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Editor’s Foreword

True to the “International” component of the title of the hosting association for this Journal, this issue begins in the U.S. and ends on the opposite side of the globe, in New Zealand. The foci of the issue’s three articles also diverge substantially: The first two address nurses’ care of near-death experiencers (NDErs), and the last addresses cultural implications of one near-death experience (NDE) account.

In the NDE integration process, nurses may play an especially important role. My own and others’ research indicates that nurses are the most common confidantes to whom NDErs first disclose their NDEs and that first disclosures can powerfully impact NDErs’ integration trajectories—for good or ill. The opening article of this issue was written by an author in a unique position to comment on these topics: She is both a veteran emergency room nurse and a two-time NDEr. In her article, Judith Mandalise, M.Ed., RN, CEN, LPC, lays a foundation of historical context resulting in ethical and clinical mandates for nurses to provide high quality care to patient NDErs. As a result of her personal and professional experience surrounding her own and her patients’ NDEs, Mandalise concludes that much remains to be accomplished for nurses to be competent to serve well their patients with NDEs.

Mandalise’s conclusion is echoed in the findings of a study of nurse educators’ knowledge of and attitudes towards NDEs and deathbed visions (DBVs) by Linda Moore, Ed.D., MSN, RN, and Christopher L. Pate, Ph.D., MPA, CQIA. Their sample of nurses-turned-faculty-members indicated that Mandalise is not alone among nurses who’ve had NDEs and who’ve cared for patients who’ve have NDEs or DBVs. Similar to Mandalise, Moore and Pate conclude that, despite decades-old admonitions that these topics be included in nursing curriculum, widespread response very much needs to be realized—but has yet to be.

This issue closes with a Brief Report by Natasha Tassell-Matamua, Ph.D., a lecturer in cultural psychology and a New Zealander of Māori descent. She brings her unique professional and personal perspectives to bear in a reexamination of an NDE reported by a Māori woman—this time to address not the extent to which the NDE account com-
pares to Western NDEs but the extent to which it compares to Māori afterlife beliefs. From her inquiry, Tassell-Matamua concludes that her findings leave open the question of whether NDE contents are universal or culturally determined.

I hope readers find that the diverse contents of this issue contribute to a further deepening of their knowledge in the field of near-death studies.

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

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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).

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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 & Ingalis, 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 non-judgmental 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. Moreover, 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 forthcoming 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.

**References**


Williams, A. M., & Irurita, V. F. (2004). Therapeutic and non-therapeutic inter-


Reflections of Near-Death Experiences and Deathbed Visions: A Study of Nursing Faculty’s Perceptions

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ABSTRACT: Nursing faculty across the United States were surveyed about their knowledge, attitudes, and perspectives of near-death experiences (NDEs) and deathbed visions (DBVs) through web-based administration of the Near-Death Phenomena Knowledge and Attitudes Questionnaire (Thornburg, 1988). Of the approximately 550 responses, 13% of respondents indicated that they personally had experienced an NDE, 48% that they have cared for a patient reporting an NDE, and 46% that they have cared for a patient reporting a DBV. Item-level ordinal logistic regression analysis was used to evaluate the two attitude components of the survey, revealing a complex set of relationships between attitudes, experience, and other individual-level characteristics. The results underscore the importance of ongoing research into near-death phenomena and inclusion of NDEs and DBVs as content areas in nursing curriculum.

KEY WORDS: nursing faculty; attitudes; near-death experiences; deathbed visions

Near-death experiences (NDEs) and deathbed visions (DBVs) have been described throughout the annals of history dating back to early beginnings of recorded ethnography (Badham, 1997). However, these experiences have been a primary focus of refereed research for just over the past 40 years (Greyson, 1983; Holden, Greyson, & James, 2009; Moody, 1975; Ring, 1980). Research in the area of NDEs has

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included both qualitative analysis of personal accounts and quantitative studies of NDE contents and aftereffects (Holden et al., 2009). Research in the area of DBVs has been sparse (for example, Osis & Haraldsson, 1988), yet a growing interest in end-of-life experiences has been gaining momentum over the past 10 years (Fenwick & Fenwick, 2008; Streit-Horn, 2011). Although conceptual similarities exist between DBVs and NDEs (See Figure 1), a primary difference between the two is related to clinical death: The DBV experiencer is not undergoing clinical death at the time of the vision but is in a terminal state and may be within minutes, hours, days, weeks, or months of dying (Greyson, 1997). End of life events (ELEs), defined as experiences associated with spiritual visions that point toward an afterlife and also include DBVs, have been expressed by experiencers to loved ones and health care personnel; however, up until the last decade, most professionals have discounted the accounts as last wisps of life—states of confusion—and, thus, these anecdotes have only rarely been explored utilizing scientific inquiry (Parnia, 2006).

Military nurse Diane Corcoran (1988) observed that NDEs and DBVs have an enormous impact on both the patient and family members. These events also have substantial meaning for clinical personnel caring for patients experiencing the events (Morris & Knafl, 2003). The direct care nurse charged with holistic care must be knowl-
edgeable and accepting of NDEs and DBVs in order to provide culturally competent care to patient and family members (Foster, James, & Holden, 2009). Because a clinical nurse may be the first licensed healthcare professional to encounter a patient having an NDE or a DBV, knowledge and understanding of these phenomena becomes even more important. Nevertheless, misunderstandings and inadequate knowledge of these phenomena among clinical personnel (Morris & Knafl, 2003) may prevent the quality of care expected in contemporary healthcare environments.

The importance of ensuring that the direct-care nurse has received instruction that enables exploration of near-death phenomena cannot be underestimated (Brayne, Lovelace, & Fenwick, 2008). The nursing educator is the individual who provides initial mentoring of the student nurse and prepares the student nurse for a lifelong career in the comprehensive delivery of care to patients and families of patients (McGovern-Billings & Halstead, 1998). In the process of mentoring students, nursing faculty members who exhibit positive attitudes toward near-death phenomena will likely be more open to exploration and inclusion of content associated with situations involving NDEs and DBVs.

Although nursing knowledge and attitudes associated with NDEs and DBVs are important in providing holistic, culturally competent nursing care, our search of the professional literature—using academically recognized data search engines, including CINAHL Plus with Full Text, Health-Wellness Resource Center, PsycINFO, ProQuest, EBSCO, Religion & Philosophy Collection, and Google Scholar—failed to yield research focused on comprehensive exploration of knowledge and attitudes toward NDEs or DBVs among nursing educators. We found a few studies in which researchers assessed NDE knowledge of healthcare workers or paraprofessionals and more literature focused on attitudes toward NDEs by healthcare providers, including clergy, hospital nurses, hospice nurses, physicians, and psychologists (Barnett, 1990; Bucher, Wimbush, Hardie, & Hayes (1997); Corcoran, 1998; Cun- cio, 2001; Holden, Oden, Kozlowski, & Hayslip, 2011; McEvoy, 1990; Moody, 2007; Moore, 1994; Morse, 1983; Oaks, 1981; Royse, 1985; Sa- bom, 1982; Thornburg, 1988; Walker & Russell, 1989; Wimbush, F., Hardie, T., & Haynes, E., 1997). Although Linda Morris and Kathleen Knafl’s (2003) did not examine knowledge and attitudes specifically, they examined nursing experiences with NDEs in terms of spiritual and practice-related domains, which have direct implications for clinical practice. We found only one empirically-based study that included
attention to implications for palliative care in regards to end-of-life experiences associated with attitudes toward DBVs (Fenwick, Lovelace & Brayne, 2007). Furthermore, it is our observation that knowledge of NDEs and DBVs is not typically acquired through undergraduate nursing education because textbooks used in undergraduate education programs lack specific content on these phenomena.

Our research focused on assessing experiences of caring for NDE and DBV patients, as well as knowledge and attitudes toward near-death phenomena, among nurses who have become nursing educators and who may have provided care for NDE and DBV patients. Specifically, we sought to investigate nurse educators’ knowledge and attitudes toward near-death phenomena and reported experiences that the nurses may have encountered.

