

## BRIEF REPORT

# Induced After-Death Communication: An Update

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**ABSTRACT:** Seventy-one clients (50 females, 21 males) who were treated with Induced After-Death Communication (IADC) therapy completed the author-developed Grief Symptom Questionnaire (GSQ) before and after the two-session treatment protocol and at six months post-treatment. Factor analyses revealed three factors—Depression, Anger, and Positive Coping—underlying nine GSQ items. Seventy-nine percent of the sample reported experiencing an IADC during treatment—an experience of communication with a deceased loved one they were grieving. In comparison with pre-treatment, at post-treatment participants reported statistically significant improvements in their grief symptoms, an increase in belief in an afterlife, an improvement in Positive Coping, and decreased Anger and Depression. Implications of the findings and methodological limitations are discussed.

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After-death communication (ADC) is a spontaneous experience in which a living person has a feeling or sense of direct contact with a deceased person (Streit-Horn, 2011, p. 1). Psychologist Allan Botkin, while experimenting with variations of the psychophysiological procedure Eye-Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995), discovered that he could facilitate ADC for his clients. In the original form of EMDR, the psychotherapist uses bilateral stimulation—visual, auditory, or kinesthetic techniques to rhythmically stimulate both sides of the client’s body—to induce a state of consciousness in which the client can process old, problematic psychological material in a new way. Botkin called his adaptation of the technique Induced After-Death Communication (IADC) and first published his findings about it in an earlier issue of this *Journal* (Botkin, 2000).

ADC is quite common. In a systematic review of all research on ADC—34 studies between 1894 and 2006 involving over 50,000 participants from 24 countries—Jenny Streit-Horn (2011) found that at least one-third of people have reportedly experienced ADC at some point in their lives. Remarkably, she found rates of reported ADC to be predominantly consistent across age groups, ethnicities, genders, education levels, incomes, and religious or non-religious affiliations (Streit-Horn, 2011). In addition to the commonality of ADC, researchers have found that the grieving people who experienced it seemed as mentally healthy as the general population and that they almost always reported that it brought relief from their painful symptoms of grief (Arcangel, 2005; Devers, 1997; Guggenheim & Guggenheim, 1995; LaGrand, 1997, 2005; Streit-Horn, 2011).

Botkin (2000, 2005) reported that of all the clients with whom he had conducted his two-session IADC therapy, approximately 75% reported an experience of ADC during the process. In nearly all cases he found that once the client, through bilateral stimulation, accessed and processed the core sadness at the center of the painful experience of grief, associated distressing emotions, such as anger and guilt, and related negative cognitions simply vanished. Once the sadness and attendant grief symptoms diminished, and when clients reported a sense of relief or peace, additional bilateral stimulation typically resulted in an ADC experience. As with ADC, clients who experienced IADC described to Botkin (2005) that they felt a lasting reduction in

distressing grief symptoms. In a 2007 survey of other IADC-trained therapists, Botkin and Hannah (2013) found they reported similar results regarding both process and outcome.

The focus of this report is a further investigation of the percentage of clients in IADC therapy who experienced ADC and a preliminary assessment of the relationship between belief in an afterlife and presence or absence of ADC among Botkin's IADC clients over a recent eight-year period. The report also includes a preliminary analysis of reported changes in grief-related symptoms from before to after IADC therapy, both among all clients and compared between ADC experiencers and non-experiencers; the relationship between belief in an afterlife and symptoms of grief both before and after IADC therapy; and the stability of reported grief symptoms from immediately after treatment to six months later.

## Method

Data for this study came from the approximately 80% of paying clients with whom Botkin used IADC between 2003 and 2010, inclusive. Excluded from the sample were clients Botkin treated with IADC pro bono, trainees in the IADC method, and approximately 20% of paying clients who were excluded for various random reasons, such as Botkin having run out of assessment instruments or having forgotten to administer the instrument post-test. Also excluded were an estimated 8–10% of clients who came to therapy for IADC but who, upon intake, evidenced primary issues other than grief; these clients did not complete the assessment instrument described below and received treatment other than IADC.

A total of 71 clients comprised the sample. Of these, 50 were females, and 21 were males. Their ages ranged from 18 to 91 years, with a mean age of 51. Botkin did not collect ethnicity data. He asked participants at three points in time to complete an instrument he had developed primarily to assess grief: at pre-test prior to the beginning of the first session of IADC treatment, at post-test immediately after the second and last session, and at follow-up six months after the last session.

The instrument for this study was the Grief Symptoms Questionnaire (GSQ) displayed in Figure 1. Beyond face validity and an exploratory factor analysis of the items, which is explained below, no further validity and no reliability had been established for this instrument. Only responses to items 1–9 were analyzed.

