The Nursing Profession and Near-Death Experiences: A Personal and Professional Update

Judith Mandalise, M.Ed., RN, CEN, LPC
University of North Texas

ABSTRACT: This article reviews professional nursing's philosophical and professional mandates that direct nurses to acquire accurate knowledge and skills in order to care competently for near-death experiencers (NDErs). In addition, the article briefly describes the NDE phenomenon and aftereffects, discusses the author's NDEs in the professional context of her status as a nurse, and addresses the challenges NDErs encounters because of a lack of knowledge by nurses about NDEs. It concludes with a review of the current state of nursing education relevant to NDEs, suggestions for and resources available to faculty to create NDE curricula for nursing students, and continuing education opportunities for nurses and other medical professionals.

KEY WORDS: nursing, near-death experiences, curriculum, education

Approximately one in five people who survive a close brush with death report an experience of typically real or hyper-real altered awareness in which one's consciousness, typically with profound lucidity and functioning apart from one's physical body, is cognizant of the material world while concurrently is able to perceive and interact with transmaterial environments and entities (Zingrone & Alvarado, 2009). Since Raymond Moody's seminal work in 1975 in which he coined the termed near-death experience (NDE), nearly 40 years of research has largely substantiated his original observations regarding individuals' descriptions of their experiences associated with brushes with death and their changes in the aftermath of those experiences (Holden, Greyson, & James, 2009).

Judith Mandalise, M.Ed., RN, CEN, LPC, is a doctoral student in the Counseling Program at the University of North Texas, Denton, TX. Correspondence regarding this article should be sent to Ms. Mandalise at email: Judith.Mandalise@unt.edu.

Results of studies conducted by the nursing profession published as early as 1981 revealed both the profession's interest in and its paucity of knowledge about NDEs, knowledge that is essential for identifying and assisting patients who disclose NDEs, referred to as near-death experiencers (NDErs; Foster, James, & Holden, 2009). Moreover, nursing research supports the findings of other, non-nursing studies that the phenomenon results in NDErs confronting life-altering changes. These findings underscore the importance of experiencers understanding and integrating into their lives the phenomenon and its ensuing transformations (Bucher, Hardie, Hayes, & Wimbush, 1998; Clark, 1984; Corcoran, 1988; Davis, 1998; Dickenson-Hazard, 2000; Duffy & Olsen, 2007; Foster, James, & Holden, 2009; Hayes & Orne, 1990; James, 2004; Lopez, Forster, Annoni, Habre, & Iselin-Chaves, 2006; Manley, 1996; McClung, Grossoehme, & Jacobson, 2006; Morris & Knafl, 2003; Noyes, Fenwick, Holden, & Christian, 2009; Oakes, 1984). Consequently, nurses, to facilitate their role in their patients' recovery and adjustment, have called for greater education about NDEs and championed the cause of appropriate care for NDErs (Foster et al., 2009).

As a nurse who has practiced since 1973, specialized in emergency nursing since 1986, and had NDEs in 1997 and 2001, I am positioned to assess the extent to which the nursing profession is responding to its call for NDE education. As I will detail in the following material, I have concluded that, despite repeated requests by its practitioners for education about NDEs, nursing has failed to respond. Thus, patients often struggle in isolation to incorporate the phenomenon into their lives. Thus, I consider it imperative that nursing finally heed the call to develop and implement educational programs addressing NDE-related issues.

In this article, I discuss how competence to care for NDErs is congruent with nursing's philosophical and professional mandates. Next, I describe my own NDEs and their lasting impact on my life, both personally and professionally. Lastly, I examine what I consider is the current state of NDE education for nurses and offer suggestions for improving it.

Nursing Then and Now

Florence Nightingale's Legacy

Florence Nightingale, founder and organizer of today's nursing profession, based her nursing school curriculum on a holistic approach to

patient care anchored in her staunch belief in the importance of creating a healing environment (Dossey, 2000, 2010; Hoyt, 2010; James, 2004; Nightingale, 1860; Tourville, 2003; Wagner & Whaite, 2010). Nightingale argued that critical to creating this environment was the development of a genuine, caring relationship between nurses and patients conducive to patients' feeling open to express their fears and to ask questions (Dossey, 2000, 2010; Nightingale, 1860; Tourville, 2003; Wagner & Whaite, 2010).

According to Nightingale, another core component of this healing environment is the incorporation of spiritual awareness into patient care. Spirituality was an essential aspect of her personal and professional life. She required her students to be cognizant of and to provide for patients' spiritual needs (Dossey, 2000, 2010; Nightingale, 1860; Tourville, 2003; Wagner & Whaite, 2010).

