SPECIAL ISSUE:
INAUGURAL CONFERENCE PAPERS OF THE
AMERICAN CENTER FOR THE INTEGRATION
OF SPIRITUALLY TRANSFORMATIVE EXPERIENCES,
PART 2

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**JOURNAL OF NEAR-DEATH STUDIES** (formerly ANABIOSIS) is sponsored by the International Association for Near-Death Studies (IANDS). The Journal publishes articles on near-death experiences and on the empirical effects and theoretical implications of such events, and on such related phenomena as out-of-body experiences, deathbed visions, after-death communication, the experiences of dying persons, comparable experiences occurring under other circumstances, and the implications of such phenomena for our understanding of human consciousness and its relation to the life and death processes. The Journal is committed to an unbiased exploration of these issues and specifically welcomes a variety of theoretical perspectives and interpretations that are grounded in empirical observation or research.

The INTERNATIONAL ASSOCIATION FOR NEAR-DEATH STUDIES (IANDS) is a worldwide organization of scientists, scholars, healthcare providers, near-death experiencers, and the general public, dedicated to the exploration of near-death experiences (NDEs) and their implications. Incorporated as a nonprofit educational and research organization in 1981, IANDS’ objectives are to encourage and support research into NDEs and related phenomena; to disseminate knowledge concerning NDEs and their implications; to further the utilization of near-death research by medical, psychological, social, and spiritual healthcare professionals; to form local groups of near-death experiencers and interested others; to sponsor symposia and conferences on NDEs and related phenomena; and to maintain a library and archives of near-death-related material. Friends of IANDS groups are affiliated in many cities to provide information, support, and networking for near-death experiencers (NDErs) and their families, healthcare providers, and anyone with personal or professional interest in NDEs and related phenomena. Information about membership in IANDS can be obtained by contacting IANDS, 2741 Campus Walk Avenue, Building 500, Durham, NC 27705–8878, USA; telephone and fax: (919) 383–7940; e-mail: services@IANDS.org; Internet website: www.IANDS.org.

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Editors’ Foreword

This edition of the Journal is a joint issue, containing both the second of two special issues focused on the first annual American Center for the Integration of Spiritually Transformative Experiences (ACISTE) conference proceedings and a regular JNDS Brief Report. As Guest Editor Ryan Rominger, Ph.D., explains, the special issue section is the conclusion of the ACISTE 2012 proceedings, and as such its articles are based on papers presented there. Journal Editor Jan Holden, Ed.D., concludes this Foreword with a summary of the Brief Report.

As stated in the Foreword to the previous special issue, the relevance of ACISTE’s work to that of the International Association for Near-Death Studies and this, its Journal, is that near-death experiences (NDEs) may be considered one specific type of STE—and STEs also include experiences related or similar to NDEs. In some circles, STEs are also called exceptional human experiences, peak experiences, or mystical experiences, to name a few. Thus, much material addressing STEs is also relevant to the topic of NDEs.

Preparation of the special issue section involved a unique review process. Instead of peer review by the Journal’s usual editorial board, each paper was reviewed by several other conference presenters—many of whom are leading figures in the scholarly and clinical domains of STEs—before final editing by us. We would also like to acknowledge the additional peer-review help on articles from both special issues from Sean (John) Hinton, Ph.D. Because the papers represent conference proceedings, they do not always reflect the Journal’s focus on strict, scholarly-oriented empirical articles; rather, they take a decidedly more clinical turn than is typical for the Journal. As with the conference itself, they are meant to provide readers with a broad base of understanding about psychotherapeutic and spiritual responses to STEs.

The first article, by Ryan Rominger, Ph.D., invites readers into a discussion regarding what constitutes integration of an STE. This paper begins by defining healthy and unhealthy integration, describing potential manifestations of unhealthy integration, and reviewing a variety of nomenclature used instead of ‘spiritually transformative experience.’ The next section enquires into four developmental models
and then covers ways that the author has worked with spiritual guidance clients with STEs. The article concludes with several pertinent research projects that inform the topic area.

Next in the issue is an article by Jenny R. Moores, Ph.D. and Sue Ammen, Ph.D., in which they review Moores’ dissertation research on adult reports regarding the use of therapy to facilitate integration of childhood NDEs. Moores’ exploratory findings suggest that therapists who accept the NDE as real, validate the experience for clients, and are willing to explore the NDE with clients are most likely to be of help to this clientele. Additionally, Moores’ study investigates the connection between wellbeing and integration of the NDE. Further research regarding therapeutic practices to facilitate integration is also discussed.

Jennifer Elam, Ph.D., contributed the third and final article, reporting on an informal study she conducted in conjunction with ACISTE. The study queried 53 ACISTE members regarding their childhood spiritual experiences, ranging from after-death communications and NDEs to out-of-body experiences and communicating with God. Findings are conveniently grouped into topics such as disclosure, confidants and their reactions, and alignment of experience with family’s religious beliefs. The article concludes with a section describing participants’ views regarding what they would have liked to have happened for them in childhood to help support them after their experience(s). This section may help inform therapeutic professionals, parents, and school staff how they might better facilitate disclosure and integration of childhood STEs.

Our hopes for readers of this special issue section are that they become aware of the complexities of STE disclosure and integration, from childhood through adulthood; that they become more aware of work that members of the psychotherapy and spiritual guidance communities are doing with regard to STEs; and that those who are researchers feel encouraged to conduct further investigation into the topics of STEs, including quantum change, transformation, and integration.

Through this and the previous special issues of the Journal, we hope readers unfamiliar with the topic of STEs are introduced to it and to how these experiences may initiate developmental process that at times may require psychotherapeutic or spiritual guidance counselor assistance. Readers already familiar with the topic will hopefully find these issues a valuable summary and perhaps enhancement of their established understanding. Our further hope is that the publishing of these conference proceedings will lead to enhanced discussion about,
research into, and assistance for individuals who are struggling after having STEs.

This issue closes with a Brief Report by Dutch NDE researchers Titus Rivas, M.A., M.Sc., and Rudolf Smit. They describe their investigation of a case of apparently non-physical veridical perception (AVP) new to the professional NDE literature. In AVP, a near-death experiencer reports having perceived phenomena during the NDE that, based on the condition and position of the experiencer’s body, he or she should not have been able to perceive—yet the perceptions are subsequently corroborated as accurate. This particular case was reported by the late cardiac surgeon Lloyd Rudy, M.D., and in their article, Rivas and Smit explain how they investigated the case as much as they could—and found only confirmation of what Rudy had described. Interested readers can watch Rudy’s online YouTube description of the case, consider what Rivas and Smit present, and then determine whether or not they agree with Rivas and Smit’s conclusion that the case makes another contribution to “those most evidential cases of AVP in which perceptions during an NDE were confirmed as completely accurate by objective observers. “

Though the editors originally “threw together” the special issue section and the Brief Report to fill the page requirement for a normal-size Journal issue, the works are—perhaps unavoidably—related. Clinicians’ belief in the reality of NDEs appears to be emerging as a critical component of the capacity to be helpful to NDErs seeking professional assistance, and perhaps more than any other aspect of near-death studies, the phenomenon of AVP provides potential empirical evidence that NDEs may be more than only subjectively real. Thus, AVP research has the potential to contribute to support for near-death and other spiritually transformative experiencers—as well as to promote a societal and global paradigm shift whereby the values promoted by STEs are more fully embraced by humanity at large.

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Integration of Spiritually Transformative Experiences: Models, Methods, and Research

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ABSTRACT: This article represents my presentation at the inaugural 2012 American Center for the Integration of Spiritually Transformative Experiences (ACISTE) Annual Conference; it contains four main sections. The first section focuses on defining the parameters of the contents and includes discussions of what constitutes healthy and unhealthy integration, spiritual emergence and emergency, quantum change, spiritual conversion, and spontaneous awakening experiences. The second section includes four conceptual models utilized to help understand spiritually transformative experiences (STE): Wilber’s, Rummet’s, and Wade’s developmental models and Assagioli’s model of the self. The third section introduces methods I use when working with clients, and the fourth section provides recent research on topics related to STEs. My goal throughout was to catalyze further discussion regarding what constitutes integration of an STE and how this process relates to current psychospiritual models, therapeutic approaches, and research.

KEY WORDS: spiritually transformative experience, exceptional human experience, integration, expressive arts, spiritual guidance

Ryan Rominger, Ph.D., an associate professor at Sofia University, studies the integration of exceptional human experiences (EHEs) and spiritually transformative experiences (STE). Dr. Rominger has conducted, and continues to conduct, research on the integration of near-death experiences (NDEs), the integration of EHEs including their potential “shadow” or distressing aspects, parent-child relationships among those who have had an NDE, and coma-related NDEs; he received a grant for a multi-phase study exploring the spirituality scale scores among those who report an NDE. Additional research topics of interest include transpersonal sociology, telepathy within the therapeutic context, transformational online learning, and presence and integration of exceptional experiences in rural America. Dr. Rominger is additionally on the Board of the American Center for the Integration of Spiritually Transformative Experiences (ACISTE) and on the Academic Review Board for Sage Publications, and he works in spiritual guidance and the expressive arts. Correspondence regarding this article should be sent to Dr. Rominger at e-mail: Ryan.Rominger@sofia.edu.
The purpose of the first annual American Center for the Integration of Spiritually Transformative Experiences (ACISTE) conference was to address STEs and how psychospiritual healthcare professionals, such as conference attendees, might work with individuals who seek support after such experiences. Generally speaking, STEs consist of an event or group of events that may lead to dramatic attitudinal, belief, behavioral, emotional, and/or psychospiritual changes within an individual and are often subjectively perceived as spiritual in nature. The focus of this article, based on my presentation at the ACISTE Conference, is the integration of STEs.

An understanding of the concept of integrating an STE rests on the meaning of the term integration. In this context, the term refers to a process of assimilation, transformation, and change. To integrate a life event is to take that process into oneself, make it one's own, whereby it becomes a part of the organizing principle of the self.

Integration may be healthy or unhealthy. Healthy integration involves such phenomena as expansion, healing, compassion, connection, growth, and development. Unhealthy integration involves such phenomena as contraction, lack of compassion, unhealthy partitioning off of oneself or one's subgroup, and arrested development. In this article, I am specifically discussing transformative experiences that are inherently healthy/potentiating—facilitating one's growth and positive potential—rather than unhealthy/depotentiating. I am not including in this review experiences such as those in which a person has a transformative experience and then, believing God or some Divine being so-directed the person, kills others or commits acts of terrorism.

Another fundamental question about STEs is whether they are inherently pathological. The answer to that question depends on the definition of pathology. If pathology is defined as an inability to fit within surrounding socio-cultural context, then STEs are sometimes, but not always, pathological; during and/or after STEs, people sometimes behave in ways that violate socio-cultural norms. In this case, the role of psychotherapy is to help the individual incorporate the experience in a way that enables alignment with prevailing socio-cultural norms. If pathology is defined as biological illness, then STEs are sometimes, but not always, pathological; during and/or after STEs, people sometimes manifest biological problems. In this case, psychotherapy includes the use of medication or other biological interventions to alleviate symptoms. If pathology is defined as a loss of soul, passion, identity, and meaning, then STEs are sometimes, but not always, pathological; during and/or after STEs, people sometimes struggle with issues of
meaning and purpose. In such cases, psychotherapy is about connection or reconnection with the soul, meaning, passion, and emerging identity—which may put one at odds with current social context (family, friends, work, religion, and one’s own prior self identity, beliefs, values, and attitudes). Thus the question of pathology is complex and can involve inherent contradiction.