For the theoretical framework for this study, we used Jean Watson’s theory of human caring (1988) coupled with Antony Flew’s (2007) concept of human perceptions—whereby an experience is real to the individual who has it (Figure 2). A central element within Watson’s theory, the actual caring occasion (ACO), sets the stage whereby the discussion of the existence of NDEs and DBVs became the focal point, creating what Watson (1984) termed the phenomenal matrix. The ACO, a multi-dimensional phenomenological experience, is greater than just the sum of the caring event (NDE or DBV). From Watson’s (1985) ACO perspective, individuals engaged in the therapeutic experience are part of the whole caring phenomenon. Individuals experiencing

![Figure 2. Theoretical framework utilizing Watson's (1985) actual caring occasion and Flew's (2007) concept of human perceptions.](image-url)
the ACO include the nursing faculty, the NDE/DBV patient, the nursing student, and the phenomenological experiences that each of these individuals has experienced and discussed.

**Methods**

For this study, we used a non-experimental, cross-sectional research design that included electronic administration of an instrument designed to assess knowledge and attitudes about NDEs. We used this approach to address the following research questions:

- What do nursing faculty members know about NDEs?
- What are the attitudes of nursing faculty members toward NDEs?
- What are the perceptions of nursing faculty members regarding NDEs?
- What are the perceptions of nursing faculty members regarding DBVs?
- How do personal experiences with NDEs and DBVs relate to nursing faculty members' knowledge, beliefs, and attitudes about NDEs and DBVs?

**Participants**

Participants were recruited from the National League of Nursing (NLN), a professional nursing organization focusing on evidence-based research and translation of research findings into practice (NLN, 2010). An application was submitted to the research department of NLN, and the primary investigator was allowed to purchase a directory listing of a subset of colleges and universities that were members of the NLN.

Members of the NLN who participated in the study were nursing educators who taught in a variety of nursing academic arenas that included vocational nursing, associate degree, bachelor of science, master of science, and doctoral programs. Using a non-random selection process of NLN accredited schools of nursing that allowed access to nursing faculty members' email addresses, faculties from 19 states and the territory of Guam were targeted to participate in the study. After receiving approval from the Texas A&M University-Corpus Christi's Institutional Review Board, the primary investigator began a systematic process of accessing nursing faculty email addresses from the identified schools.
Instruments

Nina Thornburg’s (1988) Near-Death Phenomena Knowledge and Attitudes Questionnaire (NDPKAQ) consists of three distinct components: knowledge of NDEs (Knowledge), attitudes toward NDEs (Attitudes), and attitudes toward caring for NDE patients (Care). The Knowledge component consists of 23 statements with response alternatives of true, false, and undecided. The 23-item Attitudes component and the 20-item Care component consist of five-category Likert-type items with response options of strongly agree, agree, undecided, disagree, and strongly disagree. Piloting her NDPKAQ tool with intensive care nurses, Thornburg (1988) found adequate internal consistency, with reported Cronbach’s alpha coefficients of .83, .84, and .81 associated with the Knowledge, Attitudes, and Care components, respectively. Content validity was substantiated by individuals whom Thornburg reported were experts in the field of NDE research at that time (Thornburg, 1988; Walker & Russell, 1989).

For this research study, we developed three additional sections to capture demographic and qualitative information regarding respondents’ experiences with NDEs and DBVs. The demographic section included five questions about gender, ethnicity, age, education level, religious/spiritual preference; five questions about experience with NDEs and DBVs; and a single question about teaching or mentoring experience in nursing education. We also created two sections with open-ended questions to provide respondents with the opportunity to describe experiences with NDEs and DBVs. In summary, the six-part survey allowed a combination of quantitative and qualitative measurements and consisted of: (a) demographics, (b) knowledge of NDE, (c) attitudes toward NDE, (d) attitudes toward caring for NDE patients, (e) perspectives on NDEs, and (f) perspectives on DBVs. We developed an online version of the NDPKAQ and pilot tested it prior to conducting the study to ensure its utility. Qualtrics® (2009), a web-based survey tool, was used for survey administration and data collection. Descriptive and inferential analyses were conducted using Minitab® (2010).

Results

Demographics

Out of 3,673 nursing faculty members to whom we distributed questionnaires, 588 accessed the survey and, of these, 17 elected not to participate, leaving 571 (15.55%) participants who responded to enough
of the survey to make their responses usable. The majority of participants were female (94%), and the reported age of respondents ranged from 28 to 76 years with a mean of 52.99 years and a 95% confidence interval of [52.20, 53.77]. Over half of respondents were master’s-prepared nurses, and 25% were doctorate-prepared. Of the respondents who identified ethnicity, 442 (80%) indicated Caucasian, 38 (7%) indicated African-American, 25 (5%) indicated blended ethnicity, 22 (4%) indicated Hispanic, and the remaining 22 (4%) indicated American Indian, Asian, or other. Regarding religious affiliation, 88% of participants indicated Christian, and the remaining 12% reported being of various belief systems, including Muslim, Universalist, Hindu, Buddhist, Atheist, Wiccan, and Scientist. Regarding career experience, of the 552 participants who responded, 256 (46%) indicated that their career had included teaching or mentoring entry-level licensed nurses.

Regarding experience with NDEs and DBVs, respondents were provided with five questions in a yes/no format that assessed personal, familial, or patient-related experiences. Some participants reported they had personally had an NDE (71; 13%), had cared for a patient who reported an NDE (262; 48%), had a family member who reported an NDE (127; 23%), had provided care for a patient or family member who reported a DBV (250; 46%), and had personally experienced a DBV or had a family member who reported a DBV (151; 21%).

**NDE Knowledge**

Knowledge scores were calculated using Thornburg’s (1988) scoring procedure that she developed with the original NDPKAQ, which includes reverse-scoring for false items. By individual test item, correct responses ranged from 3.5% to 76.9%, whereas the percentage of undecided responses by test item ranged from 16.1% to 83.7% (see Table 1). Although use of individual item response theory (IRT) was not a central objective of the study, we used the theoretical approach to summarize results by the proportion of correct responses, which is typical in the analysis of polychotomous scoring of item responses for nominally scaled data (Drasgow & Hulin, 1990). With 0 representing incorrect response, .5 uncertainty, and 1 correct response, the mean score (i.e., proportion correct) across all 23 items for the 519 nurse educators who completed at least one item on the Knowledge component was 0.37 with a standard deviation of 0.24. Evaluation of the missing item-level responses (i.e., those that were skipped) revealed a negligible impact on the component mean: Using complete cases for
Table 1  *NDE Knowledge Component Summary by Response Counts and Percentages*

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<th>Item Number</th>
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Note: Shaded cells indicate correct responses by item. Total n = 519 for this component and “Total” column reflects the number of non-missing responses.
the component resulted in a mean score of 0.38 with a standard deviation of 0.24. Thus, on average, nurse educators’ responses on the Knowledge component were more incorrect than correct.

The lowest percentages of correct responses were found for the following three false items: 8. Suicide-induced NDEs are unpleasant (3% correct); 14. There are no significant differences between NDEs related by those who are not given drugs (6% correct); and 19. Alcohol intoxication while close to death diminishes the likelihood of a NDE (5% correct). The highest percentages of correct responses were found for the following four true items: 13. Over 80% of NDE survivors report a greater appreciation for life and of attempting to live more fully following a NDE (69% correct); 3. A point may be described by the NDE survivor where the person was told or had the choice to return to his/her body (70% correct); 22. The NDE has a powerful effect on client’s subsequent belief in an afterlife (72% correct); and 17. The NDE has been described as being peaceful, quiet, and without sensation of pain (76% correct).

