring on the margins of modernity. It can then be dismissed with impunity as a “curious matter” or “another
instance of American millennial hysteria" (Bloom, 1996, pp. 32 and 135).

If death has replaced sex as a modern taboo, then the NDE has yet to be unambiguously regarded as providing new insights into the meaning of death and the afterlife. On the contrary, the NDE has become more vulnerable to modern debunkers intent on addressing the phenomenon as part of what Carol Zaleski (1987) described as the image-making and image-bound character of human beings. But when placed in the context of postmodernism, another dimension of the NDE is revealed. The NDE takes on a deconstructive image that challenges the meaning of death in modernity. It becomes the mirror for reflecting the anxiety of death in modernity.

From Denial to Deconstruction

The crux of modernity lies in the quest for world production. The modern meaning of the world is generated through the drive to create and preserve as actions that empower the unfolding of world mastery. Loss of life, whether intentional or not, exemplifies loss of creativity and, therefore, contradicts the means by which the world is produced and reproduced. For that reason, death in modernity is treated as the end of life, the termination of production. A gulf exists between death and modern concepts centered on life as production. Only by denying death can modern individuals pursue their quest for world mastery.

However, postmodernism as a disputation of the foundations of modernity can be construed as a means for deconstructing the denial of death (Lee, 2003a). Since deconstruction is a method of reading texts by breaking up texts, its application to the question of death entails an attempt in dismantling the assumption that death is the reversal of production. In other words, is death a mere fading from life and a descent into oblivion? To take dying as a form of disappearance is not unreasonable, but on further reflection we can see that such an assumption is both simplistic and nihilistic. If birth as the entrance to life is fraught with complexities, death as the opposite must surely be a less than straightforward process of leaving the world. The interaction of physiological, psychological and social conditions underlying birth suggests that each person's identity reflects the multiple levels of experience that determine his or her emergent path of consciousness in the world. When this path of consciousness exits the world, it is no less complicated than its coming into being.
at birth. Thus, dying cannot simply be a collapse of consciousness into nothingness because such nihilism cannot account for the emergence of identity in the first place.

If dying does not necessarily imply an absolute loss of identity but its transformation, the next question to ask is how can we understand the process by which this transformation takes place? Philosophically, we can inspect the condition of being at death. Being means consciousness coming into its own to form a particular identity. Being a person means maintaining a particular identity, but not necessarily one bounded only by physical characteristics. These characteristics may only provide a putative identification of personhood, but are not the central source of that identification. Thus, physical breakdown at death would only suggest the unraveling of the physical components of personhood. If personhood is more than the sum of its physical parts, then physical death cannot be equivalent to the termination of being. Put another way, the composition of an individual's identity is not based exclusively on his or her physical makeup. Is the arm, leg, hand, heart, liver, or some other organ the source of a person's being? If so, then when these physical attributes wither, what happens to being?

We can imagine being as unaffected by the same decay that afflicts the physical body, its mutability untouched by the death of physical form. Being is its own power for transforming. But since the advent of Cartesian dualism, the separation of mind and body has generated attitudes that belittle the question of how being transforms at death. When the relation between mind and body is treated as inconceivable, bodily decay at death implies that we cannot say anything about how it affects the state of mind. Similarly, even if the mind or consciousness remains intact at death, we are in no position to speculate on its transformation based on a withdrawal of physical action. In other words, the perceived spuriousness of mind-body relationship has limited our understanding of consciousness and being in the post-physical state.

The discourse on the NDE offers another approach to the question of identity transformation at death. The NDE deconstructs the modern assumption of life as world production by identifying death as another level of world production. But the post-physical level of world production is framed within other notions of reality that parallel those found in postmodernism. In postmodernism, the alteration of reality due to the spatialization of time deconstructs the meaning of progress as the inevitable unfolding of linear time (Harvey, 1989). When space is experienced as a sphere of action devoid of the pressure of time,
a new kind of freedom is imagined to be possible. Such new freedom has been described by some NDErs. Under these new conditions of reality, the self is no longer perceived as constricted by or limited to its given identity. The NDE seems to provide an opportunity for the deconstruction of subjectivity not unlike that found in postmodernism. By exploring these two themes of space/time compression and altered subjectivity, we will see how the NDE converges with postmodernism.

**Near-Death and Space/Time Compression**

In modernity, space is dominated by time. This leads to the experience of progress, the occupation of space, and the cultivation of its elements against the linear movement of time. Consequently, the perception of space cannot be rendered meaningful unless coupled to the unfolding of time. Time is the fulcrum for the logical interpretation of all historical movement, as space is annihilated by the past, consumed in the present, and symbolized for the future. In modernity, the value of space cannot be considered until it is subjected to the ravages of time. For instance, property values are dependent on the nature and treatment of the area before its present development and for future speculative purposes.

In postmodernism, it is the spatialization of time that leads to a kind of space/time compression, for which there is no clear sense of boundaries to demarcate the movement of time. This does not imply that time has been obliterated, but that we seem to live in an "eternal present" marked by ephemerality, speed, and volatility. There is an exaggerated sense of mobility, in which being here and there has more to do with the lack of a center than with the clock ticking away. Time is no longer the principal determinant of identity. The feeling of who we are is subsumed by the objects of pleasure and displeasure circulating with no regard to spatial barriers. In other words, we can easily find ourselves "swept up in a series of events and political shifts which [have] no obvious boundaries" (Harvey, 1989, p. 262). It is the sense of adriftness that defines how we relate to the world.

How does the postmodern space/time compression relate to the NDE? Although the NDE and postmodernism are not causally related, both share a ground of experience that challenges the modern meaning of space and time. The deconstruction of the linear conception of space/time constitutes one aspect of this challenge. George
Ritchie clearly described the deconstructive experiences with space/time compression in his book *Return from Tomorrow* (Ritchie and Sherrill, 1978). Ritchie, a psychiatrist, gave a detailed account of his NDE that occurred in 1943 when he was clinically dead for nine minutes. At the time of his NDE, he was a 20-year-old recruit in Texas. He had fallen ill with a very high temperature and was being transported to the ward at the army camp when he fell unconscious. When he awoke he did not realize that he had “left” his body. All he could think of at that moment was he had missed the train to Richmond and had to find a way to get there. Instantly, he found himself speeding along toward his destination in an unexplained way. As he put it:

Almost without knowing it I found myself outside, racing swiftly along, traveling faster in fact than I’d ever moved in my life. . . .

Looking down I was astonished to see not the ground, but the tops of mesquite bushes beneath me. Already Camp Barkeley seemed to be far behind me as I sped over the dark frozen desert. My mind kept telling me that what I was doing was impossible, and yet . . . it was happening.

A town flashed by beneath me, caution lights blinking at the intersections. This was ridiculous! A human being couldn’t fly without an airplane—anyhow I was traveling too low for a plane. . . .