Nursing in the 21st Century

Nightingale's (1860) mandates that nurses create genuine and caring relationships with patients and address their spiritual needs remain fundamental tenets of the profession in the 21st century (Dossey, 2000, 2010; Gallup, 2011; Tourville, 2003; Wagner & Whaite, 2010; Wright, 2010). Anne Williams and Vera Irurita (2004) investigated patients' perspectives regarding which interactions with nurses were therapeutic and which were non-therapeutic. Results indicated that interactions such as developing a relationship, active listening, and acquiring accurate information increased patients' emotional comfort and thus enhanced the healing process. Results of U.S. Gallup polls since 2000 have offered additional evidence that nurses succeed in creating therapeutic relationships: With only one exception—the ranking of firefighting after the terrorist attacks of 2001—nursing has consistently ranked as the most trusted profession (Gannett Healthcare Group, 2011).

Professional organizations such as the American Nurses Association (ANA; 2004) and the American Association of Colleges of Nurses (AACN; 1998), as well as the American Hospital Association (AHA; 2003) and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO; 2005), echoed Nightingale's position regarding the importance of attending to patients' spiritual needs (Dossey, 1989, 2000, 2010; Hoyt, 2010; Tourville & Ingallis, 2003). The ANA in its *Standards of Clinical Nursing Practice* (2004) and the AACN (1998, 2012) stipulated that nurses demonstrate knowledge and com-

petence in recognizing and assessing patients' spiritual needs, as well as in developing appropriate plans and interventions in their nursing practice (McClung, Grossoehme, & Jacobson, 2006). The AHA, in its *Patient Care Partnership* document (2003), affirmed that spirituality contributes to patients' overall wellbeing and emphasized the importance of patients discussing their spiritual values with healthcare providers. In addition, in 2005, JCAHO acknowledged the validity and importance of addressing the spiritual concerns of patients in the healing process by necessitating it as a requirement for accreditation (JCAHO, 2005; McClung et al., 2006).

Furthermore, results of present-day studies investigating the relationship between spiritual practices and the healing process uphold Nightingale's stance. Researchers reported that spiritually-oriented rituals, such as prayer, correlate positively with decreased post-operative complications and mortality rates and that strengthened coping mechanisms during stressful illnesses serve to increase an overall sense of wellbeing during terminal illness (Dossey, 2000, 2010; Hoyt, 2010; James, 2004; Nightingale, 1860; Tourville & Ingallis, 2003; Wagner & Whaite, 2010).

Finally, the North American Nursing Diagnosis Association (NANDA; 2005) developed and defined criteria designed to assist nurses in identifying patients at risk for spiritual distress (McClung et al., 2006). According to NANDA, spiritually at-risk patients have experienced a sense of separation from the universe possibly due to grief over a loss, to a physical illness, or to another stressful situation. Consequently, they express feelings of guilt, isolation, and anger, and they may withdraw from family and friends. Nursing interventions determined as beneficial for patients experiencing such distress include exhibiting an open, nonjudgmental attitude; listening; providing quiet times; and issuing appropriate referrals as necessary (NANDA, 2005; see also McClung et al., 2006; Rieg, Mason, & Preston, 2006). In addition, Vance (2001) argued that ideal nursing interventions for supporting patients' sense of connection with God or a higher power include (a) assisting patients in contacting pastors, priests, or other spiritual leaders; (b) facilitating spiritual activities/rituals such as baptisms; and (c) providing privacy for prayer and meditation. Clearly, the 21st-century nursing profession supports that attending to the spiritual needs of patients is essential to the healing process.

Relevant to creating an environment conducive to healing and to supporting patients' spiritual needs is the NDE phenomenon. Although

not all NDErs consider their NDEs to have been spiritual, most do (Zingrone & Alvarado, 2006). Articles by and about nurses and nursing regarding the need for increased awareness and knowledge about NDEs, found in such publications as the *Journal of Emergency Nursing, MEDSURG Nursing*, and the *Journal of Holistic Nursing,* are among the now-extensive professional NDE literature (Bucher et al., 1984; Corcoran, 1988; Davis, 1998; Dickenson-Hazard, 2000; Duff & Olson, 2007; Enright, 2004; Foster et al., 2009; Hayes & Orne, 1990; Manley, 1996; Morris & Knafl, 2003; Oakes, 1984; Wimbush, Hardie, & Hayes, 2001).