Although the distribution of raw scores by individual respondent displayed an approximately normal shape, the distribution was left-skewed because of zero scores: Approximately 5% of the individuals scored zero on Knowledge ($A^2 = 4.69, p < .005$). The respondent mean score was 8.70 out of 23, with a 95% confidence interval of [8.35, 9.04]. Regression analysis of individual raw scores on age, ethnicity (Caucasian versus otherwise), education level (master’s and doctoral level versus otherwise), religion (Judeo-Christian versus otherwise), and all five dummy coded NDE/DBV experience categories yielded an adjusted $R^2$ of 3.0% ($F = 3.32, p < .009$). Two of the predictors were significant given $\alpha$ levels of .10: The average score for nurse educators at the doctoral level was 1.01 points higher than those with education levels up to and including the bachelor’s degree ($b = 1.01, p = .085$), whereas the average score for nurse educators reporting that they had cared for patients or family members experiencing DBVs (DBV - Patient or Family Care) was .947 points lower than those that did not report this experience ($b = -.947, p = .031$).

### NDE Attitudes

Participants’ responses to Attitude items are summarized in Table 2. Out of a possible total Attitude score of 100% calculated by the number of responses that strictly fall in the most positive or most negative categories (strongly agree or strongly disagree) divided by the non-
<table>
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<td>3</td>
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</tbody>
</table>

Note: Shaded cells indicate most positive attitude. Table n represents non-missing responses; total n = 499 for component.
missing responses for individual item, for the 499 nurse educators who completed at least one item on the component, scores ranged from 1.2% (13. Nurses should be the first to hear of their client’s NDE report) to 54.9% (11. Students should not be allowed to work with clients who report NDE) with a mean of 20.8% and a 95% confidence interval of [14.7, 26.9]. Positive scoring of the top two (bottom) categories indicate that, on average, nurse educators’ attitudes towards NDEs leaned strongly toward the positive: The percentage of positive responses by item averaged 66.1% with a 95% confidence interval of [57.1, 75.2].

Over half of the participants agreed that course content about near-death phenomena should be included in nursing curriculum; however, the majority stated that it should not necessarily be the nurse who hears about the experience first. Most participants indicated that stories about near-death phenomena did not frighten them. In the questionnaire section on attitude toward caring for an NDE patient, participants expressed uncertainty that NDE stories make them feel less afraid of death. Participants agreed that open dialogue with patients experiencing NDEs should be documented in the medical record. Participants also affirmed that students should be encouraged to engage in near-death research.

Exploratory ordinal logistic regression analysis was conducted to evaluate the relationship between item responses, demographic variables, and NDE/DBV experiences. Predictors in the model included age (years), sex, religion, ethnicity, education level, and NDE/DBV experiences. With the exception of years of age, dummy coding was used for all categorical predictors, where (a) sex was coded as 1 = female, 0 = otherwise; (b) ethnicity was coded as 1 = Caucasian, 0 = otherwise; (c) education was coded as 1 = masters, 0 = otherwise; doctoral = 1, 0 = otherwise; (d) religion was coded as 1 = Judeo-Christian, 0 = otherwise; and (e) all NDE/DBV experiences dummy coded for each experience category (i.e., personally had NDE coded as 1, 0 = otherwise, etc.). Coding of the ordinal response followed the convention that the response “strongly agree” = 1, “agree” = 2, “undecided” = 3, “disagree” = 4, and “strongly disagree” = 5, with the latter category serving as the referent category in the coding scheme. We first examined overall model significance for each regression and are reporting the by-item regression results on those that had overall p-values < .05.

Table 3 provides goodness of fit statistics (G) for overall model significance, associated p-values, and listing of variables with significant Wald statistics (p < .05). Of the 23 regressions, 12 yielded model fit statistics below the threshold. The regression coefficients listed
Table 3  General Attitude Component: Ordinal Regression Analysis Summaries by Significant Predictors and Model Significance

<table>
<thead>
<tr>
<th>Item</th>
<th>Predictors with Significant Wald Tests</th>
<th>Model Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>DBV - Patient/Family Care ($b = .599, p = .009$)</td>
<td>$G = 35.24$, $p = .005$</td>
</tr>
<tr>
<td>3</td>
<td>Ethnicity ($b = .521, p = .014$); Religion ($b = -.465, p = .056$); DBV - Personal/Family Exp ($b = -.375, p = .090$)</td>
<td>$G = 25.179$, $p = .005$</td>
</tr>
<tr>
<td>4</td>
<td>NDE - Family Member ($b = -.523, p = .046$); DBV - Patient/Family Care ($b = -.435, p = .080$)</td>
<td>$G = 19.056$, $p = .040$</td>
</tr>
<tr>
<td>7</td>
<td>Education (doctoral degree, $b = 1.252, p &lt; .001$); DBV - Patient/Family Care ($b = -.143, p = .036$)</td>
<td>$G = 33.602$, $p &lt; .001$</td>
</tr>
<tr>
<td>8</td>
<td>Education (doctoral degree, $b = -.693, p = .031$); DBV - Patient/Family Care ($b = -.668, p = .006$)</td>
<td>$G = 25.654$, $p = .004$</td>
</tr>
<tr>
<td>9</td>
<td>NDE - Patient Care ($b = -.620, p = .005$); DBV - Patient/Family Care ($b = -.534, p = .014$); DBV - Personal/Family Exp ($b = .419, p = .047$)</td>
<td>$G = 18.952$, $p = .041$</td>
</tr>
<tr>
<td>11</td>
<td>Ethnicity ($b = -.623, p = .007$); Education (doctoral degree, $b = .777, p = .015$); NDE - Family Member ($b = -.614, p = .012$); DBV - Patient/Family Care ($b = -.791, p = .001$)</td>
<td>$G = 31.950$, $p &lt; .001$</td>
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<tr>
<td>12</td>
<td>Ethnicity ($b = .554, p = .010$); Education (doctoral degree, $b = -.798, p = .008$); DBV - Patient/Family Care ($b = -.589, p = .009$)</td>
<td>$G = 38.959$, $p &lt; .001$</td>
</tr>
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<td>13</td>
<td>Education (doctoral degree, $b = .711, p = .027$); NDE - Family Member ($b = -.546, p = .036$); DBV - Patient/Family Care ($b = -.860, p = .001$)</td>
<td>$G = 30.828$, $p &lt; .001$</td>
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<tr>
<td>15</td>
<td>DBV - Patient/Family Care ($b = -.622, p = .005$)</td>
<td>$G = 21.167$, $p = .020$</td>
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<tr>
<td>16</td>
<td>Sex ($b = -.935, p = .020$); Ethnicity ($b = -.588, p = .007$); DBV - Patient/Family Care ($b = .445, p = .050$)</td>
<td>$G = 40.041$, $p &lt; .001$</td>
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<td>17</td>
<td>Ethnicity ($b = .839, p &lt; .001$); NDE - Personal Exp ($b = -.712, p = .010$); DBV - Patient/Family Care ($b = -.469, p = .034$)</td>
<td>$G = 29.477$, $p = .001$</td>
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<tr>
<td>18</td>
<td>Ethnicity ($b = -.795, p &lt; .001$); Education (doctoral degree, $b = -.739, p = .018$); NDE - Family Member ($b = .498, p = .041$); DBV - Patient/Family Care ($b = .796, p = .001$)</td>
<td>$G = 39.512$, $p &lt; .001$</td>
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<td>20</td>
<td>Ethnicity ($b = -.910, p &lt; .001$); DBV - Patient/Family Care ($b = .864, p &lt; .001$)</td>
<td>$G = 42.164$, $p &lt; .001$</td>
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</table>
in the table refer to the change in the logit for a unit change in the predictor (Hosmer & Lemeshow, 1989; O'Connell, 2006). Coefficients can be changed to odds-ratios through exponentiation of and—given Minitab’s operationalization of the ordinal regression model—positive coefficients indicate greater association with the higher ranked response category, with “strongly agree” assigned as the highest ranked category. In the analysis of Item 1, for instance, education (master’s degree) was a significant predictor in a model with an overall significance of $p < .001 (G = 35.240)$. The estimated slope coefficient of 0.572 translates to an odds-ratio of 1.77, which is 1.77 times the odds for the omitted category in the agree direction rather than the disagree direction: Master’s prepared nurses were more likely to select the higher ranked response category compared to other response categories (i.e., “strongly agree” versus “agree,” “strongly agree versus “neutral,” “agree” versus “neutral,” and so on) than nurses in the referent category, which included licensed practical nurses, licensed vocational nurses, diploma level RNs, associate degree RNs, BSNs, and those listed as “other.” Regression models on the following items were significant at the prescribed threshold:

Item 1: Students should be encouraged to carry out research dealing with Near-Death phenomena.
Item 5: A course dealing with Near-Death phenomena should be available to nursing students.
Item 6: Some clients are reluctant to report their NDEs.
Item 8: Most clients who have NDEs have underlying psychological problems.
Item 9: Stories I have heard about Near-Death phenomena frighten me.
Item 11: Students should not be allowed to work with clients who report NDEs.
Item 12: Students would very likely benefit from taking a course dealing with Near-Death phenomena.
Item 14: Continuing education programs should be developed to help nurses work with clients who have had NDEs.
Item 16: An in-service conference on Near-Death phenomena is a waste of valuable time.
Item 17: Courses dealing with Near-Death phenomena should be included in nursing curricula.
Item 18: Most of what clients remember of their NDEs is wishful thinking.
Item 20: Clients need to be reassured that their NDEs are normal, and do not indicate psychological imbalances.
Although no consistent pattern emerged across the regression models, education, religion, sex, ethnicity, and NDE/DBV experiences were significant with respect to individual item responses in the general attitudes component of the NDPKAQ. Of the predictors, DBV - Patient/Family Care was significant in 10 of the items (Items 2, 4, 7, 8, 9, 11, 12, 13, 15, and 16). In seven of the items, participants were less likely to select responses associated with positive attitudes (2, 4, 7, 9, 12, 13, and 16), whereas in three of the items (8, 11, 15) participants were more likely to select positive attitude responses versus individuals in the referent group (i.e., those not in the DBV - Patient/Family Care group). Similarly, responses from nurse educators that were doctorally trained were significantly different than nurse educators with education levels at the master’s level or lower; however, the pattern of responses was not consistent across items. In three of the items (8, 11, 12), the doctorally trained nurses were more likely to select more positive attitude responses, whereas in two of the items (7, 13) the doctorally trained nurses were less likely to select positive attitude response categories. Ethnicity was a significant predictor in four of the items, with white nurses more likely to select positive attitude responses in three items (3, 12, 16) and less likely to select positive attitudes in item 11. Nurse educators who reported familial experience with an NDE (NDE - Family Member) were less likely to select positive attitude responses in items 4 and 13, whereas individuals in this group were more likely to select positive attitude response categories in item 11. With item 3, individuals classified as Judeo-Christian and individuals reporting either a personal or familial experience with a DBV (DBV - Personal/Family) were less likely to select positive attitude responses versus their respective referent categories. Females were more likely to select positive attitude responses with item 16.

Care of NDE Patients
Participants’ responses to Care items are summarized in Table 4. Out of a possible total Care score of 100% calculated by the number of responses that strictly fall in the most positive or most negative categories (strongly agree or strongly disagree) divided by the non-missing responses for individual item, for the 479 nurse educators who completed at least one item on the component, scores ranged from 5.1% (6. Nurses should not postpone talking about NDEs with a client even if his or her condition is unstable) to 64.7% (4. Clients who have NDEs should have the same quality of care as clients who do not have
NDEs) with a mean of 29.5% and a 95% confidence interval of [19.8, 39.3]. Positive scoring of the top two (bottom) categories indicate that, on average, nurse educator’s attitudes towards caring leaned strongly toward the positive: The percentage of positive responses by item averaged 72.6% with a 95% confidence interval of [63.1, 82.3].

The majority of study participants indicated positive attitudes to-

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<tr>
<th>Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
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</table>

Note: Shaded cells indicate most positive attitude. Table n represents non-missing responses; total n = 479 for component.
Table 5  **Attitudes Toward Caring Component: Ordinal Regression Analysis Summaries by Significant Predictors and Model Significance**

<table>
<thead>
<tr>
<th>Item</th>
<th>Predictors with Significant Wald Tests</th>
<th>Model Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>DBV - Patient/Family Care ( b = .599, p = .009 )</td>
<td>( G = 24.987, p = .005 )</td>
</tr>
<tr>
<td>3</td>
<td>Ethnicity ( b = .521, p = .014 ); Religion ( b = -.465, p = .056 ); DBV - Personal/Family Exp ( b = -.375, p = .090 )</td>
<td>( G = 25.179, p = .005 )</td>
</tr>
<tr>
<td>4</td>
<td>NDE - Family Member ( b = -.523, p = .046 ); DBV - Patient/Family Care ( b = -.435, p = .080 )</td>
<td>( G = 19.056, p = .040 )</td>
</tr>
<tr>
<td>7</td>
<td>Education (doctoral degree, ( b = 1.252, p &lt; .001 )); DBV - Patient/Family Care ( b = -.143, p = .036 )</td>
<td>( G = 33.602, p &lt; .001 )</td>
</tr>
<tr>
<td>8</td>
<td>Education (doctoral degree, ( b = .693, p = .031 )); DBV - Patient/Family Care ( b = -.668, p = .006 )</td>
<td>( G = 25.654, p = .004 )</td>
</tr>
<tr>
<td>9</td>
<td>NDE - Patient Care ( b = .620, p = .005 ); DBV - Patient/Family Care ( b = -.534, p = .014 ); DBV - Personal/Family Exp ( b = .419, p = .047 )</td>
<td>( G = 18.952, p = .041 )</td>
</tr>
<tr>
<td>11</td>
<td>Ethnicity ( b = .623, p = .007 ); Education (doctoral degree, ( b = .777, p = .015 )); NDE - Family Member ( b = -.614, p = .012 ); DBV - Patient/Family Care ( b = -.791, p = .001 )</td>
<td>( G = 31.950, p &lt; .001 )</td>
</tr>
<tr>
<td>12</td>
<td>Ethnicity ( b = .554, p = .010 ); Education (doctoral degree, ( b = -.798, p = .008 )); DBV - Patient/Family Care ( b = -.589, p = .009 )</td>
<td>( G = 38.959, p &lt; .001 )</td>
</tr>
<tr>
<td>13</td>
<td>Education (doctoral degree, ( b = .711, p = .027 )); NDE - Family Member ( b = -.546, p = .036 ); DBV - Patient/Family Care ( b = -.860, p = .001 )</td>
<td>( G = 30.828, p = .001 )</td>
</tr>
<tr>
<td>15</td>
<td>DBV - Patient/Family Care ( b = -.622, p = .005 )</td>
<td>( G = 21.167, p = .020 )</td>
</tr>
<tr>
<td>16</td>
<td>Sex ( b = -.935, p = .020 ); Ethnicity ( b = -.588, p = .007 ); DBV - Patient/Family Care ( b = .445, p = .050 )</td>
<td>( G = 40.041, p &lt; .001 )</td>
</tr>
<tr>
<td>17</td>
<td>Ethnicity ( b = .839, p = .000 ); NDE - Personal Exp ( b = -.712, p = .010 ); DBV - Patient/Family Care ( b = -.469, p = .034 )</td>
<td>( G = 29.477, p = .001 )</td>
</tr>
<tr>
<td>18</td>
<td>Ethnicity ( b = -.795, p &lt; .001 ); Education (doctoral degree, ( b = -.739, p = .018 )); NDE - Family Member ( b = -.498, p = .041 ); DBV - Patient/Family Care ( b = .796, p = .001 )</td>
<td>( G = 39.512, p &lt; .001 )</td>
</tr>
<tr>
<td>20</td>
<td>Ethnicity ( b = -.910, p &lt; .001 ); DBV - Patient/Family Care ( b = .864, p &lt; .001 )</td>
<td>( G = 42.164, p &lt; .001 )</td>
</tr>
</tbody>
</table>
ward caring for a patient who reports an NDE. Participants indicated that they should listen attentively to patients' descriptions of their NDEs and feel that these patients deserve to have the same quality of care as patients who do not have NDEs. Most participants indicated that they would welcome the opportunity to work with a patient who had an NDE.