I was going to Richmond; somehow I had known that from the moment I burst through that hospital door. Going to Richmond a hundred times faster than any train on earth could take me. (Ritchie and Sherrill, 1978, pp. 38–39)

Ritchie was incredulous that his thought of movement was movement itself, blending time and space without the domination of one over the other. There was no counting of seconds or minutes as he felt himself covering vast stretches of space just by the thought of going to Richmond. Later, when he realized that he was no longer in the body, he turned back toward Camp Barkeley to “look” for his body. While searching for the room where his body lay, he wandered into the x-ray department, where he saw the technician, who was the last person he had spoken to. He tried to signal him, but to no avail. Ritchie wrote:

Was it only a few hours ago that I had been carried into this room on a stretcher? Surely that was weeks ago. Years ago. Or . . . was it only minutes? Something was strange about time, too, in this world where rules about space and speed and solid mass were all suspended. I had lost all sense of whether an experience was taking a split second, or whether it was lasting for hours. (Ritchie and Sherrill, 1978, p. 45)
Ritchie was trying to figure out the experience of space/time compression in his NDE, something that he had never encountered before in his ordinary life. The familiar sense of time moving in linear sequence along with the occupation of space in a logical manner was replaced by a completely unusual experience of time and space undifferentiated from each other. He experienced again the fusion of time and space when he saw a replay of his entire life. This occurred after he "found" his body in a small room, where he also encountered a being of light. In his words:

For into that room along with [the Being's] radiant presence ... had also entered every single episode of my entire life. Everything that had ever happened to me was simply there, in full view, contemporary and current, all seemingly taking place at that moment.

How this was possible I didn't know. I had never before experienced the kind of space we seemed to be in. The little one-bed room was still visible, but it no longer confined us. Instead, on all sides of us was what I could only think of as a kind of enormous mural - except that the figures on it were three dimensional, moving and speaking.

There were other scenes, hundreds, thousands, all illuminated by that searing Light, in an existence where time seemed to have ceased. It would have taken weeks of ordinary time even to glance at so many events, and yet I had no sense of minutes passing. (Ritchie and Sherrill, 1978, pp. 49-51)

Ritchie's description of the space/time compression in his NDE is also evident in the experiences of other NDErs (Ring, 1984, pp. 37, 57, and 75-77). This corpus of experiences with space/time compression does not necessarily imply that there is something postmodern about the NDE. Rather, it is the experiential deconstruction of space and time in the NDE that authenticates the postmodern concern with the fragility of our normal perception of space and time.

The space/time compression in postmodernism is experienced partly as a function of rapid technological developments in communications that transcend boundaries around the world. The increased speed of communications tends to reduce the distinction between space and time to the extent that we are beginning to take for granted the minimization of time by space. Great distances pose no barriers to contemporary communication that seems to consume time. But the collapsibility of space and time in the NDE is generally not taken for granted, since NDEs are not daily occurrences, unlike the effects of communications technology. Thus, space/time compression in the NDE is more potent, in the sense that deconstruction is not mediated by any technological means. The NDEr is directly sensitized to the
arbitrariness of the space/time relationship that in postmodernism is likely to be a post hoc critique of reality.

Near-Death and Subjectivity

The modern subject is one who speaks with a definitive voice, a rational being who determines empirical truth from the viewpoint of the ego. Self-identity is the identity of this ego rooted to the Cartesian cogito, ergo sum ("I think, therefore I am") from which has also arisen the sense of an integrated self. The world is therefore encountered and made known from the perspective of this integrated self (Giddens, 1991; Taylor, 1989). Postmodernism takes a critical stab at the notion of the integrated self. It does this by disparaging the subject as the central reference of all thoughts and actions. Basically, the subject becomes decentered to lose its sense of integrated self-presence.

Deconstruction makes "it impossible for [the] subject to refer to itself in any consistent way," thus "the subject is doomed to perpetual exile from itself" (Lovlie, 1992, p. 124). Subjectivity without a center does not necessarily spell the annihilation of the self, but provides an alternative sense of being that is relative. It means that the hubris of the Cartesian cogito, ergo sum is replaced by a playfulness of changeable roles, each role without the integrated self-presence so vital to the maintenance of modern subjectivity. In practice, the postmodern critique of the subject suggests the transformability of all roles without an obsessive clinging to a fixed identity. As Lovlie put it, "The [postmodern] self is this proliferation of roles, the progressive showing of (sur)faces" (1992, p. 125).

In what way is the decentered subjectivity of postmodernism related to the NDE? Certainly, the NDE itself does not constitute an experience of self-annihilation. Most NDErs are conscious of their own identities as they navigate the nonphysical dimension. They are able to relate to deceased relatives and friends allegedly existing on the "other side," thus suggesting that the NDE does not obliterate self-identities in relation to the presence of significant others. NDErs generally do not lose their sense of subjectivity. On the contrary, they tend to report an increased sense of focus and well being. But their identities undergo a transformation that produces a level of perceiving without ego attachment. Russell Noyes and Roy Kletti (1976) referred to such experiences as depersonalization, a syndrome in which individuals seemed to become distanced from their own subjectivity.
In one of their examples concerning a young woman who attempted suicide, they clearly described the experience of equanimity alongside a sense of removal from a fixed identity:

I would be filled with the wisdom of things I'd wondered about but would *be myself no longer*. I would diffuse, burst apart. ... My experiences were close to being in no time at all, almost as though time were at a standstill. ... My strength was centered but scattered. I was stronger because of being more whole, because *I was no longer me* as I had once known myself. I had a feeling of becoming part of a greater whole. ... It was a *loss of identity*, and not a feeling I could relate to the realm of human experience. (Noyes and Kletti, 1976, p. 22, italics added)

This case is not about the fleeting nature of roles addressed by postmodernism, but it accentuates the meaning of decentered subjectivity at the point of death that closely resembles an NDE. The apparent self-fragmentation described by the subject is not unlike the deconstructive approach in postmodernism toward the concept of the integrated self. Her “loss of identity” exemplifies a falling away of a fictitious center to reveal a fluidity of being. Deconstruction of the integrated self facilitates an experience of detachment that eliminates perception on the level of the ego.

In the same article, Noyes and Kletti described a majority of their subjects who survived moments of extreme danger as having a sense of detachment. They quoted a mountain climber who fell 30 feet as saying, “It is difficult to describe the odd third-person viewpoint I seemed to have during the fall” (1976, p. 24). In other words, the experience of detachment allows observations to be made from outside, rather than from within the body. It resembles an out-of-body perspective that has been described by many NDErs. These accounts can be found in the major works on NDEs cited earlier.