NDEs

The Phenomenon

Psychiatrist and NDE researcher Bruce Greyson defined an NDE as "a profound psychological event with transcendental and mystical elements during real or perceived close brushes with death" (as cited in Greyson 1999, p. 8) such as a heart attack or other severe physical or psychological trauma. David Wilde and Craig Murray (2009) reported the majority of NDE researchers over the last 35 years have described NDErs as "healthy well-adjusted individuals" and "delineat[ed] the occurrence of an NDE as one free of demographic differentiation, and mostly as a positive life-affirming experience that can happen anytime during the life span" (p. 223). Although every NDE is unique, Moody (1975) compiled a list of 15 features of an NDE commonly reported by NDErs, such as a sense of profound peacefulness, unconditional love, ineffability, an out-of-body experience (OBE), and deep and lasting physical and mental alterations.

Although NDErs frequently describe their experiences as blissful, research has indicated that not all experiences are emotionally positive and loving; these are termed distressing NDEs (Bush, 2009, 2012). Studies, however, have indicated that the emotionally different experiences often yield not only some different aftereffects but also some similar aftereffects (Noyes et al., 2009).

The Aftermath

In the aftermath of distressing experiences, NDErs grapple with making meaning of the experience: their questions deeper, their doubts stronger, and their fears profounder. Accordingly, anger, guilt, and self-

recrimination often flood their psychology, thus enlarging the challenges these NDErs face (Bush, 2002, 2009, 2012; Greyson & Bush, 1992; Wilde & Murray, 2009).

According to research, in the wake of both pleasurable and distressing NDEs, NDErs report inner transformations that pose significant challenges to resuming life. In the aftermath of the phenomenon, they struggle with how to process, understand, and integrate these pivotal and permanent changes (Holden, Long, & MacLurg, 2009; Moores, 2010; Wilde & Murray, 2009). The ramifications of the physical, psychological, and intellectual alterations confronting NDErs often result in strong and, at times, conflicting emotions. For example, pleasurable NDErs may experience a sense of guilt regarding their desire to remain in that place of unconditional love, versus the joy their loved ones express over the NDErs' return to physical life. Consequently, NDErs often describe feelings of isolation and have concerns that others will consider them crazy if they divulge their experiences (Moores, 2010; Morris & Knafl, 2003; Oakes, 1984; Wilde & Murray, 2009). In addition, NDErs may experience substantial strains in interpersonal relationships that may result in the termination of meaningful relationships. A study conducted by Rozan Christian (2005) investigating the effects of NDEs on marital relationships indicated that the incidence of divorce increases when one member of a marriage experiences an NDE and the other does not.

Although each NDE is unique to the individual (Ring, 1980), experiencers typically describe their NDEs as spiritual. Indeed, researcher Cherie Sutherland (cited in Greyson, 2006) reported participants in her study expressed that the greatest adjustment related to their NDE was in the realm of spirituality or spiritual growth. In NDErs' disclosures, they consistently pointed to transformations in their attitudes about formal religion as well as in their spiritual practices. On the one hand, some NDErs reported a decreased desire or need for involvement in formal religions; on the other hand, some told of an increased desire for participation in structured religions. Still others chose to develop their spirituality independent of any recognized religion. Importantly, some NDErs, because they were not allowed to remain in transmaterial domains characterized by profound love, reported feelings of rejection by the divine as well as grief associated with a sense of attenuation—distance from that place of joy and unconditional love. Therefore, this deep sense of loss and the stress related to it predisposes NDErs to experiencing spiritual distress as defined by NANDA (2005; Christian, 2005; Flanagan, 2008; Greyson, 2006; Horacek; 1997;

Morris & Knafl, 2003; Noyes et al., 2009; Stout, Jacquin, & Atwater, 2006; Sutherland, 1996, 2009; Zingrone & Alvarado, 2009).

Pivotal to an experiencer integrating an NDE is the response of the first individual to whom the NDEr discloses the phenomenon (Noyes et al., 2009). According to James (1994), experiencers were most likely to disclose the event to nurses first, thus heralding the importance of nurses becoming NDE-literate: able to identify NDEs and to interact helpfully with patients who disclose them. Unfortunately, several studies revealed that nurses lack the knowledge necessary to recognize the symptoms/indications of NDEs; therefore, they come up short in the skills to competently care for NDErs (Bucher et al., 1998; Clark, 1984; Corcoran, 1988; Dickenson-Hazard, 2000; Davis, 1998; Duffy & Olsen, 2007; Foster et al., 2009; Hayes & Orne, 1990; James, 2004; Lopez et al., 2006; Manley, 1996; McClung et al. 2006; Morris & Knafl, 2003; Oakes, 1984). This absence of knowledge and skills became both a personal and professional reality to me following my two NDEs.