Evaluation of the relationship between personal/professional characteristics, NDE/DBV experiences, and responses on the fourth component of NDPKA followed the same approach as presented previously. We used item-level ordinal logistic regression with model level significance set at $p = .05$ as a threshold and present variables, coefficients, $p$-values, and model statistics for those regressions beyond the threshold. Of the 20 regressions, 14 produced significant $G$ statistics (see Table 5). Regressions on the following questionnaire items yielded significant $G$ statistics:

Item 2: An in-service program on NDEs would be a waste of time.
Item 3: Clients are often aware of resuscitation activities even after respiration and circulation cease.
Item 4: Clients who have NDEs should have the same quality of care as clients who do not have NDEs.
Item 7: Nurses should not interview post-CPR clients about their NDEs without supervision of a physician.
Item 8: I should listen attentively to any NDE report and allow the client to complete the story.
Item 9: Clients who are preoccupied with their NDEs should be referred for professional help.
Item 11: Clients should be able to share their feelings and recollections about their NDEs with whomever they feel most comfortable.
Item 12: I would attend a Near-Death educational program offered by NLN or other professional nursing organization.
Item 13: It is important for me to be nonjudgmental of what I hear no matter how incredible it may seem.
Item 15: Hearing a client’s NDE makes me less afraid of death.
Item 16: Clients are making up stories when they report their NDEs.
Item 17: I would like to work with a client who has had a NDE.
Item 18: Clients’ reports of their NDEs should be ignored.
Item 20: I would not want to work with a client who has had a NDE.

As before, no consistent pattern emerged with respect to significance of individual covariates; however, a predominant factor in driving attitudes towards caring for patients who have had an NDE was an individual’s experience with DBVs and NDEs. Although regres-
sion coefficients were typically in the direction of the most positive response for the respective item, among some test items the estimated coefficients for the NDE and DBV experience categories frequently ran counter to other groups. In addition to the variables that emerged in the general attitudes section, respondent sex also emerged as a significant predictor in one of the item regressions.

Of the predictors, DBV - Patient/Family Care was significant in 13 of the items (Items 2, 4, 7, 8, 9, 11, 12, 13, 15, 16, 17, 18, 20). In all but items 2, 16, 18 and 20, responses of participants who reportedly had cared for a patient or family member with a DBV represented more negative attitudes compared with those that reportedly had not cared for a patient or family member with a DBV. Ethnicity was a significant predictor in 7 items (3, 11, 12, 16, 17, 18, 20) with white nurse educators’ responses representing more positive attitudes than non-white. Doctorally prepared nurses were more likely to select positive attitude responses in items 8, 11, 13 and 18, whereas they were less likely to select positive attitude responses in items 7 and 12 versus nurses with less educational preparation. Nurse educators reporting familial experience with NDEs were less likely to select positive attitude responses in items 4, 11, 13, and 18. Nurse educators reporting either personal or familial experience with DBVs (DBV - Personal/Family Exp) were more likely to select positive attitudes with item 9 and less likely to select positive attitude responses with item 3. Individuals classified as Judeo-Christian were less likely to select positive attitude responses with item 3, and individuals reporting patient care experience with NDEs (NDE - Patient Care) were more likely to select positive attitude responses in item 9 versus nurses that did not report patient care experience with NDEs. Nurse educators classified as those with a personal NDE were less likely to select positive attitudes versus those not classified with this experience. Female nurse educators were more likely to select positive attitudes in item 16.

**Selected Narratives**

In part five of the questionnaire, we asked participants to write out accounts of NDEs that they were aware of. Again, not all participants elected to respond to this section, but of those who did, a total of 262 (45.88%) participants reported either single or multiple NDE anecdotes. In-depth analysis of the open-ended responses will be evaluated through thematic content analysis in a pending research study. Of those participants who responded, 21 (8%) shared their personal NDE
accounts. Below are samples of just a few of the hundreds of NDE accounts of the nurses who responded:

I had a report from a religious Sister who told me that twice she had a NDE. She witnessed CPR on her body and then “went to the pearly gates.” She described it as following the light, very beautiful and peaceful and was greeted by her dog that had died a few years before. She told me that someone we lost and loved would greet us and escort us.

A patient for whom I cared for was being resuscitated and when the patient was revived was able to recall every event that took place during CPR and the people that were in the room doing CPR. She described looking down on the event on herself and being able to see everything amidst very bright white light. She also described feeling most at peace.

As a pediatric oncology nurse working in an intensive care area I have had children near death reveal and share NDEs. One example I can think of is the 11 year old girl near death saying that Jesus was at the foot of her bed and he made her feel like everything was going to be ok. The remarkable part of the story is her mother told me that she didn’t know her daughter even knew who Jesus was. They did not practice any type of religion in the home. The daughter died within hours of that incident.

My grandmother shared with me a NDE that occurred when she was hospitalized in London during WWI. She claims that she remembers traveling in a tunnel towards a light and she felt an overwhelming peace but heard a voice saying she needed to return to her body. A pediatric client I cared for told me how he had been visited by his grandmother who had died and that she was coming back soon to take him to Jesus. He shared some of the words to a song she was singing and his mother said it was the same song she used to sing to her when she was a child. She did not know if the grandmother had ever sung it to her son and if so he would have been too young at the time of her death to remember the words.

For part six of the questionnaire, we asked participants to write accounts of DBVs that they had knowledge of. Again, not all participants elected to respond to this section, but of those who did, a total of 168 (29.42%) of the nurse educators described either single or multiple DBV anecdotes. Review of themes between accounts of NDEs and DBVs suggested some similar characteristics; formal thematic content analysis will be performed in a developing research article. Below are examples of just a few of these the DBV anecdotes (even in cases in which the respondent mis-labeled the experience as an NDE).
I have had many patients tell me they have had a near death experience in which their deceased family members come to get them. I have also had an experience where a cool breeze went right thru me and it was such a calming experience as though an angel went through me as my patient died.

My father dying of cancer would feel someone sitting at the end of his bed every night and KNEW it was my (dead) mother. He felt at peace when this occurred and was comforted. He told me he had “vivid dreams” of her telling him to “let go” and the “kids” (us!) would be OK.

I specifically recall my own mother asking me who the man was in the corner. She saw him on several occasions. He would just smile at her. She wasn’t afraid but she thought she knew him. She also saw many deceased relatives but could not understand why they would not speak to her. My father’s death experience was 10 years after my Mom. I can only surmise that he saw something so incredible because he was unresponsive for 36 hours and just prior to his passing he woke up and with a look of wonder stared up toward the ceiling in awe. My husband said it looked as if he was saying WOW, would you look at that.

**Discussion**

The study revealed that most nursing faculty members considered near-death phenomena to be actual experiences that many patients encounter during traumatic health events resulting in a close brush with death or as a result of end-of-life experiences. The study also demonstrated that most nursing faculty members believed that nursing curriculum should include NDE and DBV discussion topics and that nursing students should be permitted to care for patients who had experienced NDEs and DBVs.

Item-level regression analysis of the attitude components revealed a complex set of relationships between demographic characteristics and experiences with NDEs and DBVs. Although item-level analysis precludes generalizations across the components, two key findings of this analysis are particularly noteworthy. First, and not surprisingly, a nurse educators’ experiences with NDEs and DBVs were significantly related to specific items within the attitude components; however, these experiences were not necessarily associated with more positive attitudes, particularly in the caring component. For example, nurse educators who had provided care for patients and family members who had reportedly experienced DBVs were less likely to reflect positive attitudes toward caring in 12 out of 13 items in the caring component of the questionnaire. A similar finding in the general attitude component
in which nurses with this type of experience were less likely to select responses associated with positive attitudes in 7 out of 10 items is also perplexing and runs counter to previous findings that nurse educators’ experiences with NDEs have positive impacts on nursing practice (Morris & Knafl, 2003). Although nurse educators who had provided care for patients experiencing NDEs were more likely to select only more positive responses, nurse educators who reported that a family member experienced an NDE were consistently less likely to select more positive attitudinal responses in the caring component. These counterintuitive results may be explained by the possibility that other variables may be important drivers of attitudes, such as the nature of the NDE/DBV experience, but these variables were not addressed in the questionnaire and, thus were not evaluated in the analysis. Possible clarification of this matter remains for future investigation.