Stanislav and Christina Grof approached these very questions when writing of spiritual emergence and spiritual emergency. Their initial, edited text, *Spiritual Emergency: When Personal Transformation Becomes a Crisis* (1989), introduced the concept of spiritual emergency, a process wherein an individual’s natural spiritual development becomes problematic or difficult for the individual and/or one’s family and associates to handle. Grof and Grof further expanded their explanations within their next text, *The Stormy Search for the Self: A Guide to Personal Growth Through Transformational Crisis* (1990). These combined books provide a basis for understanding a difficult spiritual experience or process not as pathology but as part of a larger growth process emerging within the individual. The authors addressed times when spiritual emergence, a naturally unfolding process, becomes a spiritual emergency, a disruption of functioning. By working with the process as an inherently potentially growthful one rather than considering it a manifestation of psychological or biological pathology, one may experience expanded states of consciousness and further spiritual and moral development. Thus, the Grofs were able to redefine this disruption in terms of a spiritual process that might sometimes become temporarily difficult because of accompanying cognitive or psychological confusion.

Another way to describe dramatic personal experiences is in light of quantum change. William Miller (2004) defined quantum change as a sudden, dramatic, enduring transformation that affects a broad range of emotion, cognition, and behavior. Miller, when discussing his earlier studies (Miller & C’de Baca, 1994, 2001, as cited in Miller, 2004) noted changes in the areas of affect, values, priorities, relationships, and identity. According to Miller (2004), “my own sense of what happens is that quantum change is a kind of maturation, a developmental metamorphosis” (p. 458). Janet C’de Baca and Paula Wilbourne (2004) reported a 10-year follow-up study on the original group of participants in the earlier quantum change study. Ten years after the study completed, and roughly 20 years on average from the time of the original experience, participants continued to value compassion, spirituality, and a belief that the experience was God’s will (C’de Baca & Wil-
Of 55 participants, 82% described themselves as spiritual or as believing in God and practicing religion, whereas 17% self-identified as atheist, agnostic, or unsure about the existence of God (p. 534). Additionally, whereas 50% indicated that their quantum change experience was a one-time event, the other 50% indicated that it was part of an ongoing process (p. 535). Of those who indicated the experience was part of an ongoing process, some indicated the originating experience was only one of many big experiences, others indicated the originating experience was a single big experience followed by many smaller experiences, and still others indicated that the originating experience was viewed as part of a larger transformational process. C’de Baca and Wilbourne (2004) concluded “these rapid transformations of complex human behavior, including actions, emotions, and cognitive processes, are enduring” (p. 539).

The STE change process has also garnered other labels. Annette Mahoney and Kenneth Pargament (2004) used the term spiritual conversion, which is generally part of a larger field called religious conversion. They indicated that spiritual conversion is similar to quantum change with the addition of the belief that the sacred is inherently involved. The authors discussed two types of spiritual conversion: Classic Christian conversion wherein a person moves from a self-centered perspective through self-sacrifice into a God-centered perspective, and Reformist Feminist Christian wherein a person moves from a no-self (other-person-centered) perspective through reclamation of the individual self into affirmation of a sense of self in relation to God (pp. 443–486).

Steve Taylor (2012) referred to STEs as Spontaneous Awakening Experiences (SAEs). According to Taylor, spirituality is an amorphous term, and he proposed removing spirituality from the equation—in essence, an antithesis to Mahoney and Pargament’s position. Taylor asserted that an SAE is

an experience in which our state of being, our vision of the world and our relationship to it are transformed, bringing a sense of clarity, revelation and well-being in which we become aware of a deeper (or higher) level of reality, perceive a sense of harmony and meaning, and transcend our normal sense of separateness from the world. (p. 74)

However, Taylor (2012) did leave room for considering a spiritual aspect of an SAE so long as spirituality is considered in its most general, non-religious terms.

Having considered integration and several ways of viewing an STE, a further question is what a lack of integration might look like.
I believe common aspects of a lack of integration are splitting—the psychological partitioning off of a section of oneself, in extreme forms manifesting as a personality disorder; mismanaged or failing defense mechanisms; or becoming overly preoccupied with the experience. A lack of integration may also appear as an over-identification with the experience, whereby the experience becomes a sole defining factor of one’s identity; for example, one is no longer a parent, sibling, spouse, and someone with an established job in the world, but rather one is a near-death experiencer. Rhea White (1988) indicated another possible manifestation of a lack of integration: denial. In the beginning stages after one has had a profound experience, one might deny having had the experience or might search for purely materialist explanations of the experience. White (1998) believed this response was part of—but characteristic of only the beginning of—the developmental process as one integrates an exceptional experience.

Whether or not a person integrates a transformational experience, additional difficulties that might arise in its aftermath are numerous. For example, one might have relationship difficulties. According to Christian and Holden (2012), who conducted a study with 52 volunteers, 26 of whom indicated they had an NDE, and all of whom completed a set of marriage assessments:

on average, NDEs indicated poorer marital adjustment, stability, sense of meaning in marriage overall, marital friendship, marital communication about problems, agreement on marital rituals, agreement on life roles, sense of values in common with spouse, and sense of goals in common with spouse after the NDE compared to before. (p. 217)

Experiencers might also have an altered relationship to temporal time, that is, be less dependent on established norms regarding time. Individuals who have had an STE might also exhibit strain in social relations including work, school, and church. This strain might be manifested as a lack of focus or a more dramatic change in values and interests, thus creating stress in relationships established prior to the experience. Those who have had an STE might also exhibit identity confusion and existential and/or spiritual crisis as their identities shift, sometimes dramatically. Engaging in the integration process may not alleviate all of these difficulties, particularly as one integrates new attitudes, values, and belief systems. Difficulties may be due in part to how the newly emerging being or being-ness or identity of the person who has had the STE conflicts with pre-experience being and relationships.
Several models of development provide a diverse perspective on the conceptualization of STEs; in this section, I will discuss four. For additional discussion on models of development related to STEs, beyond those models listed here, please see Foster and Holden (2011).

First, Ken Wilber (2005/2011) developed an expanding model wherein a person moves from modes of being and functioning—developmental stages—characterized by relatively more restricted consciousness into stages characterized by relatively more inclusive and expanded consciousness. Development occurs both horizontally, within a particular stage as one resolves the developmental issues inherent to the particular stage, and vertically, as one takes a quantum leap into the next developmental stage, fundamentally shifting one's mode of being and functioning. According to Jan Holden, Wilber

admittedly arbitrarily divided what he actually perceived as a continuous developmental progression into 10 stages: three pre-personal—before a sense of self is clearly established; three personal—involving consolidation and elaboration of an established sense of self; and four transpersonal—involving identity expansion beyond a “mere” sense of self. (personal communication, 2013)

The specifics of each stage are less important here than the dynamics of how one moves through the stages. Within each stage one must address specific life issues and hopefully come to a successful resolution of them. Normal development leads one to address the issues of a stage and then to expand to the next stage; progression in the earlier stages occurs more spontaneously, whereas progression in the most expansive stages requires increasingly more purposeful pursuit by the individual. The role of STEs in this process is that, according to Wilber (2000), they are temporary states of consciousness comprised of the content and process of the stable traits of consciousness that characterize transpersonal stages of development. In other words, through an STE, an individual takes a brief experiential “dip” into the consciousness characteristic of a more expanded stage than the one at which the individual typically functions. Contact with that ‘transcendent’ stage, even briefly, impacts the current stage, acting as a catalyst with the potential of influencing both within-stage and across-stages development.

A second model, that of Roberto Assagioli (1965), a contemporary of Jung and originator of psychosynthesis, described personal development as expansion of one’s self identity to incorporate greater aware-
ness of previously unconscious material. Assagioli’s (1965) model of the psyche includes a lower, a middle, and a higher unconscious. The middle unconscious includes the individual “I,” the center of awareness, surrounded by a broader field of awareness of the conscious aspects of oneself, surrounded yet further by the unconscious aspects, those outside of but easily accessible to awareness. Below the middle unconscious is the lower unconscious similar to Freud’s unconscious but including “lower, uncontrolled parapsychological processes” (Assagioli, 1965, p. 17). Above the middle unconsciousness is the higher unconscious, the “source of higher intuitions and inspirations . . . higher psychic functions and spiritual energies” (pp. 17–18). Assagioli’s model contains two particular transcendent elements: the higher Self at the “crown,” so to speak, of the higher unconscious, and the collective unconscious that surrounds the entire psyche and to which the higher Self is particularly connected. Although not specifically part of Assagioli’s model, within spiritual direction I hold space for the belief that this higher Self is also connected to the Divine—or possibly that the Collective Unconscious and higher Self are contained within the Divine. Within this model an STE may be (a) a sudden expansion of the I and/or field of consciousness—in the middle unconscious, and possibly incorporating parts of the lower and upper unconscious—or (b) a sudden connection with the higher Self, Collective Unconscious, or Divine. Through the sudden expansion and/or transcendent connection, the post-experience definition of the self-construct changes, incorporating more than previously known/experienced/believed, and thus changing the prior amount of Middle Unconscious held within the newly ‘normalized’ field of awareness.

A third model is that of Hillevi Rummet (2006) who proposed a cyclical model originally based on the individual energy centers in the Yogic traditions, normally known as chakras. Rummet described a developmental process wherein a person may develop through life issues associated with the first three energy centers, starting at the base chakra and rising through the third chakra. The cyclical development starts after the third chakra, whereby a person develops by moving into the fourth chakra, back to resolve issues within the third, then moving into the fifth, back to resolve issues in the second, then moving into the sixth center, back to resolve issues in the first center, and finally into the seventh center (p. 17). This model differs from the normal chakra model, which assumes a linear development through the chakras. Within Rummet’s model, one might envision the STE as a sudden transcendence through the current energy center within
which one is working, or it may be a spontaneous rush up through the energy centers, with a resulting return to the prior, or possibly a higher, developmental stage.

Fourth, Jenny Wade (1996) offered a holonomic theory of personal development and, in particular, the development of consciousness. Structurally the model resembles an inverted Kabbalic diagram, with a person developing from bottom to top through various stages. Additionally, in some cases development may progress along different routes, skipping stages. As with the Rummet model, within this model an STE may be considered the sudden experiencing of a higher stage, or of experiencing the implicate order (or the Divine), with resulting transformation of the prior stage at which one was operating.

These are only a few models of many that exist. One similarity, however, is that these models fall within a set of transpersonal models of development. Transpersonal models tend to contain elements of Jungian, Rogerian, humanistic, and consciousness components and may also incorporate various wisdom or spiritual traditions, such as Rummet’s use of the Yogic chakra system. Transpersonal approaches also tend to acknowledge peak or transcendent experiences and tend to come from a philosophical tradition that is post post-modern—what Judith Miller (2012) has called psycho-spiritual, or what could be termed integral and holistic. I personally also include, when I consider transpersonal models, concepts of the Divine interacting with, or naturally part of, all that is—either in a form of dualism or spiritual/transcendent monism. With this inclusion in mind, I believe an STE could be a combination of at least three things. First, it could be the movement of the Divine or transcendent within one’s life, manifesting in such phenomena as calling, intuition, and/or grace. Second, an STE could be a spontaneous connection with the Divine or some aspect of the Divine, manifesting in such phenomena as energy flow, connection with God, and/or connection with “all that is” or with “the ground of being”. Third, an STE may also be an aspect of and catalyst for one’s natural growth potential and movement toward health, wholeness, and self-actualization.