The experience of detachment is deconstructive in the sense that a person is able to look at the world without ego involvement and to make observations devoid of the subjectivity found necessary in everyday behavior and relationships. It is as though a person becomes an outsider to his or her own actions without incurring value judgments on his or her observations. Since the perspective of the ego is absent, it is possible for all observations to be taken as objective components of a larger narrative rather than subjective events intrinsic to one’s life. The life review process reported by many NDErs could be construed as an episode of deconstruction in which a person’s entire life can be viewed with total detachment.
The decentered subjectivity of an NDE, whether it is considered depersonalization or detachment, has never been described as an effect of postmodernism. Yet, the "loss of identity" in an NDE, as in Noyes and Kletti's case of the attempted suicide mentioned above, approximates the way first-person subjectivity has been disprivileged in postmodernism. It is, therefore, not unreasonable to suggest that the decentered subjectivity of an NDE is an experiential analog of literal deconstruction in postmodernism. What a NDEr expresses as the surreal estrangement of the self, an advocate of postmodernism adumbrates as the absence of unqualified self-presence in textual analysis.

Conclusion

The NDE not only addresses the meaning of death and the afterlife, but also implicitly provides a critique of modern reality through the experiences of space/time compression and decentered subjectivity. However, postmodernism is an intellectual movement representing the conjunction of critical thought from various fields such as art, architecture, philosophy, linguistics, and sociology. It seems to be a provocative paradigm that challenges the assumptions of modernity and has nothing to do with the concerns of death and dying. Yet by inferring parallels between the two, we come to see that there is an intricate relationship between them.

This relationship can be examined as a link between two orders of deconstruction. The NDE represents a first-order deconstruction, since experiences of space/time compression and decentered subjectivity are direct, immediate, and unmediated. Although NDErs are not by definition critics of modern reality, their experiences may put them in a position where they no longer take this reality as a given. For many of them, direct realization through the NDE of transcendent realms constitutes a transformative encounter with a greater reality that surpasses modern existence. On the other hand, postmodernism disputes the truth of modern reality through abstract discussion of the rules underlying normative behavior and perception. Because of its analytical approach to the meaning of reality, postmodernism actualizes a second-order deconstruction that is removed from the experiential mode of encountering phenomena. It treats space/time compression and decentered subjectivity as conceptual problems to be understood as alternatives to the meaning of linear space/time and ego-centered subjectivity.
Yet, both orders of deconstruction are complementary. Without postmodernism as signaling the limits of modern reality, the NDE would likely be considered another anomalous spectacle consigned to the wastebaskets of science. This is not to say that postmodernism is indispensable to the plausibility of the NDE as an insight into transcendent realities. Rather, postmodernism as a second-order deconstruction of modernity provides a mirror image for the NDER’s first-order deconstruction of the mundane world. In that respect, both the NDE and postmodernism address the need to reconsider the question of death as an inquiry into the ramparts of modern existence that prevent us from accessing alternative realities.

References


Silent Journey: The Discovery of the Near-Death Experience of a Nonverbal Adolescent

Rick Enright, B.A., M.S.W., RSW
Thames Valley Children's Center, London, Ontario

ABSTRACT: This article relates the story of a boy who had a near-death experience at the age of 8, but who, because brain trauma left him quadriplegic and nonverbal, was unable to talk about his experience until I discovered it serendipitously 6 years later. Being able to tell his story and have his experience validated brought about significant changes in his emotional state, helped return personal control over his life, and ultimately led to his peaceful and fulfilling death.

KEY WORDS: near-death experience, children, nonverbal communication.

Near-death experiences (NDEs) have been reported to occur frequently in children (Morse and Perry, 1990). The effects of NDEs on children have also been reported to be significant and long-lasting (Morse and Perry, 1992). Reports of NDEs among people who are nonverbal are quite rare, for obvious reasons (Serdahely and Walker, 1990). The following account is of the serendipitous discovery of an NDE experienced by a child who became nonverbal as a result of his near-death event. The consequences of this experience changed both his life and, ultimately, his death.
David’s Background

David was diagnosed with cystic fibrosis at the age of 3 months. While many patients with cystic fibrosis have benefited from improved drug therapy and now live well into adulthood, David’s disease had a very rapid progression. By the age of 5 years, he had advanced cirrhosis of the liver. At the age of 8, he was in liver failure and his family was given the option of almost certain death or a liver transplant. When a donor became available, they agreed to the surgery.

At around 22 hours after the surgery, David developed cerebral edema; his brain underwent massive swelling and the pressure resulted in what appeared to be an irreversible coma. The prognosis was grave and his family was told that he was virtually brain-dead. His vital signs were maintained, however, and after many days in a pediatric critical care unit, he began to recover spontaneously from his coma.

His physical state after recovery was drastically different from that before his surgery. Although the transplant had been successful and his new liver was working well, the damage to David’s brain was massive. He had quadriplegia, with no useful function of arms or legs. He had lost the ability to speak. He aspirated anything he tried to swallow, and so was tube fed. He needed intermittent suctioning and ventilation. He was classified as medically fragile, so when he eventually went home it was with the maximum home-nursing support available.

The nonphysical impact of his brain damage was equally devastating. David had been an excellent student. He was an intelligent, good-natured, and extremely sensitive boy, with the advanced maturity observed frequently in children with chronic illness or disability. His mother told me that before his surgery, she had heard him crying alone in his room one day. When asked what was wrong, he replied that he was sad because he was never going to be a father and that was something he really wanted to be. Sterility is a very common symptom of cystic fibrosis, so he was probably correct. Yet, how many 8-year-old children would know that, or shed tears over the potential loss of future parenthood?

David may also have had a premonition about his future. His parents had discussed with him the known risks of the choices available to them. The surgical risks included outright transplant failure, eventual rejection of the liver, or death due to complications.
David, who by this time was visibly ill from his liver disease, said to his mother that he did not want to look worse than he already did. This was not an option that anyone had suggested, but it was precisely the outcome of his physical state after the coma.

My Initial Work With David

I first met David in the autumn of 1989, about 2 years after his transplant. He was then 10 years old. David was a student in the special school program of the pediatric rehabilitation center where I work. He was unquestionably the most disabled child in the group. He was totally physically dependent upon caregivers for all his daily needs. He had a manual wheelchair, since he had no reliable means of controlling a power chair. He was nonverbal. To communicate, he used head switches attached to a voice generator (Keenan and Barnhart, 1993). The right switch activated the word “yes” and the left switch activated “no.” The switches did not always function on cue, either due to mechanical problems or, more often, because David did not have enough control to make contact with them accurately. Over time, we relied less on the switches and more on eye-gaze direction: “yes” was gazing toward the right, “no” was gazing toward the left. He also used an eye-gaze coding system attached to the tray of his wheelchair for some common words and phrases.