A second key finding from the item-level analysis is that demographic characteristics, such as education, religion, sex, and ethnicity, were significantly related to general attitudes and attitudes toward caring. With the exception of respondent sex and religion, however, the association was not consistent across either items or components. That is, these characteristics were associated with more positive attitudes in one item and with more negative attitudes in another item within the same component. For example, doctorally-trained nurse educators were more likely to select questionnaire responses that reflected positive attitudes in only three of four items on the general attitude component of the questionnaire and in only four of six of the items on the attitudes toward care component—with their responses on the remaining item(s) reflecting more negative attitudes. Omitted demographic and other non-NDE/DBV experiential variables might explain some of the inconsistencies. For example, the finding that differences in attitudes toward NDEs may be dependent upon nurse specialty (Bucher, Wimbush, Hardie & Hayes, 1997) may be particularly relevant to the extent that the sample is non-representative of the larger nursing workforce. Again, future research may provide elucidation.

Nurses have acknowledged the importance of providing holistic spiritual care to patients and their families; however, many nurses avoid this area of nursing care, fearing an invasion of patient privacy (Catanzaro, 2004). Researchers approaching nursing curriculum from a nursing educational leadership standpoint found evidence that nursing faculties may be remiss in providing spiritual and philosophical material in nursing curriculum (Gray, Garner, Snow, & Wright, 2004). Gail Pittroff (2010) noted a global lack of spiritual care being
provided by healthcare disciplines. Patients, including those who have experienced NDEs and DBVs, have indicated a lack of supportive spiritual care from nursing and healthcare professionals. Perhaps nursing faculty members who do not integrate their own spirituality into their personal and professional activities are not serving as appropriate role models to nursing students who will someday be charged with providing health care to a patient experiencing an NDE and/or a DBV (Miklancie, 2001).

According to our participants, inquiry in the area of NDEs and DBVs should be encouraged as an appropriate research agenda for nursing students. The findings reveal a need for nursing educational leaders to support the development of experiences that facilitate the mentoring and instruction of nursing students in techniques that support lifespan nursing care interventions for patients and families who incur end-of-life experiences such as NDEs and DBVs. The findings support previous research emphasizing the importance for 21st century healthcare to include spiritually-guided nursing care aspects into nursing curriculum and nursing programs (Birkenmaier, Behrman, & Berg-Weger, 2005).

Updating curricular content to include theoretical and practical applications of NDEs and DBVs in nursing education programs may depend upon the extent to which leaders and faculty in these programs have sufficiently positive motivation and knowledge about these phenomena to drive change. Although the results of the knowledge component scores showed that most of the nurse educators were undecided with respect to the correct response to specific items in the component, with 84% of the nurse educators scoring less than 50% correct on the component and with nearly 5% scoring 0, the scores on the knowledge component of the questionnaire certainly indicate a need for continuing education about NDEs and DBVs. Incorporation of NDE and DBV content would logically fit into fundamental and advanced medical-surgical nursing courses that contain didactic content that includes death and dying, and Watson’s (1988) model of human care supports the type of learning by which nursing educational leaders can incorporate these topics into nursing course content. However, nurse educators must have knowledge of these phenomena in order to effectively prepare student nurses to provide quality and compassionate care in clinical settings where they may encounter these experiences.

The research revealed that many nurse educators have witnessed and/or personally experienced NDEs and DBVs; as such, these phe-
nomena have a place in the nursing program curriculum. Nursing leaders/instructors are called upon to be the facilitators and role models for nursing students, equipping them with the essential caretaking attributes, including comprehensive, competent, cultural, holistic, and spiritual care that will ultimately enhance the wellbeing of patients and families. Nursing is an art and a science, and those who have a calling for the profession need to ensure that the type of care provided at death is of the same magnitude as that provided at birth, especially for patients experiencing NDEs and DBVs. The incorporation of near-death phenomenal content, as well as mentoring by nursing faculty, will allow the opportunity for nursing students to understand and explore such events and to provide compassionate holistic care. To the extent that attitudes of leadership and instructors in nursing education programs partially drive the content-related development of programs of study in nursing education, recognition that varying attitudes associated with these phenomena exist may present an opportunity for faculties and leadership to engage in meaningful dialogue about these phenomena and how to best develop education programs.

This study involved several limitations. In addition to the concern of sample selectivity bias, a potential limitation is related to the instrument itself. Although use of the NDPKAQ was appropriate given the research agenda, the growth of research in NDEs and DBVs subsequent to the questionnaire’s development calls for a revision of the questionnaire in light of more recent findings about these phenomena. Indeed, Laura Pace (2013) has recently undertaken development of an updated instrument, the Knowledge and Attitudes about Near-Death Experiences Scale (KANDES).

Based on the investigation of the study, our nursing leadership recommendations for education and clinical practice include:

• Nursing curriculum should provide opportunities in the clinical environment to include simulation experiences for nursing students to engage in discussions about NDEs and DBVs which that will enhance existential learning of the nursing students to better care for patients who have had these experiences.
• Professional nursing organizations should include break-out program sessions on near-death phenomena to healthcare providers who attend nursing conferences.
• In-service hospital programs should be offered to nursing and ancillary staff to educate on existence of near-death phenomena experiences that occurring near death within the patient population, thereby facilitating
enhanced comprehensive and holistic care to patients and their family members across the age-span continuum.

Based on the findings of this study, our recommendations for future research include:

- Replication of the study utilizing a larger and more random sample of nursing educators.
- Replication of the study utilizing senior nursing students who have had previous theory/clinical content on death and dying.
- Replication of the study utilizing hospital nursing staff.
- Replication of the study utilizing a global sample of health care professionals.
- A qualitative study that can reveal the perspective of nurses who have experienced care for terminal patients.
- A qualitative study that investigates the perspective of relatives who care for terminally ill family members.

In conclusion, results of this study indicate that NDEs and DBVs are common occurrences in both the personal and professional lives of nurse educators. Though these educators’ attitudes tended to be positive both about NDEs and about caring for patients who experience them, their knowledge of NDEs was less than ideal. All three aspect of our findings—frequency, attitudes, and knowledge—point to the importance of adding education about NDEs and DBVs to nursing curriculum, in-service programs, and conference presentations and of pursuing additional research on various aspects of these phenomena.

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BRIEF REPORT

Phenomenology of Near-Death Experiences: An Analysis of a Māori Case Study

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ABSTRACT: Near-death experiences (NDEs) have been recorded in the oral and written histories of virtually every culture since antiquity. Based on some of these accounts, attempts have been made to investigate whether the phenomenology of the NDE is cross-culturally variable or similar. The present article contributes to this literature by analyzing the only known historical account of an NDE reported by a Māori individual. Although this account has been previously analyzed for its association with features typically reported in Western NDE accounts, it has not been analyzed for its conformity to prevailing Māori beliefs about the afterlife. The analysis of this single case study suggests the NDE was influenced by cultural beliefs, which supports two converging viewpoints: that NDE phenomenology is universal but expressed in culturally-relative ways and that NDE phenomenology is culture-bound.