Methods for Working with Individuals

Psychospiritual health professionals can work in many ways with individuals who have had STEs. Within the domain of “psychospiritual health professionals” I include a wide range of therapists, counselors, licensed clinical practitioners, and what ACISTE calls spiritual guid-
ance counselors. I myself, in addition to having a Ph.D. in transpersonal psychology, am trained in the practice of spiritual guidance, which is similar to traditional spiritual direction without being wedded to a specific religious tradition. A spiritual guide, like a spiritual director, may work with individuals or groups, and although psychological issues may arise during sessions, the focus is on the spiritual life of the client. In this section I will orient the reader to several tools and approaches I have found useful. Each tool or approach should be carefully considered, as some practices may be contraindicated for certain individuals and/or at certain times. Additionally, one should consider one’s own training and expertise prior to utilizing any particular therapeutic tool and use it only if one meets professional standards of competence.

Spiritually Oriented and Authentic Presence (SOAP) is an orientation I utilize when working with spiritual guidance clients. This orientation contains a number of elements, including creating a safe and sacred container within which to work, particularly if the person is presenting with difficulties due to an actual or perceived spiritually transformative experience. Additionally, unlike the case with many other clinical therapeutic settings, within this approach I invite the whole person, including her or his spiritual life; within the spiritual guidance tradition this inclusion of the spiritual is assumed. Another important aspect is that of the health professional practicing presence: being there, in the moment, open, “sitting with,” engaged in deep listening. Finally, there is also an acknowledgement in the health professional of one’s own spiritual self and openness to the Divine, however identified, as the sacred third within the therapeutic relationship, which in turn also facilitates a safe, healing environment.

In addition to SOAP, I incorporate expressive arts, which along with spiritual guidance, I refer to as creative spiritual expression. Here I cover two ways to engage the expressive arts. First, the client may bring into the session for us to review together creative art that she or he created outside of sessions—or work created by other artists that the client found meaningful. The creative art may include one or many media: visual art such as painting or sculpture, movement oriented art such as dance, auditory art such as music, or written expressions such as poetry. For example, while working with a woman who reported a near-death experience (NDE), she decided to draw, using colored pencils, where she “got stuck” in the tunnel. She brought this drawing into our session, and we discussed the various colors and elements she discovered while drawing the picture. Second, the client
may be invited to create art during a session as a way of supplementing the more narrative forms of dialogue and of enhancing expression of ineffable aspects of the STE. For example, when conducting group sessions with individuals who reported NDEs, during the sessions I introduced the use of painting and pastels on paper. Most group members found this practice to be a highly enriching and valuable way of connecting with the emotions and unconscious content associated with the original events as well as way of expressing the pleasures and difficulties of the changes they went through afterwards (Rominger, 2009, 2010).

White (1997, 1998) discussed a third tool to use with individuals who have had an STE. White, who developed the term exceptional human experience (EHE), described the EHE Autobiography (1997) as a process of identifying the narrative of one’s experience and subsequent growth after the experience. Additionally, the EHE (or STE in this case) may be understood within the larger context of one’s life, including cognitive, emotional, moral, social, and spiritual development. Through the autobiographical process, one often comes to understand the STE anew and is offered the opportunity to “re-story” the experience in relation to one’s emerging identity and understanding of reality. This re-storying aspect may be particularly important for individuals who have had a distressing experience. Additionally, the autobiographical process allows one to disclose the experience—to oneself as well as to others, should one choose to share the written or recorded account (Palmer & Braud, 2002). This disclosure process may help facilitate the integration of new attitudes, beliefs, and behaviors (Palmer & Braud, 2002).

Finally, in some instances clients may benefit from altered-state work. Altered-state work might include less intense experiences such as meditation, hypnosis, guided visualization, expressive arts work, use of a psychomanteum (Hastings, 2012), or various spiritual practices such as hatha yoga, breathing practices, or contemplation of a spiritual passage. Alternatively, altered-state work might include more intense experiences such as Shamanic practices, including journeying; more intense yogic practices; or fasting. The goals of altered state may include (a) to reconnect with the original experience or positive aftereffects of the experience, (b) to connect with the Divine as conceived of by the client, (c) to incorporate practices familiar to the client that may facilitate integration, and/or (d) to reconnect with the experience to process traumatic aspects of the experience or traumatic aftereffects.
Altered-state work does not necessarily happen during, or only during, therapeutic sessions. In some instances, altered-state work may be limited due to certain therapeutic contexts, including local laws regarding therapy, covert or overt norms within a group practice, or normative expectations within the therapist-client relationship. It is important to note as well that some altered-state work is contraindicated for particular clients; for example, only very well-trained professionals should consider dissociative altered-state work with a client-diagnosed with schizophrenia or dissociative identity disorder. It bears repeating that each therapist, counselor, or spiritual director is morally, ethically, and legally bound to function within the bounds of one’s own training and ability to hold space for any given method. In short, when considering the use of altered-state work, each professional should consider one’s expertise, one’s client’s stability and specific religious or spiritual tradition(s) and belief systems, and the context within which one is considering engaging in the work, even if the plan is for the client to engage in the work outside of sessions and then return to discuss experiences and progress.

It may be good to end this section with Arthur Hasting’s (1983) seven suggestions for working with clients who have had an anomalous experience:

1. Ask the person to describe the experience or events.
2. Listen fully and carefully, without judging.
3. Reassure the person that the experience is not “crazy” or “insane,” if this can be appropriately said.
4. Identify or label the type of event.
5. Give information about the event—what is known about this kind of situation or process.
6. Where possible, develop reality tests to discover if the event is a genuine [STE] or if there are non-psychic alternative explanations.
7. Address the psychological reactions that result from the experience, or the emotional disturbances that contribute to it whether the phenomena are parapsychological or not. (pp. 164–165)

Research

During the research section of the conference presentation on which this article is based, I covered a number of studies, including two I had previously published in the Journal of Near-Death Studies (Rominger, 2009, 2011) and one I am currently writing for publication (the second phase of the study described in Rominger, 2011). Due to space limita-
tions for this article, I focus on only two particular studies shared within this section of the presentation. The first is a study based on a research group at Sofia University that I led from 2010 to 2012. The second is an element of a completed dissertation research project at Sofia University for which I was the chairperson.

The focus of the first study was EHEs, their shadow or distressing elements, and their integration into experiencers’ self-narratives or self-constructs. This study included 36 participants, 12 male and 24 female, most age 35–54 (69%), having had their EHEs between the ages of 25–44 years (61%), and most Caucasian (72%). Within this study we utilized White’s (1998) five EHE categories: mystical, psychic, unusual death related, encounter, and exceptional normal. The most frequently reported type of EHE—reported by 15 (42%) of participants—was the mystical experience.

Three narratives exemplified aspects of EHEs and how individuals worked with them. First, one male participant had a significant Shamanic Journey experience that continued in his dream life. In his words:

I processed and integrated this experience by journaling and telling the story to others over and over again, reflecting on it over the next few weeks and months. It felt moving but I was disappointed that it ended so sharply.

I had nearly forgotten the experience when I began redreaming it at night a few years later while on a trip to Mexico. I am not sure how many times I had the same journey in my dreams, but it felt very familiar each time, like I had done this before. Each time I tumbled at the end, even as I seemed to know what was coming. Finally, at some point, I realized what was coming in the dream as it was occurring and was able to prepare myself while dreaming. This time, the bear came up and I stood my ground, panting in the sand. Next thing I remember was a feeling of enormous elation and joy as I wrestled with the bear, climbing onto its back and pulling at its fur like we were buddies.

After I made friends with the bear, I decided that it was my totem animal. I now hold bears very sacred and live in an area (The Pacific Northwest) where the bear is a traditional image of power and spiritual value. This EHE changed my life on many levels.

Second, a retired female New York police officer, who completed over 50 ‘tours’ after the collapse of the Twin Towers in September of 2001, described how an apparition experience after 9/11 affected her:

As a result of this experience, I revisited my daily spiritual practices. I incorporated prayer and fasting as a means of connecting with the
God whom I serve. I no longer walk in fear of entities seen or unseen because I have an awareness of their existence. Although the entity that visited my mother and I may have just been passing through, I am also aware that there are some that might want to stay a bit longer and may have less than good intentions for me. Thus, I have developed an awareness of the complementaries [sic] of light and dark, as well as light over dark.

Third, a young man described an influential mushroom experience:

I suddenly come to not only realize and embrace, but fully embody with every fiber of my being, the fact that I am one with the universe. The duality of my existence, the palpable separateness of “me” and that which is outside of me, has completely disappeared. The illusions of time, space, and physical existence have ceased to matter any more. I am part of all that surrounds me, and it is all an extension of me.

This experience has blown my mind wide open. Everything I thought I knew is no longer relevant. All of my ideas of right and wrong, good and bad, important and unimportant, have also melted away. My entire perspective on my life, purpose, goals, and how I engage and interact with the world and others has shifted. It is no longer just about me. This experience has encouraged the cultivation of compassion, gratitude, and a deep sense of unity, rooted to the deepest pit of my soul and reaching out across the entire universe. At the same time, a humbling sense of my own insignificance washes over me. At first, this feels slightly unsettling, but quickly shifts in mere moments, to a profound sense of relief. This experience has forever changed me. It has forever changed who I am, how I think, how I engage with the world, and how I prioritize what is important and what is not, day in and day out. It brought the dark into the light . . . the “self” merged with “other” . . . and one became enmeshed with all. I know I will never be the same.

These descriptions reveal various aspects of integration of the exceptional experiences, including changes in identity, views of reality, values, priorities, and relationships with others and oneself. Additionally, they reveal a number of practices that people used to work with their own experience, including journaling, disclosure to others, reflection upon the experience, revisiting old spiritual practices, and engaging in new spiritual practices.

The second study I wish to reference here was by Sean Hinton (2012) and was titled *Spiritual Aspects of Individuation: Numinous Experiences and Life Meaning*. Hinton identified three aspects pertaining to numinous experience—aspects that I apply to STEEs. First, they are threshold experiences in which “one is taken beyond the veil of the mundane . . . [the experience] forever alters one’s view of the uni-
verse or one’s sense of self” (p. 151). Hinton continued, the “experience becomes an initiation into a greater possibility for existence” (p. 151).

Second, STEs are touchstone experiences, serving as “a point of both departure and reference to return to for validation” (p. 152). Additionally, a touchstone experience is “used to validate future decisions or to validate beliefs about the nature of reality” (p. 152). Finally, an STE is a pivotal experience, a “point of directional change” (p. 153) that is immediate and demonstrates a change in life direction.

Conclusion

My goals in this article have included introducing ways of contemplating how one might integrate an STE and introducing several models one may use when conceptualizing an STE and its aftereffects. I fully acknowledge that the definition of integration may change along with the models one uses in one’s own practice. I encourage professionals to start with their own models of the structure of self (consciousness, ego-self, etc.) and the process of health and healing, and then consider how an STE might interact with this model. My goal also was to invite contemplation of several ways for psychospiritual health professionals to work with their clients’ STEs. I do not see these methods as prescriptive but merely offer them as a way to engage the discussion of best practices for working with clients who disclose STEs in professional psychospiritual health settings. Finally, in the source presentation for this article, I shared a number of studies in which researchers focused on various STEs—including NDEs, after-death communications, and other EHEs—and on working with spiritually sensitive individuals. However, due to space limitations for this article, I addressed only two of those: one focusing on EHEs and the other on numinous experiences.