David was moody, with sudden emotional swings being common. On good days, he had a wonderful sense of humor and enjoyed such activities as reading and art. However, there were frequent occasions when he would refuse to take any active role in lessons and he would often whimper or sob uncontrollably. At times he even had to be separated from the other members of the class because his distress was distressing to others. At other times, he could be cajoled into participation by telling him jokes. Generally he was quite passive, and over time his academic performance declined. Early on, there had been plans for some technological devices to assist with his communication. The use of a page-turner was considered so he could have the opportunity to read independently. He was also to be assessed for computer access or an electronic voice production system. Unfortunately, his attention span, his low frustration tolerance, and his frequent depressed moods sabotaged all efforts to make him more independent. Eventually, his vision deteriorated to the point where he
could no longer use an eye-gaze system, and he was left with only his head turn to respond "yes" or "no."

During this time, my direct interventions with David were brief and superficial. He was a very physically and emotionally complex child and the stress on his regular caregivers was significant. I had no known means at my disposal to do any direct work with him, in addition to having no idea what, if anything, he wanted to do. I did, however, do intermittent supportive counseling with his mother, who was his primary caregiver. She was an extremely competent case manager and advocate, but she was dogged by emotional and physical exhaustion, systemic resistance and inertia, and a chronic battle for services.

In 1991, at the age of 12, David left the school in the treatment center and transferred to a special classroom in a local public school. I maintained contact with the family and the school, but did very little direct intervention with him.

This situation changed in the autumn of 1993 when David again came back into regular contact with me. Now 14, he transferred from his elementary school to a high school program in the city for students with physical disabilities. My colleagues and I had started a weekly support group the previous school year. It was facilitated by a multidisciplinary staff team consisting of a social worker, physiotherapist, occupational therapist, and speech language pathologist. When David arrived at this school he joined the group. There were up to 10 members in this group, ranging in age from 14 to 21 years. They had a variety of disabilities, including cerebral palsy, spina bifida, muscular dystrophy, and other mobility disorders. Most of them were full-time wheelchair users. Four of them had significant communication disorders.

In the previous year, I had made the observation that most of the members of this group had a very limited level of knowledge about themselves and their specific disabilities. Initially, this had caught me by surprise. Most of these young people had had long and intimate associations with doctors in our clinics, with hospital procedures, and with other services that dealt with their needs, including mobility, communication, and a variety of social and educational support systems. However, when asked about the specifics of their condition, most of them had considerable difficulty providing appropriate answers. For example, many of them had bladder or bowel continence problems, which required special toileting procedures or schedules, as well as attendant care. So I asked them during one group, as an exercise in developing independent skills, to imagine that I was a new
teacher or employer who needed to know what their special needs were. Could they tell me some basic information about their disability, its implications, and any special procedures that I should know about? None of the group members could do so in any detail. Other than their basic diagnosis, they could not tell me the specifics of their condition, how they differed from others in the group, what were the symptoms they had to watch for in themselves, or why they had specific needs such as catheterization. I was appalled by this discovery and decided to take steps in the next school year to begin to educate them about themselves and their disabilities.

Shortly after David became a member of the group, over the course of several weeks we discussed different diagnoses in the group. We talked about the similarities, differences, possible causes, range of severity, and long-term implications of specific symptoms such as urinary tract infections, shunt blockage, medications, seizures, and other questions they raised themselves. After David agreed to this process, the group discussed his condition in terms of his two separate conditions: first his cystic fibrosis, and next his quadriplegia. I explained to the group that David had acquired symptoms similar to cerebral palsy as a result of brain damage after his surgery.

David's Near-Death Experience

David’s mother called me the next day and reported that he had come home from school very agitated. With much questioning, she had learned from him that he was upset or excited about the group that day and he wanted to talk with me individually as soon as possible. As soon as I was able, David and I met privately at school. With the starting point supplied to me by his mother, there seemed to be some very obvious questions I could ask. In the following word for word transcript, as close as my memory can approximate, his responses appear in italics:

David, do you want to talk about your disability some more? Yes.
Do you want to talk about your cystic fibrosis? No.
Do you want to talk about your liver transplant? Yes.
Do you want to talk about the time before your surgery? No.
Do you want to talk about the time after your surgery? No.
You want to talk about during the surgery? Yes.
Okay, tell me where you were. Were you in the operating room? No.
Were you in the recovery room? No.
Were you somewhere else in the hospital? No.
Were you outside? No.
At this point, I was starting to run out of logical alternatives, so I started to back-track in case I had missed something. I asked him, "Are we talking about the right thing?" He said, "Yes." I then asked if I was asking the right kind of questions. He said, "Yes," again, very emphatically. So I continued:

Were you on a bed? No.
Were you lying down? No.
Were you standing up? No.
Were you in a chair? No.
Were you on the floor? No.
Were you in the air? Yes.

I had asked this last question in a mixture of frustration and desperation, without the slightest expectation of what he would answer. The answer left me quite unprepared. My next line of questioning was to find out where he was or what he could see:

David, could you see something from the air? Yes.
Did you see equipment? No.
Did you see people? Yes.
Who could you see? Doctors? No.
Nurses? No.
Family? Yes.
All of them? No.
Your mom? No.
Dad? No.
Brother? Yes.
Grandmother? Yes.
Were they together? Yes.
Were they visiting you? No.
Were they talking? Yes.
Did you know what they were talking about? No.
Did they see you? No.

At several points during this narrative, David became visibly upset. When I asked about this, he assured me that he wanted to continue. I also checked several times to make sure that I was asking the appropriate questions, and he agreed that I was. He did not want me to stop. When our time was up, I attempted to summarize our discussion and give him some validation of his experience. I told him that I believed he had had an out-of-body-experience, that people in medical crisis reported such experiences frequently, and that he was not crazy. At this, he began to cry.

I called his mother later that day, and told her about this session. She was very surprised when I told her that David had seen his brother and
grandmother. During the period immediately after his surgery, they had not been to the hospital, but had remained at home. If David had seen them, he had to have left the hospital to do it. I told her of my suspicion that David had an out-of-body experience. I also asked for, and got, her permission to continue talking to David.

When we met for our next session, I reviewed the first interview with David. He was very eager to continue our discussion. He confirmed all our findings with no changes. He gave an enthusiastic “Yes” when I asked if he wanted to continue. Using the same slow yes/no question format, he explained that he next went someplace that was dark and empty. It was during this session that I suggested to David my belief that he had undergone a near-death experience. Without telling him the details of NDEs, I told him that I had done some reading about them, and that there were now thousands of case reports of people who had seen things similar to what he was reporting. I assured him that he was sane, that the experience was very real to him and others, and that if he wanted we would discover as much of his story as we could.