NDE: My Experiences

My First NDE and Aftereffects

As a child, my family accepted me for who I was, the "who I was" meaning that they considered me as being too sensitive to the feelings of others and slightly odd because I knew things before they happened; in other words, I possessed precognition and used it. In fact, I would say I possessed two abilities: empathy and precognition, and by being in a family that accepted me, I grew up with these faculties uninhibited, and I was rather unaware of how unconventional it was to be able to read/see the future and to care so strongly for others, especially at a young age. At any rate, grow up I did, and what is evidential here is that both these traits were intensified in adulthood by my NDEs, a change in me that I will further discuss below.

At the time of my first NDE, I was a nurse working in the emergency department of a local hospital. Despite more than 20 years of nursing experience, I did not recognize my experience one autumn night as an NDE, nor did the physicians and nurses I worked with. Consequently, none of us knew how to assist me in my attempt to understand and integrate the aftermath of the phenomenon.

On November 7, 1997, at approximately 4:30 a.m., alone and asleep in my apartment, I awakened to someone shoving my face into my pillow. Rising up on one elbow, I saw the black silhouette of a raised arm above my head, then everything went black, and I remember thinking,

"That hurt." First, I was floating above my bed; then I was standing looking down at the rumpled blankets on the bed feeling detached and calm. Although I knew I had corporeality, I felt light, almost transparent, and though dawn was still hours away, the room lay lit with a soft, gentle, white light.

Next, enveloping me was a rich and vibrant blackness that felt alive and welcoming; I felt as though I could stay there forever. However, drawing my attention upward was light in the shape of an oval—as though someone had spilled thousands of brilliant diamonds across this velvety darkness. I remember thinking, "Wow!" Desiring to get closer, I began moving towards the illumination-filled opening. However, entering that radiance was not to be; instead, I found myself back in the soft, gentle glow I first experienced, and I was not alone.

I was listening intently to two or three familiar entities speaking to me. Although I have no memory of the details of the information, the sense of importance of it continues with me today. As they finished, I asked, "What do I do now?" to which they clearly replied, "Scream!" which I did, forcefully. As I began to scream, I felt a thud; I no longer felt light and airy, but solid and heavy, as I once again associated with my physical body. Still screaming loudly, I became aware of someone running past me and then leaving my apartment. My injuries included a broken finger and several others I learned subsequently were potentially lethal: an open head wound, a concussion, and an externally dislocated left clavicle.

In the days and weeks that followed, I realized I had become different; there were changes in me both physically and otherwise. I became very sensitive to audio; everything sounded as though the volume was at its highest level, and sound was often physically painful. Consequently, I stopped going to some restaurants and movie theaters because I found the noise levels intolerable.

Another physical change proved adverse to my work as a nurse: I became unable to wear a wristwatch. Within a few days after my NDE, I realized wearing a watch created a rash, and intense itching; then the piece stopped working altogether. I have not been able to tolerate wearing a watch since that time. However, it was not until years later that I learned the correlation between my inability to wear a watch and my NDE was a common electromagnetic aftereffect amongst NDErs (Nouri & Holden, 2008). As uncomfortable and inconvenient as the physical differences were, internal changes were of an even greater concern.

The first inward transformations affected my thoughts about reli-

gion. Prior to my NDE, I questioned religion, death, and the existence of an afterlife. Post-NDE, these struggles dissipated. On the one hand, I no longer perceived the need to participate in an organized system; on the other hand, my connection with all beings deepened. Previous questions about death and the existence of life after death disappeared, replaced by a deep peace and a certainty that life continues.

The inner peace I experienced after my NDE extended to my empathic abilities. The capacity to experience empathy for others can be a powerful agent for comfort; for the person who possesses this ability, however, it can be taxing both emotionally and physically. Therefore, in the years leading up to my NDE, in order to protect myself, at work I had steeled myself emotionally from my patients. After the NDE, despite my heightened pathos, I realized I was able to empathize with others, to "hold" their pain without feeling personally distressed or drained. I am deeply cognizant of the fact that my transmutation was not a result of my efforts but was a spontaneous and immediate effect of my NDE.

Prior to my NDE, I often shared with my co-workers my precognitions, such as the phone about to ring with a call for a specific person or the future arrival of seriously ill/hurt patients, and although my co-workers perceived me as unusual, they still accepted me. However, after my first NDE, as my precognitive abilities became sharper and more precise, my peers responded increasingly adversely to my disclosing these premonitions. I discovered that sharing my knowledge now served to augment others' perception of me as "weird and spooky." Sensing the shift in their acceptance of me, I endeavored to suppress this natural aspect of myself. Unfortunately, rather than diminish my feelings of loneliness, attempting to downplay my experiences increased my sense of isolation from my peers and even from myself: I felt the inauthenticity of living a lie.