I encourage continued research on STEs, particularly with regard to how they are (a) integrated into the self-construct, and (b) invited into and responded to in therapeutic and professional settings. Through ongoing research, psychospiritual health professionals will continue to refine an understanding of both the STE integration process and how professionals might best facilitate it.

References


tive narratives in clinical practice (pp. 88–121). Washington, DC: Brunner/Mazel.


Adults’ Reports of the Role of Psychotherapy in Integrating Their Childhood Near-Death Experiences: A Preliminary Investigation

Jenny R. Moores, Ph.D., and Sue Ammen, Ph.D.

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**ABSTRACT:** The purpose of this exploratory research was to learn if adults who had childhood near-death experiences (NDEs) sometime between pre-birth to age 17 years had psychotherapy and if they believed it helped them achieve psychological integration of their NDEs. Participants completed three instruments: the NDE Scale (Greyson, 1990), the author-developed Childhood NDE and Psychotherapy Questionnaire, and the three Subjective and Psychological Well-Being Scales (Diener & Biswas-Diener, 2008). Of 29 respondents, 23 met the NDE Scale criteria for an NDE. Results for the 15 (67%) who had engaged in psychotherapy showed statistically significant correlations with large effects between psychological integration of NDEs and more positive emotional feelings ($r = .77, p < .01$) and fewer negative emotions ($r = -.84, p < .01$). The correlation between psychological integration of NDE and success of psychotherapy in facilitating NDE integration was not statistically significant with a small effect ($r = .16, p > .10$). The psychotherapy factors identified by participants as successful in helping them process and integrate their NDEs included having a therapist who accepted the NDE as real and validated the experience and who helped the NDEr express thoughts and feelings about, explore the meaning of, and resolve any guilt around the NDE. Results supported the idea that psychological

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integration of NDEs is related to subjective and psychological wellbeing, and they provided clues about features of psychotherapy that might promote NDE integration. Limitations of the study, implications of results for psychotherapeutic interventions, and suggestions for future research are discussed.

**KEY WORDS:** near-death experience, childhood, psychotherapy, counseling, spirituality

The American Center for Spiritually Transformative Experiences (2010) asserted that

an experience is spiritually transformative when it causes people to perceive themselves and the world profoundly differently: by expanding the individual's identity, augmenting their sensitivities, and thereby altering their values, priorities and appreciation of the purpose of life. This may be triggered by surviving clinical death, or by otherwise sensing an enlarged reality . . . [such as] near-death experiences (NDEs) [and] near-death-like experiences (NDLEs) . . . STEs include or may be called numinous, noetic, transcendent, transpersonal, mystical, anomalous, religious, paranormal, parapsychological or ecstatic experiences . . . STEs can be catalysts for permanent and dramatic changes . . . Many also involve difficult challenges for the experiencer before integration of the experience into one's life is complete. (para. 1, 2, & 4)

An estimated 8 million Americans have experienced one specific type of STE, childhood NDEs (Gallup & Proctor, 1982). Bruce Greyson (as cited in International Association for Near-Death Studies, 2009) defined an NDE as

a profound psychological event that may occur to a person close to death or, if not near death, in a situation of physical or emotional crisis. Because it includes transcendental and mystical elements, an NDE is a powerful event of consciousness; it is not mental illness. (p. 1)

Extensive research has now firmly established a pattern of NDE aftereffects that manifest psychologically, spiritually, physically, and socially and that often are challenging for experiencers as well as their intimates and associates (Flanagan, 2008; International Association of Near-Death Studies, 2010; Noyes, Fenwick, Holden, & Christian, 2009). Researchers have found that these aftereffects and challenges characterize near-death experiencers (NDErs) of all ages but may be particularly challenging for childhood NDErs because of their less developed egos and limited life experience (Atwater, 1996; Sutherland,
2009). Extremely little is known about the frequency and effectiveness of psychotherapy in the NDE integration process among NDErs in general and child NDErs in particular (Foster, James, & Holden, 2009).

The purpose of this research was to learn if adult childhood NDErs reported having had psychotherapy and if they believed it helped them achieve psychological integration of their NDEs. For the purpose of this study, psychological integration is defined as a person being fully aware of one’s experience without creating blocks in one’s current functioning (Seeman, 2008).

Adult childhood NDErs were adult participants who reported having experienced an NDE any time during an age range from pre-birth to age 17 years. Hypotheses included a direct relationship between (a) self-reported psychological integration of childhood NDEs and self-reported subjective and psychological wellbeing outcomes, and (b) self-reported psychological integration and self-reported successful psychotherapy. In addition, content and types of psychotherapy were explored with the adult childhood NDErs to learn what they believed would be helpful with their NDE integration processes.

Method

This study was approved by the Institutional Review Board at Alliant International University.

Participants

Participants were recruited from an International Association for Near-Death Studies (IANDS) conference, IANDS e-mail lists, and word-of-mouth communication between NDErs. Criteria for initial inclusion in the study were age 18 years or older, fluency in English, and a self-reported NDE prior to age 18 years. All 29 participants who met these criteria completed an assessment battery that included the NDE Scale (Greyson, 1990), a psychometrically sound instrument used widely in NDE research to assess the presence (score 7 or higher) and depth (higher score indicating deeper) of an NDE; it is further described below. Six participants scored 6 or lower and comprised the near-death-like experience (NDLE) group. The 23-member NDE group was almost evenly split between males (48%) and females (52%), and the majority (82%) was Caucasian (U.S.). NDErs’ ages ranged from 33 to 75 years, with over half in their 50s ($M = 53.1$, $SD = 10.8$). Educa-
tion of NDE group members was approximately equally distributed across levels ranging from high school education to doctoral degree.

The NDLE group consisted of 100% males and 67% Caucasian (U.S.). Group members ranged in age from 33 to 72 years ($M = 61.2, SD = 14.5$) and were predominantly in their 60s or older (85%). The NDE and NDLE groups were compared on selected demographic data; given the very small NDLE sample size, results are only tentative. With 52% females and 48% males in the NDE group, but 100% males in the NDLE group, the gender patterns were notably different. The majority in both groups was Caucasian (U.S.). Though the mean age of the NDLE group was older than that of the NDE group, the difference was not significant, $t(27) = 1.53, p = .14$).

**Instruments and Analysis**

Participants completed three instruments either online or in paper form: the NDE Scale (Greyson, 1990), the first-author-developed Childhood NDE and Psychotherapy Questionnaire, and the Subjective and Psychological Well-Being Scales (Diener & Biswas-Diener, 2008). The online form was created using Qualtrics, a secure, password-protected online survey program. The paper form was either given to and returned from the participant in person or sent to and returned from the participant via U.S. Postal Service.

The Childhood NDE and Psychotherapy Questionnaire (CNPQ) was a self-report instrument designed to assess past experiences with psychotherapy and explore possible future therapeutic interventions that could be utilized for the benefit of individuals who had an NDE as a child. It consisted of multiple questions and short answer style questions divided into two sections. Section I was subdivided into two subgroups: (a) demographics, NDE, and awareness of NDEs; and (b) disclosure of NDE, experience of psychotherapy, and psychological integration. Section II was subdivided into two subgroups: (a) beliefs and attitudes about psychotherapy for childhood NDEs, and (b) types of groups and therapy suggested for childhood NDEs. Participants who reportedly had not had psychotherapy skipped Section I and completed Section II. The CNPQ was not assessed for validity or reliability.

The NDE Scale was designed by Bruce Greyson (1983) to assess presence and depth of an NDE. The Scale was originally designed as a 33-item scaled-response questionnaire that Greyson (1990) subsequently refined into a shorter 16-item version. It is comprised of four sets of four questions that identify cognitive, affective, paranormal,
and transcendental NDE features. Total possible score ranges from zero to 32; for research purposes, a minimum score of 7 indicates an NDE. The Scale was found to have good internal consistency, split-half reliability, and test-retest reliability (Greyson, 1983, 1990, 2007; Lange, Greyson, & Houran, 2004).

The three Subjective and Psychological Well-Being Scales (SPWB) were developed by Diener and Biswas-Diener (2008) to be used in conjunction or separately for research and clinical purposes to assess emotional wellbeing. According to the SPWB Scales authors, subjective wellbeing refers to how people rate their lives based on terms of global judgment; domains of the person’s life such as work or domestic life; and emotional states or feelings, either positive or negative. The three component scales are the Satisfaction With Life Scale (SWLS) to measure “global life satisfaction” (Diener, Emmons, Griffin, & Larson, 1985, p.71); the Emotional Wellness Scale (EWS) to measure current emotions with three subscales—Pleasant Feelings, Unpleasant Feelings, and a Happiness Balance score that is the difference between pleasant and unpleasant feeling scores; and the Psychological Flourishing Scale (PFS) to measure psychological wealth—a person’s overall attitude, goals, and engaging attitude toward life.

Hypotheses were tested on the NDE group using Pearson product moment correlations. The criterion for statistical significance was set at $p < .05$. In the absence of norms for effect size in NDE research, the strength of the relationship effect size index ($r$) was defined as .1 for small, .3 for medium, and .5 for large, based on Jacob Cohen’s (1992) power primer.

**Results**

**NDE Integration, Wellbeing, and Success of Psychotherapy**

Only the NDEr participants who indicated they had participated in psychotherapy were asked the NDE integration question; therefore, the following results are limited to those participants ($n = 15$). They were asked to rate the extent to which they felt they had integrated their childhood NDEs. Sixty-seven percent of these childhood NDErs reported that they felt they had psychologically integrated their NDEs and that it was an important part of who they are. The remaining NDErs reported feeling mostly integrated (13%), somewhat integrated (7%), and not at all or don’t know (13%).
The first research question addressed the relationship between NDE integration and various aspects of subjective and psychological wellbeing as measured by the SPWB scales. Results showed statistically significant correlations with large effects between psychological integration of NDE and more positive emotional feelings ($r = .77$, $p < .01$) and fewer negative emotions ($r = -.84$, $p < .01$). The relationship with Satisfaction With Life Scale (SWLS) also yielded a large effect at $r = .50$, but did not reach significance ($p < .10$). The relationship between NDE Integration and Psychological Flourishing (PFS) yielded a medium effect but also was not significant ($r = .44$, $p > .10$). The results from these correlations support the idea that psychological integration of NDE is related to positive emotional wellness.

The second research question addressed the relationship between reported NDE integration and success of psychotherapy. When the 15 NDErs who had attended psychotherapy were asked, “Overall, do you believe psychotherapy was successful in helping you process and integrate your NDE?” their responses ranged from 1 (Not Helpful or Don’t Know) to 5 (Yes, Very Helpful) with a mean score of 1.6 ($SD = 1.5$). The relationship between reported NDE Integration and success of psychotherapy to facilitate that integration was not significant with a small effect ($r = .16$, $p > .10$). Only 27% ($n = 4$) of the subjects who had participated in therapy reported that psychotherapy was mostly or very helpful in supporting their psychotherapy integration. However, all of those who reported the psychotherapy as helpful also reported that they had psychologically integrated the NDE into their current life functioning. We next examined what contributes to successful psychotherapy for individuals who have experienced an NDE.