Over the course of the next several months, we continued to add details to what could reasonably be called a full-fledged, clinical near-death experience. This discovery had extraordinary significance for David. We met weekly to continue the process. I began our sessions by asking him if he had more to tell me. If he said “Yes,” then I would review briefly our last session and ask if there were mistakes. We would then carry on from there, using past context as the clue for where to go next. This process was frequently interrupted by blind alleys, wrong assumptions, and bad guesses on my part. When we seemed to be into a new area, I would stop every few minutes to ask him if I was asking the right questions. We gradually accumulated the following narrative:

After observing the conversation with his grandmother and brother, and his sense of a dark space, he then experienced moving through a long, dark passage toward a light. In the light he met beings who were familiar to him, although he could not name them and they were not people he knew here. They communicated with each other without talking. Although he felt as though he knew them, he was anxious and missed his family. At about this point, he was accompanied by a male figure who took him on a “guided tour.” David described seeing fragments from both his past and his future. He was then either told or persuaded that he should return to his body. He had rather mixed emotions to this advice, wanting both to stay and to return to his family. His next memory was of gradually regaining awareness in the
pediatric critical care ward, where he remained for many weeks until he was stable enough to be discharged home.

Aftereffects of David's Experience and Our Discussions of It

David's dominant feelings after returning to his body were frustration and anger about the circumstances to which he had returned. Prior to his surgery, he had expressed his fear to his mother that something awful was going to happen to him. He had been assured that everything was going to be fine. When he discovered that his negative premonition had been accurate, he was devastated. He had gone from being a curious, highly sociable boy to a state of extreme intellectual and social isolation, and total dependence on others for his care.

This was a very emotional process for David. During our first few weeks of work, he would frequently break into tears. Whenever I explored this, it was always a mixture of relief and frustration. He was greatly relieved finally to be able to tell this story, but frustrated by the limitations of the process, as was I. Gradually, his emotional vulnerability began to give way to a sort of philosophical sense of irony. We would hit dead ends where I could not find the right question to ask, and just agree to try again another day. He began to cry less, and laugh more. Initially he indicated he had been quite frightened by his experience.

The major factor here seemed to be the accumulated result of living absolutely alone with his memories of this experience with no way to share it and, more importantly, no way to be assured that what he saw was real. He was 8 years old at the time of his surgery and had no exposure to, or knowledge of, near-death phenomena. Although his experiences during the NDE had been pleasant, his interpretation of them was very confused and overall had frightened him. When we finally stumbled upon this experience, David was 15 years old. He had lived alone with this memory for more than 6 years. He frequently had wanted to talk about it but, until our accidental discovery, had never found a way to do so.

As we went along, I kept his mother informed of our conversations. I also let her know about questions or blocks we hit, and she would try from her much more intimate knowledge of her son to find new ideas to explore. About every 3 weeks, we got together to review what was happening, and try to assure ourselves that we were not crazy.
This process began in October, 1993. It continued, off and on, for almost 2 years. From time to time we took breaks because of school holidays, David's frequent bouts with illness, and sometimes just because he asked for a break. But it was clear to all involved with David, including medical personnel, school staff, and his family that there was a clear and lasting change in David. From almost total passivity, he began to take an increasing role in attempting to communicate his needs and interests to others. His former persistent depression was largely alleviated.

For about 6 months, I did not mention the nature of the work I was doing with David to anyone but his family and several close professional colleagues. I also tried very hard to keep this as David's personal story and to give him control of how and when we continued. After we had outlined the majority of his experience, I recommended several books and a videotape about near-death experiences to his mother. I suggested that they use these to further validate his experience and to raise possible areas for future discussion.

About 7 months into this process, although we continued to work on his NDE narrative, David began to change the agenda of our meetings. He spent less time talking about the past, and began to identify some current issues. He began to request changes related to his communication system. He requested a case conference of his therapists and school staff to discuss the general topic of communication. I expected him to want to discuss computers, light talkers, or other augmentative devices. However, when the conference took place, what he wanted was for me to communicate his near-death experience to other members of the team. David's professional contacts were formidable. At school, he had occupational therapists, physiotherapists, speech language pathologists, teacher's assistants, a resource teacher, and nurses. He conveyed to us that his purpose in doing this was so that we could understand his emotional state and his frequent impatience with other people's agendas. He asked for a new wordbook with categories relating to death, medical issues, and emotional states, so that staff would be better able to understand his needs. We agreed that whenever possible we would give David as much information as we could about things affecting him, and that we would try to respond to his priorities as much as possible.

David's motivation for this meeting was something we discussed a number of times, and relates back to his experiences in school when he seemed moody and distractible and unresponsive. He was able to convey to me that during these times he was trying to make sense of his
near-death experience and, in comparison to that, virtually nothing else seemed important. He wanted the people working with him to know that our priorities were not always his priorities.

This soon translated into a totally new agenda for our counseling sessions. David began to focus on issues related to his personal autonomy. He was able to identify that he was much brighter than he could convey to most people working with him, and that he wanted a larger role in making choices about his life. He was very specific about this in conversations with his mother, and he began to object to some of the regular treatments and procedures that were part of his routine. We discussed this in some detail just before summer holidays, and then David chose to take a break from counseling during the summer.

When we resumed work in September, a year after we had started, we sat down with a list of his medical treatments and went over them. We talked about what they did, their side effects, and what would happen if they were stopped. He then indicated what he wanted to happen. In about half of the cases, his choice was to terminate the treatment. This discussion took place several times between David's mother and myself, and his wishes caused some problems for her. Some of the treatments he wanted to end were significant and probably life-sustaining. After a number of long conversations with his mother, a meeting was requested with one of David's doctors to discuss the issue of continued consent to treatment.

Of particular concern to me were other professionals' perceptions of David's competence to give consent to treatment. It would have been easy to conclude in a brief assessment that David was seriously cognitively impaired. Subjectively, I believed he was not. I consulted with colleagues in medicine, psychology, and ethics regarding this issue. The general consensus was that the determination of competence in a person with severe physical and communication impairment could not be demonstrated by objective indicators only. In fact, for patients with severe impairment, formal testing almost always shows them to be seriously cognitively impaired because of the limitations of the testing and because of their inability to respond. I therefore wrote a formal assessment of my observations of David over a year of one-to-one counseling. David and his mother took this note to the appointment, and with guidance from the doctor he was able to indicate clearly which treatments he wanted to continue and which he wanted stopped. The doctor involved treated David and his decisions with exemplary respect. By and large, David kept those treatments that would maintain his comfort level. Among the ones he chose to stop
were intravenous antibiotics, a bronchodilator, and his anti-rejection drugs.

Following this appointment, in April, 1995, it was clear that David had made a major shift in focus. Our new dominant topic was death and dying. David’s premature death had never been in doubt. Since his surgery, he had undergone several life-threatening illnesses, including pneumonia, gastric bleeding, and short-term rejection of his liver. His anti-rejection drugs kept him balanced on the narrow safe path between liver failure and kidney failure. His family had been told that his vision was in measurable decline and that he would probably undergo further perceptual and cognitive deficits over time. As our ability to communicate improved, David expressed repeatedly that he was in almost constant discomfort and occasionally in acute pain. The major complaint was tube feeding through a tube into his small intestine, which caused him frequent gastrointestinal discomfort. As his cystic fibrosis progressed, he suffered from chronic diarrhea, nausea, and vomiting. He was also producing copious mucous, which made suctioning a growing necessity. With this medical history as a backdrop, David began to make specific plans for his own death.