I was both personally and professionally confused about these changes. Unfortunately, efforts to disclose my experience to my co-workers, all of whom were physicians and nurses, resulted in either benign pats on the shoulder, or reassuring statements about suffering a head injury—not to worry, that it would get better. Neither my medical associates nor I ever once considered the term "NDE" as an explanation. Furthermore, no one could advise me regarding resources where I might learn more and find others who had undergone similar experiences. Becoming increasingly aware of the dismissive and patronizing responses by my coworkers, I decided to stop sharing. Instead, I resolved to deny that anything had happened and to

ignore both the experience and the changes. This decision served only to exacerbate my sense of isolation and confusion. Compounding these feelings was what came next: another NDE in 2001.

My Second NDE and Aftereffects

I woke up one morning in 2001 with the most excruciating toothache. Seeking immediate treatment, I got an appointment from a local dentist for that morning. The dentist informed me I needed a root canal; he applied a local anesthetic for the pain, and we scheduled an appointment to perform the procedure later that afternoon. Pain free, I was able to eat lunch before I returned to the dentist office, an unfortunate action that I lived to regret.

Having had nitrous oxide during dental procedures, I knew to expect giddiness and relaxation; however, this time proved dissimilar. Before the dentist placed the mask on my face, I clearly heard a voice say, "You are going to leave your body." Previously, thoughts of having an OBE left me feeling anxious, and yet, that day, I remember feeling quite calm.

Next, similar to what I had experienced in my NDE years before, I felt the same feeling of physical lightness come over me, the same awareness of standing on the edge of a space, and the same impression of conversing with familiar beings. The impression, I recall, was that the entities were offering me a choice; after they conveyed to me that my children would be okay without me, I began moving into and merging with the brightest, and yet softest, white light. At the center was a warm orange light, and emanating from the center was pure unconditional love. I perceived my human form falling away and felt my remaining self merging with this incredible source of love and unconditional acceptance. Merging into this living essence of love, knowing I was home, I felt an inexplicable joy!

Sensing someone calling to me, I turned, and far away was the face of a living person I knew in my physical life, urging me to return; nonetheless, I chose to remain where I was. Then from behind him, a smaller, glowing, female stranger's face appeared and spoke, "But what about me?" Only then did I become aware of any conflict regarding staying or returning; suddenly there surged up into my face a living woman I knew from the physical side. Her edict was strong: "You must complete this lifetime." I remember entering into a discussion with her about the reasons for this, but I cannot recall them now. However, as evidenced by my writing this article, I returned.

Once again, sensing the heaviness of my body, I realized I could barely move my head; lifting my arms was not possible. I heard someone behind me say, "Oh, you're awake;" I realized I was nauseated, and at that moment I vomited my lunch. Fortunately, it was the dental assistant speaking; she rushed to my side and held my head up so I did not choke and suffocate. It became rudely clear to me I was back in my physical form and in this material world.

What intensified after the second NDE were the physical and inner alterations: the inability to wear a watch, the physical discomfort due to audio, the enhanced precognition, and the augmented empathy. However, another shift, one that continues to challenge me, concerns my perception of time, which seems as though there is a "pause in the action" of life, and when time resumes, I have the awareness that I have conversed with someone, someone not of this physical world. There is no memory lapse, the clock does not indicate a passage of time, and no one seems to notice anything different. This, in addition to the above changes, augmented my confusion, amplified my concerns regarding my sanity, and intensified my feelings of isolation. After the misfortune I went through during my initial attempts at disclosing my first experience—which I only much later knew to call an NDE—I knew it would be unwise to speak to anyone else about the second.

Yet I knew I was not the same person after these two pivotal events, and I still did not have insight as to why or what to do about these changes. I was isolated from my friends and peers, all of whom were highly trained medical professionals, due to their lack of knowledge and understanding regarding NDEs. It was not until 2009 that I finally comprehended these events.