Factors in Successful Psychotherapy that Support NDE Integration

The 15 NDEr psychotherapy participants indicated the degree and manner in which their NDEs were addressed in their psychotherapy, from not at all (1), somewhat (2), quite a bit (3), to yes (4). These factors included whether the therapist was aware of the NDE(s), whether the therapist accepted the NDE as real, and whether the NDE was a focus of treatment. They were also asked whether the mental health professional had helped them (a) express their feelings and thoughts about the NDE and how it had affected them, (b) acknowledge and validate the experience as real for them, (c) resolve any guilt that may have
arisen for them related to the NDE, and (4) explore the meaning of the NDE in understanding themselves and their experiences (see Table 1).

Table 1
**Therapist Factors in Addressing NDEs and Correlations with Treatment Success**

<table>
<thead>
<tr>
<th>Therapist Factors</th>
<th>M (SD)</th>
<th>Correlation with Treatment Success²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore meaning of NDE</td>
<td>2.36 (1.1)</td>
<td>0.89**</td>
</tr>
<tr>
<td>Resolve guilt related to NDE</td>
<td>1.92 (1.1)</td>
<td>0.82**</td>
</tr>
<tr>
<td>Express feelings &amp; thoughts about NDE</td>
<td>2.14 (0.8)</td>
<td>0.73**</td>
</tr>
<tr>
<td>Validate NDE as real for myself</td>
<td>2.29 (0.9)</td>
<td>0.70**</td>
</tr>
<tr>
<td>Therapist accept NDE</td>
<td>2.80 (1.4)</td>
<td>0.58*</td>
</tr>
<tr>
<td>NDE focus of treatment</td>
<td>2.27 (1.2)</td>
<td>0.34</td>
</tr>
<tr>
<td>Therapist aware of NDE</td>
<td>2.73 (1.1)</td>
<td>-0.02</td>
</tr>
</tbody>
</table>

Note. n = 15. ¹ Therapist Factors: 1 (Not at All) to 4 (Yes). ² Treatment Success from 1 (Don’t Know/Not Helpful) to 5 (Yes, Very Helpful). *p < .05; **p < .01.

The most commonly endorsed factors were therapist awareness and acceptance of the NDE, with means of 2.73 and 2.80 respectively. The least endorsed factor was that the therapist helped resolve guilt related to the NDE, with a mean of 1.92.

The relationship between these therapist factors and belief that the psychotherapy was successful in helping them process and integrate their NDE was examined with Pearson’s product moment correlations. There were statistically significant positive correlations with large effects between perceived treatment success and all of the therapist factors except whether the therapist was aware of the NDE and the NDE was a focus of treatment. Specifically, a therapist just being aware of NDEs and addressing them in therapy was not sufficient for therapeutic success; rather, having a therapist who accepted the NDE as real and helped the NDEr explore the meaning, express thoughts and feelings, resolve guilt, and validate the NDE was strongly related to reported success in treatment.
Discussion

This research evaluated whether a group of 15 adult childhood NDErs who had received psychotherapy found the therapy effective in helping them integrate their NDEs. Reported integration of NDEs was highly related to indicators of wellbeing, with more positive emotions and fewer negative emotions. However, only 27% of the participants indicated that their psychotherapy supported their NDE integration. The psychotherapy factors that were successful in helping participants process and integrate their NDEs included having therapists who accepted and validated the NDEs as real and who helped NDErs explore the meaning of, express their thoughts and feelings about, and resolve any guilt related to their NDEs.

Thus, the relationship between psychotherapy and psychological integration was somewhat complicated. When psychotherapy was successful, that is, accepting and validating the NDE, supporting expression of feelings and thought, resolving guilt, and exploring the meaning of the NDE, participants reported being more psychologically integrated. However, over 70% of the participants reported that they found their psychotherapy experiences to be minimally helpful. This finding suggests that the psychological services being delivered to childhood NDErs may need to be refined. The most commonly endorsed psychotherapy factors were that therapists were aware of and accepting that the NDEs were real. Less commonly endorsed were the more specific factors related to how the therapist helped them process and integrate their NDEs. Yet the more specific factors have the strongest relationship with NDErs reporting that the psychotherapy successfully helped them integrate their NDEs. It may be that the psychotherapy process is not leading to the next phase of psychological treatment, which is psychological integration of their experience and aftereffects. When childhood NDErs had successful therapy, psychological integration and emotional wellness were the positive outcomes.

Childhood NDEs can be confusing, which may require therapy to integrate and adjust to the experiences of different phenomena and emotions related to their NDEs. NDErs have identified challenges in communicating their experiences that affect their relationships and coping strategies. Successful clinical support for spiritual and psychological issues might expedite integration sooner than the reported 20+ years after NDE. These results invite mental health and medical professionals to become educated in the unique attributes of spiritual issues in treatment.
As is always the case, there are limitations to this study. It was difficult to find childhood NDErs who qualified for the study. The sample size was relatively small, decreasing the reliability of the results and possibly contributing to Type II error whereby results may have been negative not because a relationship did not exist but because the sample size was inadequate to show a relationship that actually existed. It also was difficult to have a wide variation in ethnic diversity of participants, although the sample was diverse with regard to religion, age, education level, and occupations. It is suspected that depending on perceptions of near-death and other spiritually transformative experiences, individuals may not view their experiences as out of the ordinary because the experiences fit in individuals’ cultural schemas. More research is needed to examine the relationship between ethnicity and NDEs.

There is a need to develop definitions and empirically validated psychometric instruments for assessing NDE integration. It would be useful to empirically validate the efficacy of psychological interventions and treatment plans to assist with the integration and transcendent stages of psychotherapy. It is suggested that future researchers analyze the effectiveness of different treatment approaches, in particular experiential approaches such as sandtray (Homeyer & Sweeney, 1998) that supports integration of internal experience. It is imperative future researchers assess which types of treatments to use at certain stages of cognitive development and stages of adjustment to NDEs. For example, a child may need trauma-focused cognitive behavioral therapy or EMDR if the child requires treatment for traumatic circumstances surrounding their NDEs. Many of the participants in this study reported that in therapy they preferred not to focus on the precipitating events but rather on their NDE aftereffects. It is suspected this is the case because the NDE aftereffects are the prominent feature of the current functioning of adults who experienced NDE as a child many decades ago. It is hoped that from these findings of this study, therapeutic treatment programs and interventions can be designed and researched specifically for childhood NDErs.

References


An Exploratory Study of Recalled Childhood Spiritually Transformative Experiences Among a Specialized Population

Jennifer Elam, Ph.D.

Media, PA

ABSTRACT: Fifty-three adult members of the American Center for the Integration of Spiritually Transformative Experiences completed an online author-created survey about their spiritually transformative experiences (STE) as children. Included among the survey questions were age at STE; STE contents and aftereffects, both beneficial and challenging, both at home and at school; and recommendations for both experiencers and their parents. Results are reported as descriptive statistics with selected narrative responses. Findings of this exploratory study include that, following their STEs, some participants reportedly felt supported by those around them, but most felt isolated and different from their peers and needed acceptance and affirmation from those closest to them. The article concludes with limitations of the study and recommendations for future research.

KEY WORDS: spiritually transformative experiences, childhood, near-death experience, P-12 school

Grown men may learn from very little children, for the hearts of little children are pure, and therefore, the Great Spirit may show to them many things which older people miss.

—Black Elk

Jennifer Elam, Ph.D., is a licensed psychologist in both Kentucky and Pennsylvania. She specializes in working with 3–5-year-olds and works currently as a School Psychologist in Early Intervention in Glen Mills, PA. This article is based on Dr. Elam’s presentation at the inaugural conference of American Center for the Integration of Spiritually Transformative Experiences (ACISTE) in October of 2012. Correspondence regarding this article should be sent to Dr. Elam at e-mail: jenelam@aol.com.
Since 1969 I have studied, taught, researched, and practiced psychology. For the past 12 years, I have practiced school psychology specializing in work with preschool children and their families. Although addressing spiritually transformative experiences (STEs) falls outside the scope of my job description in the public schools, many times parents have confided that they believe their child’s difficulties may be related to an experience the child reported to them and they describe to me—an experience I recognize as an STE. Often, they then get shy and don’t want to talk more about it the matter, as it is not part of our formal relationship. I listen compassionately, then do the formal assessment of eligibility for special education, and the STE issues go unaddressed. I have felt both honored that they shared these meaningful experiences with me and frustrated not to have had mechanisms or referral resources to acknowledge and address the important issues surrounding childhood STEs. Because of my interest in these phenomena, I was honored when Yolaine Stout, president of the American Center for the Integration of Spiritually Transformative Experiences (ACISTE) invited me to partner in conducting the research described in this article. Later she invited me to present some initial results of this research at the first annual ACISTE Conference; this article comes from that presentation.

Defining spirituality is like asking a fish to define water (Hart, 2003, p. 6)—a bit difficult to hold onto and know. Hart (2003, p. 7) defined spirit as that unquantifiable force, the mystery that animates all things and of which all things are composed. There is no separating humans from it. ACISTE (2012) has defined an experience as “spiritually transformative when it causes people to perceive themselves and the world profoundly differently: by expanding the individual’s identity, augmenting their sensitivity and thereby altering their values, priorities and appreciation of the purpose of life” (para. 1). An STE has the potential for creating greater wellbeing. If the STE is a catalyst for positive growth it is by nature not pathological in itself, even in the minority of cases in which it accompanies a mental disorder. STEs happen to people with strong or weak coping strategies, and a distressing spiritual experience may have the same potential for healthy growth as a non-distressing experience. Though STEs generally have progressive effects on values, attitudes, beliefs, behaviors, and functioning, they also can have regressive or mixed effects (ACISTE, 2012).

A fundamental question about childhood spiritual experiences is how common they are. In a major study, child developmental psychologist
Tobin Hart and a colleague asked 450 young adults about specific spiritual experiences, including “moments of wonder and awe, unitive experiences, and receiving spiritual guidance from a nonphysical source” (Hart, 2003, p. 6). They found that, depending on the specific type of experience, 10–80% reported having experienced it, and 60–90% reported having first experienced it during childhood (pp. 6–7).

Their findings corresponded to my own research experience. When I began researching mystical experiences and word got around that I was a safe person to talk to, I had more people to talk to than I could possibly arrange. Many of the people I did talk with described experiences from their childhoods, and most told me they had never or almost never talked about their experiences because they did not feel safe to do so. From research like Hart’s, from Sutherland’s (2009) summary of research on the childhood STE of near-death experiences (NDEs), and from my own experience, I have concluded that people representing a large segment of the child population have had and are having non-ordinary experiences that they are not sharing (Elam, 1999, 2002). In Hart’s words, their experiences do, indeed, represent a largely secret spiritual world (Hart, 2003).

**Methods**

The present exploratory research involved asking adults about their childhood STEs. Members of ACISTE, along with other individuals in related social networks, were invited by e-mail to complete a 25-question survey inquiring as to the details of their childhood STEs. The online research tool Survey Monkey was used to gather survey responses. General qualitative analysis was performed on survey responses, as was descriptive quantitative analysis such as counting the frequency of occurrence for particular phenomena. In order to protect participant confidentiality, the names that appear below are pseudonyms.