His first issue was to communicate with more people about what he had experienced. He asked me to talk to his brother, his estranged father, and other professionals about his near-death experience. He also asked me to convey his story to others who work with nonverbal clients because of his conviction that other people may have stories to tell and no way to tell them, unless someone asks the right question. Over the next several months, David chose to revisit these discussions repeatedly, and also began to refuse a growing list of medical interventions. In spite of the topic of these discussions, his attitude was philosophical, good-humored, and, at times, serene. There was a great deal of laughter in our conversations. He expressed neither fear nor avoidance of death, although he was upset about leaving his family again. As part of this process, we reviewed his entire NDE. It remained consistent and, although it followed the classical pattern, retained details that were unique to him. At about this time, he also indicated that he had experienced other out-of-body experiences since his original NDE. He was quite insistent that these experiences were not dreams. He was also very specific that he knew he would die in the summer of 1995.

In June, 1995, we connected David with a palliative support team, which would facilitate his and his family’s wishes that he should die at home. By July, David had terminated all treatments except digestive enzymes and tube feeding. He had requested their termination on
numerous occasions, but his family had resisted because it felt to them like willful starvation. Finally, in August, we held a conference of all the family and professionals in David’s living room. He was insistent, and he gave the same response to everyone who asked him: stop the drugs and take out the feeding tube. One of the telling arguments in this substantial moral dilemma was that the digestive enzymes were drugs, manufactured substitutes for the natural enzymes that are missing in a person with cystic fibrosis. David had systematically refused every other drug, so what made this drug any different? Yet, if he were granted this wish, then feeding him would be a completely meaningless gesture. Without those enzymes, food would pass mostly undigested through his body, bringing him little nourishment but considerable discomfort. We concluded that he understood the consequences of his decision, and the digestive enzymes were terminated that day. Two days later, his mother removed his feeding tube. He accepted only one medical intervention from then until his death: an intravenous line for the possible infusion of pain medication. He never needed to use it.

During the last week of his life, though he was now permanently in bed, he was conscious, alert, and utterly in control. We had the following conversation:

David, are we finished? Yes.
Have we done everything you wanted to do? Yes.
We have talked a lot about your NDE, but I suspect there is a lot I did not discover. How much of what happened to you have we found?
Half? No.
More than half? No.
Less than half? Yes.

This last answer was accompanied by a spontaneous wide grin. He then managed to convey to me that he thought there were experiences he remembered from his NDE that perhaps he was not supposed to be able to explain. He died quietly at home less than a week later, two weeks before the end of summer vacation, 1995. His death was peaceful, unmedicated, and he was lucid until the end, surrounded by his family.

**Conclusion**

David left me a clear and specific legacy. He wanted this story told. His primary target audience was professionals and parents working with children with severe disabilities. It was his belief that somewhere there are others like him, who have been traumatized by medical
crises or near-death experiences who could possibly benefit from the chance, however difficult or remote, to tell their story. I believe he was correct in that assumption, although I suspect that the special combination of circumstances, opportunity, motivation, and luck that contributed to this story will happen rarely. That in no way diminishes the importance of this story.

David’s story contributes little that is new or different to the literature on near-death experiences. There are many stories more detailed and instructive in the existing literature. Neither is David’s story unique because of his eventual death. Like many millions of people everywhere, his death left a huge void in the lives of his family and closest friends, but his passing was not newsworthy and history will take no notice of his brief life. What makes his story so important is what he was able to demonstrate through patience, persistence, and a desperation born of necessity that it is possible to be heard and understood even when all of the usual means to do so appear to be blocked. Most people, myself included, made the quick assumption based on his appearance and his functional limitations that David was helpless and totally dependent, and that his cognitive abilities were as damaged as his body. We were wrong. Ironically, David’s NDE eventually gave him back control over his life, and ultimately, his death.

David also changed my life profoundly. What I previously knew about near-death experiences was based on a remote academic curiosity. David’s experience gave me a window into a spiritual realm that I had never experienced in any personal or meaningful way. I do not know with any certainty what David experienced, but I now believe that there are facets to physical reality that we have not yet begun to understand, which demand, at the very least, an open and wondering mind. That key alone has the power to open doors that can lead us to discoveries we have not even imagined. I will never again look upon any of my severely impaired, nonverbal patients without wondering what they may want to tell me if they only had the means; and I will try to find the means. If this experience helps someone, somewhere, to break through the physical barriers and feel connected instead of isolated, then it will vindicate David’s wish.

References


Life After Death presents a treasure of information regarding the afterlife by drawing on two impressive sources: sacred literature of the world’s major religions and studies of the modern near-death experience. In just 175 pages, Farnáz Ma’súmián provides the reader with a concise but comprehensive overview of her topic. First published in 1995, the book has been recently reissued. In the first seven chapters, she presents ideas of afterlife in Hinduism, Zoroastrianism, Judaism, Buddhism, Christianity, Islam, and the Bahá’í faiths, using a distinctive compilation of “chapter and verse” quotations from the sacred texts of each religious group. In the final three chapters, the author goes on to discuss reincarnation and transmigration, the near-death experience (NDE), and religion and the NDE phenomenon.

Ma’súmián is careful to use the universally accepted scriptures of each faith, while remaining mindful of the divergent and sometimes conflicting views of the different sects and denominations within each religion. Her crisp summations of the vast and complex literature of the world’s major religions are brilliant. More importantly, she treats each faith group with respect, possibly because of her personal belief as a Bahá’í that all the religious literature she examines is Holy.

The chapters focusing on a religion include the major writings of the religion, the primary concepts that relate to afterlife, and the influence...
and/or similarities of that religion in relationship to other religions. Ma'súmián points out, for instance, that some concepts within Judaism, Christianity, and Islam appear to have been influenced by Zoroastrianism, such as the struggle between the forces of good and evil (God versus Satan), belief in individual judgment after death, and, at the end of time, resurrection of the body and life everlasting. Additionally, she cites the overlapping traditions and teachings of all three Abrahamic religions (Judaism, Christianity, and Islam). Conversely, she points out that religions can develop religious beliefs and practices that vary widely from their origins, as in the case of Buddhism and Hinduism. The most significant differences between Eastern and Western religion, she writes, involve the concepts of reincarnation and transmigration, which form the cornerstone of Eastern belief but remain largely esoteric ideas in the West.

The chapter on the near-death experience presents a standard and basic overview. The author concludes that the most plausible explanation for NDEs is that they are "universally available mystical experiences" (p. 134).