Understanding and Integrating the Aftermath of My NDEs

It was the summer of 2009; I had just entered the doctoral program in counseling at the University of North Texas. During a meeting with my professor, Jan Holden, who knew I was an emergency department nurse, she inquired about any unusual stories patients may have shared with me after a medical crisis. Whereas I had not disclosed the events to anyone for several years, hesitantly, I commenced sharing my own story with her. After listening attentively, she asked me if I knew the name of, the term for, my experiences; I said no. Thereupon, Holden showed me a questionnaire and inquired if I was acquainted

with it; again, I replied no. She then invited me to complete one for each of my experiences. I did so with both willingness and curiosity. Afterwards, Holden scored them and informed me that the questionnaires were the Near-Death Experience Scale developed by Greyson (1983). His purpose had been to create an assessment tool to differentiate NDEs from other experiences, such as organic brain syndromes and nonspecific stress responses, as well as to evaluate the depth—the number and intensity of features—of the experience. Holden further advised me that out of a possible maximum score of 32, scores of seven or greater were indicative of an NDE and that the higher the score, the deeper the experience (Greyson, 1983, 1984; Morse & Perry, 1992). My scores were 18 for my first experience and 28 for my second. Although my scores clearly and resoundingly indicated my experiences were NDEs, I was not convinced.

Initial Response

My first response to this information was skepticism. After all, I had not been in a hospital when either of the events occurred, and no one had ever pronounced me clinically dead, so how could I have had an NDE? My lack of information—that NDEs occur in close brushes with death that both do and do not explicitly include cardiac arrest—continued to prevent me from accurately recognizing and labeling my own experience. As I grew more comfortable with Holden's assertion that I had had not just one but two NDEs, I began researching NDEs. As I began investigating, the similarities between descriptions of others' NDEs and my own experience were striking. My research confirmed what Holden was conveying to me: that my experiences were examples of this recognized phenomenon. Moreover, the details of the challenges NDErs faced in processing, understanding, and integrating what they experienced because of their NDEs resonated deeply with me. Slowly I allowed myself to acknowledge thoughts and feelings I had ignored for years, and I embraced the reality of the physical, emotional, and spiritual changes that had happened to me. Fears regarding my sanity abated as they were replaced by a sense of relief and reassurance that I was not alone in my struggles.

Nevertheless, my sense of comfort soon diminished. As I allowed my precognitive abilities to come to the forefront, I realized yet again that disclosing my precognitions, rather than being helpful, was upsetting to others. Sensing the discomfort—at times intense—that my coworkers, fellow students, and faculty experienced when interacting

with me, I distanced myself from many relationships, thus augmenting my sense of estrangement.

As I allowed myself increasing awareness of NDE aftereffects, the discomfort I sensed from others was not my only distressing experience. I remember the moment clearly: a strange and startling realization when I suddenly perceived my sense of self only occupied a small area just above my eyebrows. At the time, I was not sure why, but intuitively I knew it was important that I remedy this situation. Despite the reassurance I received from Holden and from the reading I had done, this experience shook my confidence in my sanity. Consequently, I was reluctant to share it with anyone else; therefore, I sought to determine a plan of action on my own. Finally, I decided to practice a mental exercise, similar to putting on pieces of clothing: I envisioned my inner self "putting on" my body, pushing my "self" into the different parts of my physical being. Starting at my neck, I visualized this process progressing sequentially down my trunk, into my arms, my hands, and my fingers, then down into my legs, my feet, and my toes. Though not painful, it was an odd sensation, one that I had to practice many times a day and, at times, still have to perform. The effects of this ritual, a form of grounding, also known as being psychologically and physically present in the here and now, enabled me to better function in this physical world.

The Journey 2009 to Present

Over time, I became cognizant of a strange feeling of homesickness, a lingering yearning to return to the light. Mixed in with these feelings, however, I was aware of intense negative emotions. I was surprised by and uncomfortable with an intense anger that was becoming increasingly evident. The absence of clarity regarding the source of my anger was perplexing, but my lack of insight into why I was so angry was more troublesome. Research indicates many NDErs return to their lives with a definite sense regarding the reasons for returning to this world (Noyes et al., 2009). This was not my experience; I was among another substantial group who did not have any conscious memories about why they returned or what to do. Therefore, I grappled with feelings of frustration, anger, and confusion about the direction my life should take. However, my continued inner sense of unconditional love and belonging helped to ease these feelings.

Over the past three years, I have processed many emotions and learned much about the NDE phenomenon, NDErs, and the impor-

tance of healthy integration of the aftermath of this event into one's life. The open, nonjudgmental attitude displayed by Holden as I disclosed my experience was the crucial component that encouraged me to, once again, endeavor to disclose my experience to someone and, thus, begin the process of understanding and integrating the physical, emotional, and spiritual changes that accompany an NDE. Regrettably, studies indicate that the difficulties I bear, and the lack of knowledgeable, supportive individuals to assist me in the aftermath of my NDEs, mirror the experiences of other NDErs (Foster et al., 2009).