KEY WORDS: near-death experiences, phenomenology, Māori, Aotearoa New Zealand, case study, culture-bound, universal

Near-death experiences (NDEs) are evident in the written and oral histories of virtually all cultures since antiquity, with some of the earliest examples recorded in the pre-Christian era from the Sumerians and classical Greeks (Knoblauch, Schmied, & Schnettler, 2001; Schroter-Kunhardt, 1993). Contemporary research indicates the characteristic features of NDEs are consistently reported in NDE accounts, at least in Western cultures (for an overview see Kelly,

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Greyson, & Kelly, 2007). Further studies indicate these features were evident prior to NDEs becoming popularized by the work of Moody (1975; e.g., Athappily, Greyson, & Stevenson, 2006; Long & Long, 2003). This finding has led some authors to suggest that NDEs are a universal phenomenon (e.g., Atwater, 1988; Grosso, 1981).

However, other authors have argued that although NDEs have and continue to be evident across cultures, the phenomenology of the experience may be culture-bound (Kellehear, 1993; Murphy, 2001; Parricha & Stevenson, 1986; Schorer, 1985). A recent analysis by Kellehear (2009) revealed some non-Western NDEs may not be experienced or explained in the same way as Western NDEs. For example, travel through a tunnel does not appear in studied NDE accounts from India, Tibet, and Guam. Out-of-body experiences (OBEs) are not evident in NDEs reported from African and Australian Aboriginals. The life review is not apparent in cases from Hawai‘i, Guam, and African cultures. Case studies from Thai (Murphy, 2001) and Melanesian (Counts, 1983) cultures provide compelling analyses of how cultural expectations may play a role in the phenomenology of NDEs.

The purpose of the present article is to analyze a single case study of an NDE reported by an individual of Aotearoa New Zealand Māori descent to investigate whether NDE phenomenology may be at least partially culture-bound. The case has been described by other researchers (e.g., Kellehear, 2001, 2009), with the features of the NDE being compared to NDE accounts reported in Western cultures and a non-Western (Hawaiian) culture. However, previous descriptions of the case have not examined whether the phenomenology of the NDE conforms to Māori cultural expectations or beliefs about what happens when one dies.

**Traditional Māori Beliefs About the Afterlife**

Arriving from eastern Polynesia over 1,000 years ago, Māori established practices, values, and customs that were permeated by spirituality, hierarchical leadership, safety and risk, and collective advancement (Tassell & Locke, 2012). Beliefs regarding what happens at death were also well established. The arrival of Europeans in the early 1800s facilitated a substantial numerical decline of Māori as a people, such that Māori are now an ethnic minority in Aotearoa New Zealand, comprising approximately 15% of the total population (Statistics New Zealand, 2012). Years of “colonisation, exploitation, and
oppression” (Walker, Eketone, & Gibbs, 2006, p. 332) facilitated the erosion of cultural institutions, including language and traditional ways of healing and living. Despite this decline, traditional cultural beliefs and customs regarding what happens at death (such as tangihanga [funeral or death rituals]), are still evident to varying degrees (Dansey, 1992; Jacob, Nikora, & Ritchie, 2012; Nikora, Masters, & Te Awekotukui, 2012).

The heterogeneity of contemporary Māori, combined with slight variations according to iwi (tribe), hapū (sub-tribe), and whānau (immediate and/or extended family), make it difficult to provide a definitive overview of Māori death and afterlife philosophies (Ngata, 2005). Much Māori knowledge is intimately intertwined with notions of spirituality and tapu (sacredness), the content of which is beyond the scope of this article (Manihera, Pewhairangi, & Rangihau, 1992). Consequently, the following synopsis is not comprehensive and does not focus on Māori bereavement rituals, processes, and arrangements that occur following the death of an individual (for an overview, see Ngata, 2005). Rather, the focus here is on beliefs regarding what happens to the consciousness, soul, or spirit of an individual after physical death and on the viewpoint that the spirit departs its physical form at death and makes a return journey to Hawaiiki, the place of Māori origin.

Traditional Māori view dictates that all individuals are imbued with a wairua (spirit) that leaves the physical body at death (Ngata, 2005). The Māori custom of not leaving the body unattended until burial (Dansey, 1992; Nikora et al., 2012) is derived from the belief that the deceased’s wairua remains disembodied but in close proximity for several days after physical death. The return journey of the individual’s wairua to Hawaiiki is believed to commence once the physical body has been laid to rest by burial. This return journey takes a specific direction: always towards the northernmost point of the North Island of Aotearoa New Zealand, to a place known as Te Rerenga Wairua – the Leaping Off Place of Spirits.

Once the wairua has traveled to Te Rerenga Wairua, it is believed to make a ritualistic descent to the underworld via a specific route. Firstly, the wairua cleanses itself in the spring known as Te Waiora ā Tāne (Life waters of Tāne). Traditional Māori believed that if the wairua journeyed beyond this spring, there could be no returning to the physical body, suggesting the spring serves as a border between the spiritual and physical realms, or a point of no return. After bathing in Te Waiora ā Tāne, the wairua plunges down the rocky cliff that is the northernmost tip of the North Island, to Te Aka. Te Aka is the
term used to refer to a root of the sole pohutukawa tree that clings to the edge of the cliff and that is rumored to be centuries old. Having descended down Te Aka, the wairua finally meets the ocean where, just beneath the surface, the place known as Maurianuku is located. Maurianuku is believed to be the entrance to the underworld and the afterlife. From Maurianuku, the wairua travels to Te Manawatawhi (“last breath”), which is the largest of the Three Kings Islands, and takes a final look back at Aotearoa New Zealand before continuing on its journey to Hawaiiki (Mitcalfe, 1961). The remainder of the journey of the wairua is unknown.

The Case

The case to be analyzed is that of an indigenous Māori woman named Nga. Notably, it is the first known published NDE account of a Māori individual. Described by Michael King (1985), the experience apparently occurred in the early 1960s after Nga became seriously ill, although it was recounted to King in the early 1970s. The account given to King is quoted here in full:

I became seriously ill for the only time in my life. I became so ill that my spirit actually passed out of my body. My family believed I was dead because my breathing stopped. They took me to the marae, laid out my body and began to call people for the tangi. Meanwhile, in my spirit, I had hovered over my head then left the room and travelled northwards, towards the Tail of the Fish. I passed over the Waikato River, across the Manukau, over Ngāti Whatua, Ngāpuhi, Te Rarawa and Te Aupouri, until at last I came to Te Rerenga Wairua, the Leaping-Off Place of Spirits. I cleansed myself in the weeping spring and then descended to a ledge from which hung Te Aka, the pohutukawa root. Here I crouched. Below me was Maurianuku, the entrance to the underworld, covered by a curtain of seaweed. I began to kāranga to let my tūpuna know I had come. Then I prepared to grasp the root and slide down to the entrance. But a voice stopped me. It was Mahuta. “Who is it?” he asked. “Ko au,” I said. “It is I, Ngakahikatea.” “Whom do you seek?” he questioned me further. “My parents. My old people. I have come to be with my tūpuna.” “They are not here,” said Mahuta. “They do not want you yet. Eat nothing and go back where you came from until they are ready. Then I shall send for you.” So I did not leap off. I rose and returned to my body and my people in Waikato. I passed over all the places and things I had seen on the way. My family and those who had assembled from Waahi for the tangi were most surprised when I breathed again and sat up. So it is that I live on. Because the spirits of my dead will not claim me. I shall not die until they do. (King, 1985, p. 87–88)
Congruence with Māori Beliefs

A number of features of Nga’s NDE conform to traditional Māori beliefs about what happens to the wairua at death, whereas several others do not. Firstly, Nga described her spirit leaving her body and travelling northwards towards the “Tail of the Fish.” These aspects of the NDE conform to Māori belief that the wairua, or spirit, becomes disembodied at death and eventually makes a journey northwards. In Māori mythology, the North Island of Aotearoa New Zealand is referred to as a large fish, with the northernmost part of the island representing the fish’s tail, which is known as Te-Hiku-o-te-Ika in the Māori language (Mills, 2005). Therefore, Nga’s reference to the direction of her departure suggests her wairua was traveling toward the northernmost tip of the North Island, to Te Rerenga Wairua.