The final chapter, "Religion and the NDE Phenomenon," is an excellent integration of the NDE into the literature of the world's religions. For example, the author notes the parallels between the NDE and the intermediate or Bardo state described in the classic Buddhist work, the Tibetan Book of the Dead (Evans-Wentz, 1957/11th century). Within this text is a judgment by Yama, the King and Judge of the Dead, who reviews the life of the deceased; in Hinduism, Yama is the Judge of the Dead and King of the intermediate state between death and rebirth. This phenomenon of judgment and life review has a definite parallel in religions of the West, where a similar judgment of the dead plays an integral role in Zoroastrianism, Judaism, Christianity, and Islam. Interestingly, each religion has its own name for the "Being of Light" present during the life review.

Anyone who is a student of comparative religion will be reassured that the author does not overlook the minor discrepancies between NDE accounts and religious writings. I personally am not troubled that the two constitute an "off-the-rack" fit rather than a "tailor-made" fit. While a blissful NDE generally resembles descriptions of Paradise in the world's religions, the life review of NDErs sometimes varies from the judgment stories in the world's religions. For example, the Tibetan Book of the Dead mentions only negative life reviews for the sinful. Also, most NDErs who have had a blissful experience feel that it is the beginning of eternal life, whereas Hindu and Buddhist texts
maintain that these Heavens are transitory and present prior to rebirth. And in the Bahá'í view, there are countless spiritual realms through which souls can progress.

Ma'súmián notes that whether there is a temporary nature to the particular Heaven the NDEr is experiencing is not easily verified by NDE accounts. She states that the traditional Hell with “fire and brimstone” is not mentioned by NDErs and that the afterlife torments of NDEs have a positive outcome. This is one of the few points in the book that is dated, in view of the recent research on unpleasant NDEs (Greyson and Bush, 1992; Rommer, 2000).

Overall, Life After Death is an outstanding presentation of both ancient and modern views of the afterlife. In my view, Ma'súmián’s compilation of specific verses that address the afterlife from the world's sacred scriptures provides an excellent resource that alone would be worth the price of the book. Added to this is her careful analysis of the concepts and contradictions both within and between the various religions. This book is a “must” for all students of life after death in general and the NDE in particular.

References


British scholar Mark Fox’s recent volume infuses the field of near-death studies, heretofore dominated by the natural and human sciences, with the new wine of the humanities and liberal arts, bringing a fresh perspective to many of the field’s persistently baffling questions. Equipped with a background in philosophy and theology, Fox grapples with traditional understandings of dualism and essentialism as he revisits questions of whether or not mind and body may be separable, whether near-death experiencers (NDErs) share a common core experience, and whether that core experience, if it exists, points to an underlying divinity transcending boundaries of race, culture, and class. Through close reading, active listening, and rigorous analysis of scholarly literature and personal NDE stories, he concludes that continual revisions to existing research models are necessary and offers hope for dialogue between established NDE scholarship and new, potentially fruitful lines of interdisciplinary inquiry.

Fox begins by taking inventory of work already done, tracing the historical development of scientific NDE studies and marking each decade’s dominant disciplinary paradigm: Raymond Moody’s composite medical model of the 1970s, Kenneth Ring’s evolutionary model in the 1980s, and the sociological perspective advanced in the 1990s, particularly by Cherie Sutherland. I must say here that although any history is selective, partial, and necessarily incomplete, I found some...
of the omissions surprising. For example, the discussion of frightening NDEs mentions the work of Margot Grey (1985) and of Maurice Rawlings (1978), but overlooks a more recent and rigorous study by Bruce Greyson and Nancy Evans Bush (1992), as well as Barbara Rommer’s extensive collection of “less-than-positive” narratives (2000). Despite its flaws, however, this broad overview provides a clear and proper context for Fox’s subsequent reflections and conclusions.

In the second chapter, Fox stakes his claim to a place for the humanities in NDE studies of the 21st century, and particularly for theology, which largely heretofore has maintained a “deafening silence” (p. 55). His introduction of current scholarship fertilizes old theological issues with new possibilities. For example, from J. C. Hampe (1979) he borrows the elegant and brilliant metaphor of the organ and organist to suggest a relationship between matter and spirit surpassing Cartesian dualism.

Yet this same pregnant and refreshing chapter is more than a little unsettling to me as well. For instance, Fox’s ambivalence toward Carol Zaleski’s literary and theological scholarship is completely baffling. He credits Zaleski for her recognition of literary devices in the construction of NDE narratives like intertextuality and emplotment (the process of creating narrative order out of chaos, constructing a plot out of more-or-less random memory, fantasy, or creative effort to make a comprehensible story). Nevertheless, he finds it “difficult to escape from the conclusion that her relegation of the NDE to the religious imagination is a tacit acceptance that the NDE, after all, exists only in the mind’s eye” (p. 343). Here he seems to succumb to cultural bias against fantasy, a false dichotomy that fails to recognize the interplay of subjective and objective realities in mental life and dismisses imaginative activity as “unreal.” What Zaleski’s body of work suggests to me is not the “agnosticism” Fox attributes to her (p. 343), but faith operating in full grasp of the subtle and complex ways that reality and fantasy not only overlap but frequently interpenetrate in language and symbol. “If God, the unknowable, wishes to be known,” wrote Zaleski from her Christian theological perspective:

[then] what other recourse does God have but to avail himself of our images and symbols, just as he has availed himself of our flesh [in the incarnation of Jesus the Christ]. [And] if God is willing to descend into our human condition, may he not also, by the same courtesy, descend into our cultural forms and become mediated to us through them? (1996, p. 35)
In this passage Zaleski, fully cognizant that "no symbol can ever become completely transparent to the reality it represents" (p. 35), seamlessly blended her scholarly insight with what I take to be a personal testimony of faith. Having not met Zaleski personally, I admit that I could be projecting my own wishes onto her text in my optimistic reading; in my view, however, it is Fox who errs on the side of parsimony.

Having said that, I am convinced that Fox’s project is destined to be studied, referenced, discussed, and highly valued for long time to come. First of all, it suggests multiple sites where the arts and humanities could intersect with scientific NDE research. “Testimony,” he writes, “is what analysis of the NDE is ultimately called upon to explain” (p. 188). Testimony is exactly what scholars in narrative theory, psychoanalysis, literature, linguistics, rhetoric, and composition studies – to name a few – immerse themselves in every day of their working lives. Priming the creative pump for such as these, Fox poses questions such as, “Which is primary, language or experience?” (p. 113). He raises the dialogue to a sophisticated level, affirming that the NDE is necessarily mediated, though not fully captured, by language (p. 140).