**Grief Symptoms Questionnaire (GSQ)**

IADC—yes\_\_\_ partial\_\_\_ no\_\_\_                      Pre\_\_\_ Post\_\_\_ Follow-up\_\_\_

Name\_\_\_\_\_ Date\_\_\_\_\_

Name of Deceased\_\_\_\_\_ Date of Death\_\_\_\_\_

Relationship to Deceased\_\_\_\_\_

Cause/circumstances of Death\_\_\_\_\_

Please rank the following items (1–5), where . . .

0=not at all  
 1=only a little  
 2=somewhat  
 3=considerably  
 4=to a great degree  
 5=completely or maximally

(For people responding post-treatment, answer how you have felt since your treatment)

1. My loss is having an overall negative impact on my life\_\_\_

2. I believe in an afterlife\_\_\_

For items 3–5, rank the intensity of each feeling you have associated with your loss:

3. anger\_\_\_

4. guilt\_\_\_

5. sadness\_\_\_

6. I have unwanted and distressing thoughts or images associated with my loss\_\_\_

7. I believe I can get on with life in spite of my loss\_\_\_

8. I feel disconnected from the person I lost\_\_\_

9. I believe the person I lost is still with me in an important way\_\_\_

For those who have completed treatment:

10. I feel satisfied with the treatment I received\_\_\_

*Figure 1.* Grief Symptom Questionnaire.

A principal components factor analysis of responses to GSQ items at pre-test was performed to identify the underlying constructs measured by the GSQ. This analysis also provided scores on these underlying factors that were used in subsequent analyses. Three interpretable factors emerged from this analysis: “Depression” (GSQ items 4, 5, 6), “Anger” (GSQ items 2, 3, 8), and “Positive Coping” (GSQ items 1, 7, 9). All three factors appeared to reflect the quality of a person’s coping: Depression was characterized by items tapping sadness and

Table 1 *IADC Paired Samples Pre-Post T Tests for Grief Symptom Questionnaire (GSQ) Items*

Item	Mean Diff	SD	df	<i>t</i>	<i>p</i>	$\eta^2$
1. Negative impact of loss	2.30	1.21	69	15.93	< .001	.80
2. Belief in afterlife	-.43	.81	69	-4.43	< .001	.22
3. Anger	2.06	1.36	70	12.73	< .001	.70
4. Guilt	2.18	1.44	70	12.80	< .001	.70
5. Sadness	3.27	.96	70	28.81	< .001	.92
6. Unwanted/distressing thoughts/ images	2.37	1.68	70	11.84	< .001	.67
7. Get on with life	-.97	1.47	70	-5.56	< .001	.30
8. Disconnected from deceased	1.63	1.33	69	10.23	< .001	.60
9. Deceased with me	-1.00	1.55	70	-5.44	< .001	.29

depression, whereas Anger was associated with agitation and anger. Thus, based on the weightings (correlations) between the items and the factors, the first two factors reflected variants of negative coping, whereas the third factor reflected positive coping.

To answer our research questions, we analyzed data for both statistical significance and effect size. In the absence of norms for effect size in ADC or IADC research, we adopted Jacob Cohen's (1988) cautious suggestion for *r* minimum thresholds of .1 for small, .3 for medium, and .5 for large effect and for  $\eta^2$  of .01 for small, .10 for medium, and .25 for large effect.

## Results

Of the 71 IADC therapy participants, 56 (79%) reported experiencing an ADC during the two-session treatment process. Relatively stronger afterlife belief at pretest was associated with greater likelihood of reporting ADC;  $r = .48$ ,  $df = 69$ ,  $p < .001$ , with a medium effect.

Statistical results from *t* tests analyzing pre- to post-test differences on the nine belief- and grief-related GSQ items for all participants appear in Table 1. From pre- to post-treatment, participants showed significant increases on all Positive Coping items—belief in an afterlife, getting on with life, and feeling the deceased with them, all with a large effect, and significant decreases on all negative coping items—both depression-related (guilt, sadness, and unwanted or dis-

troubling thoughts) and anger-related (negative impact of loss, anger, and feeling disconnected from the deceased)—all with a large effect. Thus, after IADC treatment, all participants reported substantial improvement on all grief related symptoms.

Changes in scores from pre- to post-treatment were compared between the two subgroups of IADC experiencers ( $n = 56$ ) and non-experiencers ( $n = 15$ ). IADC experiencers scored significantly higher than non-experiencers on all three GSQ factors: Depression,  $t(67) = 3.37$ ,  $p < .01$ ,  $\eta^2 = .14$ , with a medium effect; Anger,  $t(67) = 4.42$ ,  $p < .001$ ;  $\eta^2 = .23$ , with a medium effect; and Positive Coping,  $t(67) = 5.02$ ,  $p < .001$ ,  $\eta^2 = .27$ , with a large effect.