Although I remain acutely aware of being different from other people, my sense of isolation and estrangement from others has lessened. More importantly, I know that knowledge and insight alone about NDEs and the subsequent alterations is insufficient; critical to the process of integrating this phenomenon into one's life is the opportunity to share the event with an accepting, knowledgeable, and nonjudgmental person. However, there are reasons for hope for the future.

Today, although I remain reticent about both disclosing my NDEs and the associated transformations, when I broach the broader subject of NDEs with my peers, their responses are decidedly less skeptical and judgmental. In addition, I am cautiously encouraged by their desire to know more and their acceptance of the validity of the experience. Indeed, on several occasions, nurses have shared with me their own experiences or those of close friends and family. Tentatively, they inquired if I thought the experiences were NDEs and if I knew how they should proceed. However, the nature of their questions reflect the continued absence of (a) the rudimentary knowledge necessary to recognize NDEs, (b) the awareness of the unique needs of NDErs, and (c) the skills required to support NDErs. Although some progress regarding the attitudes of nurses is apparent, it is equally apparent that nurses continue to lack crucial information necessary to identify NDEs and to administer aid to NDErs. In addition to insufficient knowledge, nurses encounter an additional challenge: an inherent reluctance by NDErs to disclose the happening.

Assisting NDErs in Integrating the Experience

NDErs, fearing others will label them crazy, will challenge the validity of the phenomenon, or will demonize the events, are reluctant to disclose their NDEs (Foster et al., 2009; Noyes et al., 2009; Oakes, 1984). According to research, the responses and attitude of others concerning NDEs are often the decisive factors in NDErs' decisions about

when, where, and with whom to share the experience, if ever. More-over, listeners' reactions such as disbelief, minimizing the experience, or dismissing it as the side effects of medication deter NDErs from speaking of their experiences (Foster et al., 2009; James, 2004; Morris, 1998; Morris & Knafl, 2003; Oakes, 1984). Studies indicate sharing the NDE with supportive individuals is essential to NDErs understanding and integrating the aftermath into their lives. Furthermore, without the assistance of knowledgeable, supportive individuals with whom to share this phenomenon, NDErs may fail to achieve healthy integration of this phenomenon and its far-reaching effects into their lives and relationships (Bush, 2002, 2009; Corcoran, 1988; Flynn, 1984; Foster et al., 2009; James, 2004; Morris, 1998; Morris & Knafl, 2003; Noyes et al., 2009).

In the ensuing years since my first conversation with Holden, I have often wondered what effect a different response on the part of even one of my fellow healthcare professionals might have made in easing my NDE aftermaths. If even one had recognized my experiences as NDEs and would have been able to offer me the support and resources so essential to the healthy integration of the phenomenon, might he or she have lessened the severity of my struggles and challenges? My sense is that the answer to that question is yes. Consequently, as an NDEr and as a nurse, I join the demand of other nursing professionals regarding the necessity for educating nurses concerning NDEs.

Recommendations for Nursing Educators

Design and implement curriculum. The advent of increased medical knowledge and sophisticated technology regarding resuscitation and treatment of patients after life-threatening crises such as a heart attack, stroke, and trauma heightens the likelihood of nurses attending to patients who have had NDEs. Current conversations with my professional peers confirm the findings of studies conducted since the 1980s (Foster et al., 2009): Nurses continue to lack the knowledge base needed to care for NDErs. Despite nurses' repeated appeals for education regarding NDEs (Foster et al., 2009), there appears to remain an absence of nursing education programs concerning this subject. Hence, nurses remain woefully ignorant regarding this phenomenon and uninformed about how to identify and support patients who disclose NDEs. Thus, I have concluded that it is paramount that nursing educators create curricula to remedy the situation.

Designing quality educational programs is both challenging and

time consuming for educators: developing syllabi, identifying appropriate textbooks, researching relevant audiovisual aids, locating and contacting knowledgeable guest speakers, and creating engaging activities. Fortunately, the efforts of psychologist and NDE researcher Kenneth Ring at the University of Connecticut (see Foster et al., 2009; Ring, 1995) and NDE researcher and physician Robert Sheeler at the Mayo Medical School of the Mayo Clinic College of Medicine have pioneered the way by teaching classes about NDEs at their institutions (Foster, et al., 2009; Sheeler, 2005).