Fox’s project offers yet another major gift to near-death research by drawing attention to relatively obscure and thus underappreciated original scholarship. The collection of the Religious Experience Research Centre at the University of Wales, Lampeter, heretofore unknown (at least to me) and apparently never published, is of particular significance. If literary scholarship holds that perception can be shaped by psyche and culture; if composition shifts, selects, and arranges; if memory is shown to be partial and often unreliable; then the apparent similarities among these testimonies collected by unaffiliated scholars from experiencers of many different cultural and national backgrounds prior to the rise of modern near-death studies in the 1970s makes them all the more compelling and valuable. Furthermore, Fox’s analysis of neuroscientific research provides an up-to-date and solid rationale for rejecting explanations based in unitary models that fail to respect the diversity among NDErs’ own stories. This work could very well stimulate a whole new body of scholarship seeking to identify, analyze, and thereby understand the processes by which private experience becomes public confession and ultimately cultural property (p. 190).

In his closing chapter, Fox’s well-crafted chronicle of the religious wars within near-death studies serves as a cautionary flag for scholars and lay people alike who care deeply about this subject matter. From
its beginnings modern near-death study has faced opposition from mainstream science and religion; now, with that battle at a stand-off, the field seems to have been overtaken by internecine wars – and rumors of wars. Fox’s project signals that a fresh challenge, fraught with possibilities both liberating and terrifying, is about to overtake the field.

Most of the established scholarship in near-death studies is grounded in the sciences. Generally speaking, science is embarked upon a search for truth, privileges facts that can be either falsified or verified, and is necessarily pragmatic. On the other hand, the new face at the welcome table – that of the arts and humanities – is primarily poetic. It finds itself in search of meanings (notice that the plural form suggests multiplicity), and privileges the playful and paradoxical relationships between the private world of fantasy and the shared space of everyday life. Ambiguity is not only tolerated but preferred over certainty. We poets make much of the fact that Martin Luther King, Jr. said to the world, “I have a dream,” not “I have a hypothesis.” We are convinced that dreaming is prior, yet also interpenetrates invisibly with planning and execution.

The incursion of the arts and humanities into scientific near-death studies offers hope for new and vigorous intellectual activity – opportunities for dialogue, interdisciplinary collaboration, new discoveries to be sure – but also bears the ancient warning about the danger of putting new wine into old wineskins. Both established scholars and newcomers – and I include myself in the latter group – must learn to appreciate one another’s vastly different ways of knowing, embrace pluralism and tolerance for diverse academic and philosophical cultures while rejecting fundamentalisms of all stripes, and understand that even vigorous disagreement need not equate to disrespect. If the scholarly NDE community can make room for one another, the ensuing conversation can only enrich and enlarge the body of knowledge to the ultimate benefit of academic culture, society, and the world. Fox’s book is like a fresh gust of wind upon the waters. Watch the ripples and one may know which way the wind blows.

References


THE ESSENTIAL TOOL FOR NDE RESEARCHERS

Near-Death Experiences Research Bibliography

Part 1
version 1.1

- Interactive CD-ROM for PC and Mac
- Searchable database citing all Journal of Near-Death Studies and Anabiosis articles from 1981 through 2001
- Includes abstract for most articles
- Indexed by over 150 topics, such as:
  - Accounts of NDEs—autobiographical
  - Characteristics of NDEs—out-of-body
  - Definition of NDEs
  - Famous People’s NDEs
  - Media Treatment of NDEs
- Enables you to create a customized list of citations for ordering reprints—from either your own source or the Near-Death Literature Clearinghouse (order form included in CD).

Price of CD: $49.95 for Professional Members of IANDS and JNDS subscribers
$59.95 for all others
...plus $4 shipping and handling

Purchase with check, money order, or major credit card:
IANDS
P.O. Box 502
East Windsor Hill, CT 06028-0502
www.iands.org
860-882-1211
INSTRUCTIONS TO AUTHORS

JOURNAL OF NEAR-DEATH STUDIES encourages submission of articles in the following categories: research reports; theoretical or conceptual statements; papers expressing a particular scientific, philosophic, religious, or historical perspective on the study of near-death experiences; cross-cultural studies; individual case histories with instructive unusual features; and personal accounts of near-death experiences or related phenomena.

GENERAL REQUIREMENTS: Logical organization is essential. While headings help to structure the content, titles and headings within the manuscript should be as short as possible. Do not use the generic masculine pronoun or other sexist terminology.

MANUSCRIPTS may be submitted in electronic format (preferred) or hard copy. Electronic manuscripts may be submitted by e-mail to the Editor, Bruce Greyson, at cbg4d@virginia.edu, or by mailing a computer diskette or CD-ROM to the Editor at the address below. Please clearly designate the name of the file containing the manuscript and the hardware and software used. IBM-compatible files are preferred in WordPerfect, but other programs for IBM-compatible or Macintosh computers are acceptable. Manuscripts submitted as hard copy should be submitted typed on one side of the page only, double spaced throughout, with a margin of at least one inch on all four sides, and all pages should be numbered. There are no absolute limits on length of articles, but authors should strive for conciseness.

Send manuscripts and/or computer diskettes or CD-ROMs to: Bruce Greyson, M.D., Division of Personality Studies, University of Virginia Health System, P. O. Box 800152, Charlottesville, VA 22908-0152, USA.

TITLE PAGE should contain the names of the authors, as well as their academic degrees, institutional affiliations, titles, and telephone number, fax number, and e-mail address for the senior author. Include a name, postal address, and e-mail address for reprint requests.

ABSTRACTS: Abstracts of 100-200 words are required with all articles. Abstracts should include the major premises of the article, intent, hypotheses, research design, results, and conclusions. For research reports, include the purpose, hypotheses, method, major results, and conclusions. For review or discussion articles, identify the main themes and conclusions and reflect them in a balanced fashion; if sources are important (for example, previous research), include these. For other types of articles, including replies to other authors’ articles or case histories, refer briefly to the main themes and conclusions and cross-reference if necessary. Abstracts should be nonevaluative in tone, and should include as much information as possible within the constraints of space.

KEY WORDS: Articles should include two to five key words, listed after the abstract, which will be printed in the Journal and used by abstracting services for indexing the article. This is unnecessary for book reviews and letters to the editor.

FOOTNOTES AND ENDNOTES are strongly discouraged.

REFERENCES should be listed in alphabetical order (and chronologically for each author) at the end of the article, and referred to in the text by author(s) and year of publication. Only items cited in the text should be listed as references. Personal communications and Internet websites may be cited in the text, but should not be included in the list of references. Include all authors in references with multiple authors. Do not abbreviate journal titles. Capitalize principal words in journal titles, but only the first word in a book title or subtitle. Page numbers must be provided for direct quotations.

ILLUSTRATIONS should be self-explanatory and used sparingly. Tables and figures must be in camera-ready condition and include captions. Electronic artwork submitted on disk should be in TIFF, EPS, or PDF format (1200 dpi for line and 300 dpi for halftones and gray-scale art). Color art should be in the CMYK color space. Artwork should be on a separate disk from the text, and hard copy must accompany the disk.