The following data are based on a total of 53 completed response sets. Comparison of the response sets revealed unique answers that indicated each set was submitted by a different participant. However, as we did not block multiple submissions from the same IP address, submission of two unique response sets from the same participant cannot be ruled out. The assumption for the following material is that the response sets represented 53 different participants.

Participants’ ages in years ranged from the teens decade to the 80s decade, with most respondents in their 50s and 60s. We did not ask re-
spondents to report their gender or ethnicity. However, from narrative responses, we sometimes could discern a participant's gender; when we could, we used the appropriate pronoun in reporting qualitative findings, and when we couldn't we used "s/he."

Results
The following material reflects what I consider the most salient from among all the results of the survey. Results appear in an order that makes conceptual sense rather than the exact order of the survey questions.

First STE
Age. We asked participants their age at their first STE—from pre-birth up to 15 years—and determined the percentage of participants at each age. The most likely ages in order of highest percentages were 4 (n = 9; 17%), 5 (7; 13.2%), 7 (6; 11.3%), and 3 (5; 9.4%) years. Two participants (3.8%) reported pre-birth memories, and in the age range 12–15 years, only one participant (1.9%) reported an STE—at age 15.

Memory. When participants were asked if they remembered their first experience immediately after it happened, 42 (79.2%) said yes, and 11 (20.8%) said no, that they recalled it only later. If they recalled the experience later, we asked how much later and asked them to describe any circumstances that might have prompted them to remember the STE. As detailed below, the circumstances around the remembrance were quite varied. Some involved others telling them of the experience, some had a re-occurrence such as another STE, and others had a non-spiritually-transformative experience that triggered the memory of the childhood STE.

One participant said s/he heard voices and did not pay attention to them at age five but discovered the importance of them later. One did not feel s/he had the intellectual development to understand the experience but later recalled it in an insight as an adult with a greater capacity for understanding. One reported that when s/he sees or hears something out of the ordinary it's recorded like a biological video in the mind. One had a recurring dream for years throughout childhood and put the pieces together later, stating that "The 'Dream' is my spirit returning to my fetus." One said the experiences tended to happen at bedtime; in later years, "whenever I lay down, I would remember the
experience and wonder if I could make it happen again.” One said that she forgot about the experiences as an adult until she had a life review in an NDE at age 32 and then saw herself as a child “hanging out in the tunnel.” Similarly, another said she forgot until she later connected with the experience in an awakening. Another participant said s/he realized after 50 that, “I could still feel the tension from the original experience within my chest. It was like a ball of boiling energy. As I began for the first time to focus in on this energy, it began to give up all the memories related.” Another participant used hypnotic regression to recover memories from a “missing week.” Similarly, another participant remembered the experiences while doing a psychotherapy exercise for the treatment of obsessive-compulsive disorder.

Duration. Participants were asked to estimate how long the first experience lasted—from an observer’s point of view. Responses ranged from impossible to estimate (n =14; 26.4%) to less than a minute (10; 18.9%), 1 to 60 minutes (18; 34.0%), more than an hour (2; 3.8%), more than a day (2; 3.8%), more than a month (3; 5.7%), and it never stopped (4; 7.5%). Thus, duration showed a pattern of decreasing length, with approximately one-quarter of participants indicating they could not estimate, one-half indicating less than an hour, and the remaining one-quarter indicating more than an hour including a few who indicated the experience had been ongoing to the present.

Circumstances. When participants were asked whether their first STE was triggered by physical or emotional trauma or involve abuse, illness, injury, drowning, accident or other adverse circumstances, 29 (54.7%) said yes, 18 (34%) said no, and 6 (11.3%) said they were not sure. If yes or not sure, they were asked to describe what happened. After examining the “not sure” narratives, we concluded that at least 35 (66.0%) of our participants’ STEs were either directly or indirectly related to trauma. Analysis of the themes of their narratives revealed that these participants have been doubly challenged, both by the original trauma, that was often ongoing, and by the predominant culture, that often not only did not support these childhood trauma victims but also labeled their spiritual experiences as mental illness.

Some of the specific circumstances were described as follows: “was found dead in my crib, smothered then revived violently,” “much emotional and some physical trauma with an aggressive, alcoholic mother,” “was run over by a car,” “had stopped breathing while asleep and was aware of my heart stopping and my body shutting down,” “was stung
by a nest of bees, fell unconscious, and woke up in the emergency room,” “was raped and had a near death experience,” “my father beat my mother during my gestation,” “was attacked by a dog and as his mouth was about to close around my throat I had my life review; from this, ‘other’ experiences began to occur,” “had measles twice around 8 months old,” “was a nervous child,” “I had been being sexually, physically and emotionally abused by family members for most of my life,” “suffocated with a pillow in the cradle at age three months, but recovered,” “suffered fetal trauma and then birth trauma,” “was drowned by my own mother but brought back to life by her too; luckily she was a nurse,” “tonsillectomy,” and “it happened during child abuse event.”

**Alignment with family’s religion/spirituality.** Participants were asked the religious or spiritual orientation of their closest parent, foster parent, or other adult in charge of their upbringing at the time of their first experience and to choose the most accurate answer from a series of choices. From most to least of those who indicated a choice, 17 (32.0%) indicated Catholic, 13 (24.5%) Protestant, 7 (13.2%) Baptist, 2 (3.8%) Jewish, 1 (1.9%) Native American, 1 (1.9%) Spiritual, non-denominational, and 1 (1.9%) Atheist. One participant (1.9%) indicated s/he didn’t know, and of the 10 (18.9%) who indicated “Other,” participants noted Mormonism, Scientology, secular Judaism, Quaker grandmother, and Jehovah’s Witnesses; one participant thought the caretaker believed in God; and one said the household was mixed, as the mother was Protestant and the father was Catholic; and one noted that her mother was bitter about religion.

Participants were then asked if their experience was in alignment with their family’s religious beliefs. Only 4 participants (7.5%) indicated alignment; 2 (3.8%) indicated No, but my parents were supportive anyway; 7 (13.2%) indicated No, and it created problems, 15 (28.3%) indicated they didn’t know, and 25 (47.2%) indicated Other.

**Confidantes and their reactions.** When participants were asked if they shared their first spiritual experience with someone soon after it happened, 21 (39.6%) said yes, and 32 (60.4%) said no. Eventually, all participants did disclose their first experience to someone else. From most to least reported, 12 (22.6%) indicated a parent, 10 (18.9%) indicated a friend, 2 (3.8%) indicated an extended family member, 2 (3.8%) indicated a psychotherapist, 1 (1.8%) indicated a teacher, none indicated a sibling, and 26 (45.3% indicated Other. Two participants (3.8%) said they had never shared with anyone until now. Among those who
responded Other, written responses indicated that as adults they have shared their experiences with many people: spouse, adult children, siblings, grandmother, mother, teacher, friends, family, therapist, Taoist priest, church congregation, school, spiritual director, counselor, and spiritual mentor. Some have shared with so many people, they don’t remember who all they were.

The nature of their confidantes’ responses, from most to least frequently reported, were 13 (24.5%) who thought the experience was the participant’s imagination, 8 (15.1%) who were supportive, 7 (13.2%) who didn’t know what the confidante thought, 6 (11.3%) whose confidantes wanted to hear everything about the experience, 5 (9.4%) who ignored it, 4 (7.5%) who were angry, 4 (7.5%) who were worried, 2 (3.8%) who were encouraging, 2 (3.8%) who took the participant to a minister or other spiritual advisor, 1 (1.9%) who were excited, 1 (1.9%) whose mother and father responded oppositely, and none who took the participant to a mental health professional either in or out of school. Thus, 17 (32.1%), or about one-third of participants, reported responses that could be considered beneficial—supportive, encouraging, excited, wanted to hear everything; 9 (17%) reported responses with a neutral or undeterminable valence—didn’t know what the confidante thought, took participant to religious/spiritual advisor; and the remaining 27 (50.9%), or about half of participants, reported unhelpful or detrimental responses.

Twenty-one participants (39.6%) made comments related to responses they received from disclosing their first childhood STEs as teens or adults. The responses seemed to range from somewhat supportive to mixed to somewhat dismissive to very dismissive. Somewhat supportive comments included “They couldn’t understand it but accepted it. The Taoist priest had a better understanding,” “Supportive but not that interested,” “Before my mother passed, I read her some NDEs off the web; she then remembered smelling and hearing her mother during a time she was in a coma,” “Mother was resistant at first, has become more interested and open,” and “In my country, spirits are a common sight and it’s part of life, common knowledge in other words.” Mixed responses included “Some like it. I have been told it was creepy or weird. My mother found it fascinating. Never told my dad,” “They thought I was either nuts or that I was finally a good Catholic, but wanted me to think and talk about it less,” and “What little they showed interest, they mostly showed shock and fear that it happened at all, most likely because it involved a sibling and was violent and caused me to die and then return.”
Several participants never shared their experience or said they had to wait for just the right time to share it. They did not perceive it to be safe, others told them not to tell, or they tried to tell it and got an angry or other negative reaction as an initial response and did not attempt it again, but most did talk about it years later. Some of the negative responses included “My dad thought I was possessed, got me blessed by a priest, and his mother would douse me with Lourdes water (Holy Water) every time I entered her home,” “At age 4 I shared an after effect (seeing a fairy) with my parents; when they rejected both the experience and fairies, I determined never to share ESP events with them again and never did, although my entire life has been filled with them,” “I told my mother a few years ago; she was dismissive and uninterested,” “I told my teacher and she told my mother who seemed embarrassed,” and “I tried to talk to my mother once about the ghosts and witches in my bedroom at night, but she thought it was imaginary, so I never shared anything else.”

Some participants referred specifically to labels and diagnoses they had received in response to disclosing their STEs. One participant said s/he was described as “creative and dark.” Another was called a “deep weirdo.” “Over-active imagination” was a common label.

One participant noted that the family was following scientology so, for religious reasons, they did not seek professional help that might or might not have led to diagnosis. Diagnoses given to other participants and thought perhaps related to their STE included: premature baby ($n = 2; 3.8\%$), ADHD (1; 1.9\%), sleep disorder (3; 5.7\%), and PTSD (1; 1.9\%). Some diagnoses were made but were thought not related to the STE and included: premature baby (1; 1.9\%), ADHD/ADD (2; 3.8\%), personality disorder (3; 5.7\%), dissociation (2; 3.8\%), and post-traumatic stress disorder (PTSD; 2; 3.8\%).

Some participants spontaneously commented on the role of confidante responses in participants’ integration process. For most participants, the STEs had both a blissful, peaceful, beautiful component as well as a painful component, and several described becoming fearful when the people around them could not cope with the STE or its aftereffects. Thus, reactions of others could make the experience easier or more difficult to integrate. Acceptance from others and the ability to make meaning from the experience seemed to be associated with more ease in integration.
Subsequent to First STE

STEas after the first. Participants were asked if they had spiritual experiences after the first and were given specific choices for answers. From most to least frequent, 32 (60.4%) participants reported multiple STEs throughout their lives, 11 (20.8%) indicated a few STEs as both a child and an adult, 7 (13.2%) indicated more than one, and 3 (5.7%) indicated recalling only the one childhood STE. Thus, the great majority of participants reported many STEs throughout their lives.