Just as Ring and Sheeler have led the way in establishing courses for undergraduate and medical school students, equally important is the need for nurse educators to develop and implement curriculum to inform nurses about NDEs, the unique challenges encountered by NDErs, and best practices to assist NDErs in integrating the phenomenon (Foster et al., 2009). Mary Dee McEvoy (1990) proposed a model for teaching nursing students about NDEs based on accurate knowledge and pragmatics. She (1990) advocated that nursing students should be able to fathom the nature of NDEs and the subsequent aftereffects, be aware of their own beliefs about and attitudes towards transpersonal phenomenon such as NDEs, and be knowledgeable about relevant strategies to assist patients in the discussion of their experiences (also see Foster et al., 2009). Despite the fact that more than two decades have elapsed since her proposal, I found no evidence from the professional literature that McEvoy's model nor any other coursework has found its way into current nursing school curricula. Thus, a good starting point for nursing educators wishing to integrate the topic of NDEs into their nursing education curricula is to investigate McEvoy's model. Although simple, her guidelines provide a sound foundation for nursing educators to build and expand upon today.

Other print resources include the two books that Holden, an experienced NDE researcher and educator, recommends for people wanting to learn about the phenomenon: *Lessons From the Light* (Ring & Valarino, 2000), a summary of research findings about NDEs written for non-experiencers, and *The Handbook of Near-Death Experiences: Thirty Years of Investigation* (Holden et al. 2009), an edited volume with contributions by leading NDE researchers worldwide who provided comprehensive, critical reviews of all research on NDEs through 2006. In addition, the *Journal of Near-Death Studies*, a peer-reviewed journal, offers nursing instructors access to a wide range of scholarly articles on current NDE research and theory from authors around the world.

Regarding online resources, the website of the International Association for Near-Death Studies (IANDS; www.iands.org) offers several educational resources such as a recommended reading list, a bibliography of books on NDEs and related topics, and a speakers' bureau. Also at that website under the Research tab, nursing professionals with IANDS membership can find the scholarly periodical references to research any NDE-related topic through the *Near-Death Experiences Index to the Periodical Literature*, in which every scholarly article ever published on NDEs is indexed by author, title, and topics; it currently covers publications through 2011 and is periodically updated. Another website of possible value to nurse educators is that of the Near-Death Experience Research Foundation (www.nderf.org).

Of particular interest to nurse educators are two recently-developed programs designed specifically to educate health professionals. One is online at the IANDS website: a self-paced, audiovisual course currently accredited for continuing education contact hours by the nursing boards of North Dakota and Texas (http://iands.org/education/online-nde-course.html). This 1.5-hour module was designed to help professionals recognize a pleasurable NDE; in the planning phase are four additional parts that will address NDE aftereffects, characteristics of NDErs, and best practices in assisting NDErs in the short and long terms. Additionally, an educational program designed specifically for medical professionals entitled *Near-Death Experience: What Medical Professionals Need to Know* (Roberta Moore Video Productions, 2013) is due for release in September 2013 and will be available for purchase at the IANDS website. The program packet will include a 30-minute DVD, reading lists, a professionally designed Powerpoint presentation for lectures, possible discussion questions, and suggestions for role-playing.

Conduct research. Clearly, the necessary resources are readily available for nursing faculty to begin to educate future nurses about NDEs and NDErs. Equally important to filling the gap in nurses' education is the need for nursing educators to build on and expand the extant body of research.

Among the topics in need of research is the exact extent of nurses' knowledge about and attitudes toward NDEs. This topic has become difficult to study because the only available assessment instrument has been Nina Thornburg's (1988) Near-Death Phenomenon Knowledge and Attitude Questionnaire, which scholars recently reviewed and found to be outdated (Foster et al., 2009). Fortunately, researcher

Laura Pace (2013) has sought to remedy this situation with her forth-coming methodologically sound instrument: the Knowledge and Attitudes Toward Near-Death Experiences Scale (KANDES). Researchers motivated to further the nursing profession's knowledge and understanding of NDEs and NDErs now have the KANDES to use in their studies—to examine both the current state of affairs and the effectiveness of interventions designed to improve it.

Conclusion

As members of the most trusted profession in America (Gannett Healthcare Group, 2011), nurses are uniquely positioned to assist NDErs to understand and to integrate the changes accompanying an NDE into experiencers' lives and relationships, to create a healing environment, and to address the spiritual needs of patients. In keeping with Nightingale's mandates and the edicts of professional nursing and hospital organizations, it is imperative that nursing faculty design and implement educational courses focused on understanding NDEs and caring for NDErs. In so doing, the profession is likely to substantially reduce the kind of patient suffering to which I can attest and to more completely fulfill its potential to promote patients' optimal wellbeing.

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