Regarding the relationship between belief in an afterlife and other grief-related symptoms among all participants, analysis of pre-test scores yielded a significant positive correlation between belief and Positive Coping ( $r = .61$ ,  $df = 69$ ,  $p < .001$ ) with a large effect but not between belief and Depression ( $r = -.12$ ,  $p = .304$ ), with a small effect, or Anger ( $r = -.02$ ,  $p = .895$ ), with no effect. Thus, at pre-test, clients who reported stronger belief in an afterlife also reported significantly better coping but did not report any particular pattern of greater or lesser Depression or Anger.

Analysis of post-test data among all participants yielded significant correlations between belief in an afterlife and each of the three factors: Depression,  $r = -.23$ ,  $df = 69$ ,  $p < .06$ , with a small effect; Anger,  $r = -.37$ ,  $p < .01$ , with a medium effect; and Positive Coping,  $r = .44$ ,  $p < .001$ , with a medium effect. Thus, at post-test, clients—both with and without ADC—who reported stronger belief in an afterlife also reported significantly better coping and significantly less depression and anger.

A subset of 16 of the participants (23%) mailed back the completed GSQ assessment at six-month post treatment follow-up. Among these participants, two-tailed  $t$  test on all nine items revealed no significant difference between post-test and follow-up GSQ scores, with results ranging from  $t(14) = -1.74$ ,  $p = .10$ ;  $\eta^2 = .17$  with a small effect, to  $t(14) = .00$ ,  $p = 1.00$ ;  $\eta^2 = .00$ , with no effect. Thus, for this subsample, the substantial improvements in grief symptoms participants reported immediately after IADC treatment were maintained at six-month follow-up.

## Discussion

For several reasons, the results of this analysis must be considered only preliminary and their implications only tentative. These reasons

include the relatively small sample size, the fact that the sample consisted of only about 80% of the total population of clients who received IADC treatment from Botkin during a given period of time, the exclusion of the other 20% on the basis of non-uniform criteria, the small size of the follow-up subsample, and aside from the preliminary factor analysis, the lack of evidence of reliability and validity of the GSQ. In addition, the absence of wait-list and alternative-treatment control groups leaves open the possibility that any psychotherapeutic intervention might have yielded similar results—though the grief-related psychotherapy literature would indicate otherwise; for a brief review, see Foster & Holden (2013). Nevertheless, with these important limitations in mind, the results of this study can be considered only suggestive.

Of note is the fact that the rate of participants who reportedly experienced an ADC during IADC therapy in this study was similar to Botkin's (2000) initial observation and to what Botkin found upon collecting similar data on clients treated by other IADC therapists whom he had trained (Botkin & Hannah, 2013). Thus, the results seem to substantiate an expectation that about three-fourths of clients in IADC therapy will actually experience an ADC during the therapy.

Among this sample, the more strongly participants reported at pre-test that they believed in an afterlife, the more likely they were to experience an ADC during the therapy. This finding surprised us in that our clinical observation has been slightly the opposite: Clients' prior beliefs about an afterlife actually have made a successful ADC induction more difficult. Our assumption has been that the expectations and emotional investment that accompany strong beliefs have interfered with the state of mind critical to experiencing ADC: openness and receptivity—akin to the concept in biofeedback of passive, rather than active, volition. A factor that might explain the discrepant finding between clinical observation and this study is one we did not assess: clients' prior ADC experiences. That is, prior ADC may have both increased belief in an afterlife and also facilitated ADC during the therapeutic procedure. Thus, it may still be the case that, among clients who have not experienced ADC prior to therapy, a strong belief in an afterlife presents an impediment to experiencing ADC during IADC treatment. Resolution of this issue remains for future research.

In this sample, all participants reported, from pre- to post-test, a significant increase in belief in an afterlife and, regarding grief-related symptoms, increased positive coping and decreased depression and anger. These results are encouraging in two ways: They suggest that IADC may be an effective psychotherapeutic approach to heal-

ing grief, and they provide justification for future research on this approach. Such additional research should include studies with large, well-formed samples, using randomized assignment and assessment instruments with previously established strong psychometric properties. Future analyses of the nature and effects of IADC should also ideally include brain studies to ascertain the neurophysiological changes induced by IADC treatment. In fact, such studies incorporating methodological improvements are presently either in the planning stage or already underway. For example, researchers at the University of Virginia are currently engaged in sophisticated EEG studies of IADC therapy and of the brain-based concomitants of IADC experiences.

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