The narrative indicates Nga’s family took her to the marae (traditional gathering place) and laid her body out for her tangi (also referred to as tangihanga by Māori). Such customs are typical in Māori culture with regard to arrangements for the deceased (Ngata, 2005; Nikora et al., 2010). However, it is unclear whether Nga observed these events from a disembodied state; whether they were recounted to her; or whether, upon regaining consciousness, she made assumptions about what had occurred. If she had observed the events from a disembodied state, this experience would suggest Nga’s wairua remained in close proximity to her physical body for several days, thereby conforming to Māori beliefs. If, however, the events were recounted to her, or she surmised what occurred to her physical body without observing them from a disembodied position, this implies Nga’s NDE departs from the traditional Māori belief regarding the wairua remaining near the deceased’s body until burial.

Nga described travelling over a range of geographical locations and traditional iwi regions. The order in which she identified these regions conforms with their sequence when travelling northwards from the geographical location where Nga was residing, to Te Rerenga Wairua (for a map of iwi areas see Te Aka Kumara o Aotearoa, 2013). Although Nga’s narrative indicates her wairua traveled over these regions, it is uncertain whether she had any imagery or other perception of the physical features of each, thereby allowing her to identify them, or whether previous knowledge informed her descriptions of the areas she would have expected to pass by on a journey northwards.

Upon reaching Te Rerenga Wairua, Nga explained how she cleansed herself in the weeping spring before descending to Te Aka. Although
the spring is not specifically identified by Nga as Te Waiora ā Tāne, it is assumed it is the same spring that the Māori refer to, where ritual cleansing should take place before descent to Te Aka. The act of cleansing followed by the descent to Te Aka are consistent with Māori views about the sequence of occurrences at this stage of the wairua’s journey. However, in contrast to the traditional belief of the spring as a border, beyond which if one advanced one would be unable to return to one’s physical body, Nga’s wairua reportedly progressed beyond Te Waiora ā Tāne and still returned to her body. After reaching Te Aka, Nga described her wairua crouching at the entrance to the underworld and commencing a kāranga (call) to her tūpuna (ancestors). The kāranga is a traditional act performed to announce one’s arrival or to greet visitors, such as during the process of pōwhiri (ceremonial greeting), and may also be performed at various other occasions, including tangihanga (Karetu, 1992). It is congruent with cultural expectations for Nga’s wairua to perform this act at this point of the journey, to indicate her arrival at the entrance to the underworld.

Nga identified the voice that had questioned her wairua as belonging to Mahuta. It is not known exactly who Mahuta is in this account, but it is likely Nga was referring to the god of the forest, Tāne Māhuta. In Māori mythology, Tāne Māhuta is implicated in the creation story, facilitating the separation of his parents Pāpātuanuku (Earth Mother) and Ranginui (Sky Father) and, thus, bringing light to the world. He also facilitated the creation of the first human by fashioning earth into the shape of a woman and breathing life into her (Marsden, 1992). The presence of Mahuta as an authoritative figure instructing Nga at this point of the journey is congruent with Māori mythology in which Tāne Māhuta is represented as a commanding and effective leader as well as an instigator, facilitator, or determiner of physical life.

**Discussion**

NDEs are typically described by those who have them as profound, life-changing experiences, the content of which is often difficult to explain in words (Moody, 1975). Given their ineffability, it is logical to suggest the phenomenology of NDEs is similar across cultures but explained using the cultural models individuals have available to them. It is equally plausible that the perception one has died leads the NDE to be constructed in a way that sensibly conforms with cultural beliefs and expectations about death and the afterlife, thus providing more
comfort and meaning to the individual. This current analysis suggests Nga’s NDE supports both of these viewpoints.

Specifically, previous analysis of this case (see Kellehear, 2001, 2009) indicates features of the experience are similar to those typically described in NDE accounts. These include one’s consciousness functioning apart from the physical body, observing the physical world, sometimes traveling away from the vicinity of the physical body, encountering spiritual entities, and being told by spiritual entities that it is not one’s time to die and that one must return to physical existence.

Nga’s NDE occurred and was recounted before the publication of Moody’s (1975) work, when the characteristic features of NDEs became popularized, suggesting the elements she described could not have been reconstructed as a result of exposure to common information about NDEs. Similarly, Nga herself reported having little contact with European individuals or society prior to meeting King and recounting her experience (King, 1985). This cultural isolation suggests Nga’s account could not have been reconstructed based on an ideal Western perception about what an NDE should constitute. Instead, the features of Nga’s experience are similar to those typically described in other NDE accounts but were explained in a way that made sense to Nga according to the cultural environment she resided in. This point supports arguments and previous research about the phenomenology of NDEs being similar across cultures and thus possibly universal, although the interpretation of the experience is in accordance with cultural belief systems (Atwater, 1988; Grosso, 1981; Osis & Haraldsson, 1977; Ring, 1980).

Alternatively, this single case study suggests the NDE was influenced and possibly constructed by Māori cultural expectations regarding what happens at death. With a few exceptions, features of Nga’s NDE closely complied with Māori cultural beliefs related to the spirit leaving the physical body and making a journey to Te Rerenga Wairua. Nga had little contact with European individuals or society at the time of her NDE, suggesting the socio-cultural environment she lived in was based on traditional Māori cultural values, philosophies, and customs. As a result, Nga is likely to have been heavily exposed to and endorsed beliefs about death and the afterlife. This enculturation would have given her a psychological frame of reference about what to expect when one dies, from which the NDE could have been created and informed. This point supports the argument and previous research that her NDE was constructed according to cultural condi-
tioning (Sutherland, 1995) and that the phenomenology of the experience was culture-bound (Kellehear, 1993; Murphy, 2001; Pasricha & Stevenson, 1986).

Although this analysis appears to support the convergent viewpoints that NDEs are universal and that they are culture-bound, certain concerns limit the extent to which this single case study can be interpreted. Among these concerns is that no researcher has conducted organized studies or even presented other case studies describing reports of NDEs by Māori individuals. Because of this void in the professional literature, it is difficult to determine whether Nga’s NDE is representative of the phenomenology of NDEs experienced by other Māori during the same historical period.

As Kellehear (2001) indicated, methodological issues restrict the extent information derived from historical accounts can be interpreted. For example, the NDE is reported by Nga retrospectively and described by a non-Māori individual, suggesting the re-telling and interpretation of the experience may be subject to bias. Given Nga’s lack of exposure to Europeans, it is likely Te Reo Māori (Māori language) would have been her language of communication. It is possible—even likely—that Nga recounted her NDE to King and that he subsequently translated it to English. If so, the account could be subject to misinformation due to translational difficulties, which may explain some discrepancies between Nga’s NDE and Māori beliefs, such as the ability of Nga’s wairua to proceed past Te Waiora ā Tāne and still return to her physical body.

Generalization more widely as representative of Māori NDEs, whether historical or contemporary, is also limited. The historical period when Nga’s NDE occurred differs substantially from the cultural milieu of contemporary Māori. Since Nga’s time, the influence of colonization, education, experience with racism, lack of access to culturally knowledgeable people, and acculturation may have rendered traditional beliefs about the afterlife not meaningful to, known by, or endorsed by all people affiliated with the Māori cultural group in contemporary Aotearoa New Zealand society (Nikora et al., 2012). For example, urban dwellers may be hindered more than rural dwellers from exposure to such beliefs (Durie, 2008). Some Māori strongly endorse concepts of the afterlife espoused by Christianity more than traditional Māori beliefs, whereas others combine both belief systems or do not endorse either (Elsmore, 1989). All these factors could influence the phenomenology of more contemporary Māori NDEs.

Future researchers who investigate the extent to which contempo-
rary Māori NDE reports conform to traditional and/or Westernized beliefs would provide more information on NDE phenomenology and the degree to which it is culture-bound. Similar research conducted with other indigenous and non-Western cultures around the globe could also advance knowledge in this area of scholarly inquiry. Such inquiry can help to clarify the extent to which NDEs are culturally constructed and/or point to universal phenomena that people everywhere might expect upon their deaths.

References


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