Six participants commented on their later STEs. One said that none of the later ones were as profound as the first. One said that as an adult, s/he continued to have many different kinds of spiritual and mystical experiences. One said she did not remember the experiences until, during her NDE life review, she saw herself in the tunnel as a child. One said she has had some strange events in her life but would not call them STEs; for example, she heard someone talk to her as if they were in the room with her, but no one was there. One described a feeling of “other worldliness” of communication with the divine while in the mountains by a creek. Another described being saved from death or severe physical trauma in inexplicable ways and experiencing an omniscient Presence, an energy full of love and benevolence much larger than herself that enveloped her body multiple times throughout her life.

Contents of most profound or transformative childhood STE. Participants were asked to describe what happened in their most profound or most transformative childhood spiritual experience thus, this particular topic included what might or might not have been respondents’ first STEs. Responses were varied. The largest subgroup reported NDEs. Several of these involved drowning, and these participants all reported a very similar pattern. They described going under the water. Very soon, they entered a peaceful, beautiful place and could look down on the(ir) body. Often a voice told them it was not yet their time to stay, and they were then catapulted back into their bodies—a process that most participants described as painful, except for one for whom it was a calm re-entry. Angels were often involved in these drowning NDEs.

The second largest subgroup of STEs also involved various kinds of out-of-body experiences, though not apparently during close brushes with death. The third largest subgroup of experiencers heard voices and/or had visions, such as lights and auras. Some participants could
see or hear spirits that others could not perceive. Communicating with spirits, God, or angels was often involved. Some participants reported “knowings” during their experiences—knowing things they could not have known by rational means.

For several participants, traumatic content was co-mingled with STE contents. For some of those participants, the traumatic contents involved abuse by another person.

**School experiences and performance.** Participants were asked to indicate all items that applied from a list of various school experiences that they attributed directly or indirectly to their STEs. Of the 34 (64.2%) of participants who indicated one or more listed items, 15 made comments. Responses appear in Table 1, first participants who did not indicate any items or indicated no STE-related school issues and then items from most to least indicated.

<table>
<thead>
<tr>
<th>Type of Experience</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the below items indicated</td>
<td>19</td>
<td>35.8%</td>
</tr>
<tr>
<td>I had no issues at all at school because of my STEs.</td>
<td>7</td>
<td>20.6%</td>
</tr>
<tr>
<td>I kept to myself because I felt different.</td>
<td>21</td>
<td>39.6%</td>
</tr>
<tr>
<td>I found an outlet through play, art, music or dance.</td>
<td>12</td>
<td>22.6%</td>
</tr>
<tr>
<td>I was bullied or teased by other children.</td>
<td>9</td>
<td>17.0%</td>
</tr>
<tr>
<td>Other children thought I was weird and avoided me.</td>
<td>7</td>
<td>13.2%</td>
</tr>
<tr>
<td>My STE(s) distracted me from my learning.</td>
<td>7</td>
<td>13.2%</td>
</tr>
<tr>
<td>I made friends with kids who also had spiritual experiences.</td>
<td>4</td>
<td>7.5%</td>
</tr>
<tr>
<td>I was placed in a class for the gifted.</td>
<td>4</td>
<td>7.5%</td>
</tr>
<tr>
<td>I was sent to the school psychologist.</td>
<td>3</td>
<td>5.7%</td>
</tr>
<tr>
<td>I was placed in special education.</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>I was sent to private or religious school.</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>My teacher embarrassed me about my experience(s) in front of the class.</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>I acted out or was angry.</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>My parents kept me out of school. I was home schooled.</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>My friends and teachers were very receptive and accepting.</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Note. N = 53. Percentage exceeds 100% because some of the 34 respondents who indicated at least one item indicated more than one item.*
Participant comments indicated a full range from those who excelled in school to those with significant difficulties. Comments indicating no school difficulties included, “I excelled in all areas, top of my class.” Regarding peer relations, comments included, “I was compassionate toward sad, poor or disadvantaged children.” One participant made friends because she was always drawn to others who had had spiritual experiences. Another noted that she did not know she was different until years later. Yet another said, “While I felt older than my peers, I adapted and got along with them.”

Seven of the 15 participants who commented indicated that they had difficulties in school ranging from mild to more significant school difficulties. Comments included: “I longed to feel connections and wanted to feel like I belonged somewhere,” “I felt different and did not like a lot of what they were trying to teach me,” “I was sent to the guidance counselor. I had a genius IQ but was not doing well in school. I told her that I sometimes talk with plants and animals but she thought I was just ‘imaginative,’” “I became solitary and trusted no one other than the enlightened few,” “I was (am) dyslexic. I struggled in school yet was considered very mature for my age,” “I couldn’t learn like other children and found that any distraction prevented my ability to learn. Once I was placed in an isolated setting, I excelled in everything and got straight A’s,” and “immediately after the NDE, I knew how to read though no one had taught me. I was bored and disaffected throughout K-12 years, and made terrible grades. Though I had a high IQ, I was always in trouble. No problems in college/grad school (it wasn’t so boring),”

Observations in Retrospect

Effect of childhood STEs on adult lives. Fifty-two (98.1%) participants responded and commented on how the STEs of childhood affected their adult lives; one could not because of being only 15 years old. Because participants could indicate more than one answer, the following percentages exceed 100%.

Three (5.7%) participants commented in essence that the change had been pervasive. Among the seemingly constructive effects: Five (9.4%) indicated that the experiences had enhanced their spiritual lives in such ways as enhancing her/his belief in the supernatural, having opened her more fully to her spiritual life, transforming her life spiritually, moving from an agnostic to a more spiritual outlook on existence, or relating to the experiences when she studies spiri-
ualism. Three (5.7%) participants talked about how the experiences provided a foundation to their later vocations as a pastor, an NDE researcher, and a writer of books on angels. Among the seemingly challenging effects: Feeling different was a theme that arose for one (1.9%) who said she still feels as if she does not belong and one (1.9%) who said she feels like she was treading water all her life but finally understands why she has been the way that she was. Fear was a part of the feeling for three (5.7%) people, one who said she felt different, not loved, alone and was afraid to be alone; one who said people became afraid of her so she had to be very careful; and one who said her family became afraid of her, which was very hurtful.

There were those who found the experiences to enhance their lives in very desirable ways, for some it was very difficult and for some the experiences both enhanced their lives and made life more difficult. Those for whom the experience enhanced their lives said “it opened my eyes and all the senses to observe things in greater detail and beyond the ‘normal,” “made life amazing and enlightening,” “steered me onto a spiritual path which has brought immense gifts of grace and love to me, am grateful, and wish it could be transmitted or induced,” “understand why it happened and am at peace,” and “helps me understand the afterlife and my life is whole . . . my heart is pure with no anger or grief.” Other said, “. . . empowers me . . . it provides assurance that I am not fabricating stories,” “I feel deeply enriched and blessed by grace and hope,” “. . . more receptive to other people’s spirituality,” “made me who I am,” “made me a very strong and peaceful person. I help many people cross over to death. I never search it out but there have been many opportunities that have dropped into my awareness.” One said, “more understanding of people, not afraid of death and try to let people know that death is not the end.” Three participants stated that the effect was positive or it helped.

Those who found their experiences made life harder said, “I have the spirit of a warrior, martyr, it hasn’t been easy,” “I’m constantly feeling inadequate and depressed with a mixture of anger,” “. . . professionally, it is much harder because my reputation is on the line and I wish I had had the support that I see available now . . .”, “. . . more problematic. Less idealistic and more serious about eternal security/after death. . . .” Those for whom the experiences have had mixed effects said, “. . . double-edged sword-gifts and challenges,” “. . . still afraid of the dark and can’t sleep alone. However, it has made me very curious about the spiritual world . . .,” and “. . . have come into
more acceptance of my unusual life and I’ve found ‘kindred spirits’ who respect my path and share aspects of it.”

**Life challenges created by STEs.** Participants were asked about what challenges were created in their lives by their STEs; once again, due to multiple responses by some participants, the following percentage exceeds 100%. Nine participants (17.0%) said none, and one attributed an absence of challenges to not having disclosed the experience to anyone. Five participants (9.4%) indicated not being able to talk about their experiences or having no one to talk to. One person (1.9%) indicated not having someone to help her or him.

Most frequent was the 17 participants (32.1%) who reported feeling different, with some noting their efforts to be “normal” while believing they were not. Values were different and fitting in was difficult. One person described feeling like she was “born on the wrong planet.” Associated with the feeling of being different were other feelings of isolation or loneliness (n = 4; 7.5%), mistrust (2; 3.8%), and one (1.9%) each: fear or anxiety, anger and depression without an identifiable source, difficulty sleeping, and lowered self-esteem. Two participants (3.8%) reported an increased sensitivity to seeing through falsehoods, facades, or deceit. “Knowing too much” (1; 1.9%) was an issue. Five people (9.4%) reported issues with peers: feeling older than peers, being drawn to adults, and being bored with what peers are typically interested in. Two people (3.8%) reported needing to be very careful so that they did not scare others.

Other challenges included disclosure met with discounting or disbelief (n = 3; 5.7%) and school difficulties (3; 5.7%) to the point of “torture” (1; 1.9%). Two participants (3.8%) reported that they did not want to live their given human lives, with one stating that she just wanted to be with the angels. Living with two opposite realities, one accepted by the culture they lived in and one marginalized by the culture was very challenging.

**What was needed in childhood.** When adults were asked specifically what they needed as children, the responses presented a clear picture. Most said validation/affirmation and knowledge to help them understand the experience(s). An open-minded mentor, teacher, counselor, someone safe, a loving adult to give knowledge (n = 22; 41.5%) as well as validation, affirmation, telling them it was ok or normal, and that there were other children like them (12; 22.6%). Respondents
would have liked to be listened to without judgment or fear (9; 17.0%), with adults interested enough to ask questions (1; 1.9%) and help with integration (1; 1.9%). One participant (not the same one) indicated each of the following: Being protected from their own fear was important, as was privacy, nature, art, and changing to a different school. Four respondents (7.5%) felt their needs were well taken care of as children, and four did not know what they would have needed.

Advice to children and parents. Participants were asked what advice they would give to children having STEs and to their parents; again, multiple responses caused total percentage to exceed 100%. Responses to children included to trust themselves and their own experience as real, normal, and acceptable and to find trustworthy others and confide in them \( n = 21; 39.6\% \). Other advice included to release fear (4; 7.5%); to find a mentor (3; 5.7%). Each of the following recommendations was endorsed by one (1.9%) participant (not the same one): to know that they are special and gifted, to not allow their experiences to be discounted, and to seek out others like themselves; not to try to convince others; to seek knowledge about experiences like theirs; to live the spiritual life; to ask for help from their higher power; to spend time in nature; and to have a pet.

Participants advised parents to listen \( n = 15; 28.3\% \) nonjudgmentally (3; 5.7%), love unconditionally (6; 11.3%), and physically hold (2; 3.8%) and emotionally support (8; 15.1%) their STEr children. They urged parents to allow children to talk about the experience (3; 5.7%) when they are ready (1; 1.9%) and make no big deal about it (3; 5.7%). They also recommended that parents take their children’s experiences and feelings seriously (3; 5.7%), not dismissing them as mere imagination and that they believe in the reality, or believe in the possible reality, of their children’s STEs (8; 15.1%). They advised parents to get involved, be interested, and ask questions that help children to further clarify/define (5; 9.4%) and integrate (3; 5.7%) their experiences. They admonished parents to be honest with their children about what they do and don’t know about STEs and to educate themselves about them (14; 26.4%), with the specific suggestion of Tobin Hart’s (2003) book The Secret Spiritual World of Children. One participant (1.9%) urged parents to use discernment to find children that their children felt were like them to be with. Participants suggested that parents write down the experiences or make notes to come back to later (2; 3.8%), consider using the arts to help with expression (1; 1.9%), and consider taking their child to play therapy (1; 1.9%), a counseling intervention.
appropriate for children ages 3–9 years old. They said parents should help children discover and cultivate what they love in life (1; 1.9%) and should normalize (3; 5.7%), avoid labels, and not treat children as if they are crazy (3; 5.7%). They advised parents to consider their children's experiences a blessing rather than a worry (2; 3.8%), to know it is a gift that will also be a blessing to others (3; 5.7%), and, if they find themselves unable to listen deeply to their children, to find someone who can (1; 1.9%).

Participants expressed mixed opinions on some parenting issues. Some found psychotherapists helpful and some said to avoid therapists or professionals; the key seemed to be whether or not the therapists had had STEs themselves and were knowledgeable about them. Some advised participation in church, but most advised to avoid church if the church philosophy was judgmental. One person advised avoiding public schools and teaching the child at home; others indicated that public or private school experiences could be good for childhood STEs but that parents should monitor their school experiences to identify and address any problems that might arise.

**Limitations of the Study, Future Research, and Conclusion**

The generalizability of the results reported herein is restricted by numerous limitations. These included that the sample size was small, that the population from which the sample came was very specialized, that reports of childhood STEs and reactions to them were mostly distantly retrospective, and that the instrument did not have established psychometrics such as validity and reliability—a limitation that became clearer when respondents indicated that their answers to the questions did not appear among the response choices. Thus, the results of this study can be considered only preliminary and exploratory.

However, the results herein establish that at least some childhood STErs recall a variety of experiences and responses to their STEs. From the participants sampled in this study, the takeaway messages for both children and those who interact with them are numerous. As most STEs reportedly occurred between ages 3–7 years, and four-fifths of STErs recalled the experiences immediately, it should not be surprising that children at such young ages report STEs—especially, but not only, if they have survived physical or emotional trauma. Most children will report experiences that lasted less than an hour, though
a minority may report longer experiences—even ongoing to the present. Drowning NDEs may be a most frequent circumstance and type of STE, though children may also report other out-of-body experiences and/or voices and visions of entities such as spirits, angels, and God. If a child reports one STE, they almost certainly will report subsequent ones.

Among this sample, the most likely people to whom children disclosed their STEs were parents and friends, and participants affirmed that confidante’s responses were important—often crucial—in STErs’ integration process. Although one-third reported beneficial responses, one-half unfortunately reported detrimental ones. As one-tenth of this sample indicated that a conflict between the contents of the STE and one’s caretaker’s religious/spiritual beliefs created particular difficulty, caretakers who wish to be most helpful to their children need to be prepared to open their minds beyond cherished beliefs and values—for many an admittedly challenging process. And though some participants in this sample reportedly excelled at school, two-thirds reported some difficulty in school—occasionally agonizing.

Though these childhood STErs reported both positive and negative effects of the STE throughout their lives, a persistent theme across the lifespan was a sense of psychospiritual isolation. Not surprisingly, then, these participants reported that what they had needed most as children was affirmation/validation of their experiences and themselves as well as information about STEs and how to manage them. Their most endorsed advice to children was to trust themselves and find trustworthy others to validate/affirm and inform—and to parents was to be that trustworthy source of validation/affirmation and information. In utilizing community resources to help STEr children, these respondents recommended religious/spiritual consultants who also will nonjudgmentally validate/affirm and inform, and mental health professionals with at least professional expertise about, if not personal experience with, STEs. In summary, participants encouraged children, and encouraged parents to help children, to acknowledge rather than avoid the STEs and to take any of a number of possible actions to integrate the experiences, cultivating their enhancing aspects and managing or reducing the challenging aspects.

It remains for future research to determine how representative the results of this survey are among children at large in both U.S. and other cultures as well as how effective participants’ recommendations prove to be in easing and facilitating the STE integration process for children. For example, whether the absence in this sample of reported
STErs at ages 12–14 years represents a sampling error or an actual trend remains to be determined; certainly, no such trend has been identified with regard to NDEs (Sutherland, 2009). Pending further research, it is noteworthy that participants’ recommendations to STErs children and their parents correspond to professionals’ advice about responding to transpersonal experiences among children and in general (Bell, Holden, & Bedwell, 2010; Foster, Holden, & James, 2009; Kason, 2009; Sutherland, 2009); as such, in the absence of effectiveness research, these recommendations represent the best available guidance for childhood experiencers and their parents. The results of the study described herein hopefully will inspire future researchers to further examine the nature of childhood STEs and aftereffects and the most helpful ways for experiencers and their parents and other associates to respond to them.

Some participants reported quite distressing childhood abuse experiences arising from their STEs, primarily in their families but sometimes in their schools. As a school psychologist, this finding is quite concerning to me. I am hopeful that parents and families, school personnel, and health professionals will use the information in this article to create physically and psychologically safe spaces for people of all ages to share their STEs and move toward integration in a timely manner so that they do not have to spend decades struggling with experiences that have the potential for enhancing life with joy and spiritual connection.

References


BRIEF REPORT

A Near-Death Experience with Veridical Perception Described by a Famous Heart Surgeon and Confirmed by his Assistant Surgeon

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ABSTRACT: The professional near-death literature contains cases in which near-death experiencers reported that during their experiences (NDEs), they perceived phenomena in the material world that, based on the condition and position of their physical bodies, they should not have been able to perceive, and yet these perceptions were subsequently verified as accurate. Only a few of these cases of apparently non-physical veridical perception during NDEs have been carefully researched. In this article, we report a case described originally by cardiac surgeon Lloyd Rudy in a YouTube Internet video. We describe our process of following up exhaustively on all avenues of investigation available to us and our conclusion that this case is among the most evidential in which perceptions during an NDE were confirmed as completely accurate by objective observers.

KEY WORDS: near-death-experience, veridical perception, cardiac valve resection surgery

As early as 1882, the professional near-death literature has contained accounts describing near-death experiences (NDEs) in which the ex-

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perciever, upon regaining consciousness, reported perception during the NDE that was later confirmed as accurate (Holden, 2009). When such perceptions should have been impossible based on the condition and position of the experiencer's physical body, they have been termed apparently non-physical veridical perception (AVP). The most evidential of these cases involve perceptions that seem impossible to attribute to sensory processes—such as vision or hearing—or to logical deduction or previous knowledge on the part of the experiencer. Upon gleaning the professional literature, Holden (2009) found 107 cases of AVP, of which 27% belonged to the most evidential category in which the perceptions had been verified as completely accurate by objective observers. We've been personally involved in a follow-up on one of these accounts, the case of the “Man with the Dentures” (Rivas & Dirven, 2010; Smit, 2008). A recent online case appears to add one more to that category; that case is the subject of this report.


Rudy graduated from the University of Washington Medical School, completed a residency at the University of San Francisco Medical Center, and after serving in a M.A.S.H. unit in Vietnam became a Board Certified Cardiovascular and Thoracic Surgeon, was Dean of the Heart Program at the University of Georgia School of Medicine, and was a member of the first heart transplant team at Stanford University. The Governor of Montana proclaimed a Dr. Lloyd Rudy Day in honor of his pioneering work in cardiac surgery in that state. Interested readers may refer to his obituary: http://www.heritagefunerals.com/fh/obituaries/obituary.cfm?o_id=1464561&fh_id=11479)

In the YouTube clip, Rudy discussed two cases he had witnessed, the first of which concerned a classic NDE involving veridical perception during clinical death. Following is a transcript of this portion of the interview:

RUDY: We had a very unfortunate individual who on Christmas Day had, from an oral infection, infected his native valve [gestures to indicate a valve of the heart,
with “native” referring to the patient’s biological valve rather than an artificial, prosthetic valve. If your native valve has the slightest defect, whether you were born with it or you developed it later—it calcified a little and the valve leaflets don’t move or whatever—the body recognizes that as something abnormal that it’s got to take care of. So that’s what happened to this man, and one of my junior partners was on call, and he had to do an emergency valve resection. Once we were able to accomplish the repair of the aneurysm and the replacement of the valve, we could not get the person off of the bypass. Every time the four or five liters of blood that we were pumping around his body, we would reduce down to two or three, he’d begin to weaken and his blood pressure would go down, and so on. To make a long story short: We simply couldn’t get him off the heart-lung machine. Finally, we just had to give up. I mean, we said: We cannot get him off of the heart-lung machine, so we’re going to have to pronounce him dead. So we did that. And so the anesthesiologist turned his machine off and the bellows that were breathing for the patient stopped. That machine was quiet.

The anesthesiologist went into the surgeon’s lounge. He hadn’t eaten anything all day so he went in to have a sandwich. Then the people, who usually clean up the instruments and all that, were coming in and taking away all these tools. And my surgical assistant closed the patient in a way that a postmortem exam could be done, because anyone who succumbs on the table by law has to have an autopsy. So he closed him up briefly, with a couple or three wires here and a big stitch to close his soft tissue.

Well, that machine that records the blood pressure, and the pulse, and the left atrial pressure and all the monitoring lines and things, continued to run the paper out onto the floor in a big heap. Nobody bothered to turn it off. And then we put down a trans-esophageal echo-probe, which is just a long tube that has a microphone on the end of it, and we can get a beautiful picture on a monitor of the heart beating. Well, that
machine was left on, and the VCR-tape continued to run.

Well, the assistant surgeon and I went in and took our gowns off, and gloves and masks and things, and came back, and we were in our short-sleeve shirts, and we were standing at the door, kind of discussing if there was anything else we could have done and any other medicines we could have given, whatever, to have made this a success. And as we were standing there, it had been at least 20 minutes. I don’t know this exact time sequence, but it was close to 20–25 minutes, that this man recorded no heartbeat, no blood pressure [gestures to indicate the monitoring machine’s continuous paper readout], and the echo showing no movement of the heart, just sitting.

And all of a sudden, we looked up, and this surgical assistant had just finished closing him, and we saw some electrical activity. And pretty soon, the electrical activity turned into a heartbeat. Very slow, 30, 40-a-minute, and we thought, “Well, that’s kind of an agonal thing,” and we see that, occasionally, that the heart will continue to beat even though the patient can’t generate a blood pressure or pump any blood. Well, pretty soon we look, and he’s actually generating a pressure. Now, we are not doing anything; I mean, the machines are all shut off. And we’d stopped all the medicines, and all that.

So I started yelling, “Get anesthesia back in here!” and, “Get the nurses!” To make a very long story short, without putting him back on cardiopulmonary bypass or heart-lung machine and stuff, we started giving him some medicines, and anesthesia started giving him oxygen. And pretty soon he had a blood pressure of 80, and pretty soon a blood pressure of 100, and his heart rate was now up to a 100 a minute.

He recovered and had no neurologic deficit. And for the next 10 days [to] two weeks, all of us went in and were talking to him about what he experienced, if anything. And he talked about the bright light at the end of the tunnel, as I recall, and so on. But the thing that **astounded** me was that he described that operat-
ing room floating around and saying, “I saw you and Dr. Cattaneo standing in the doorway with your arms folded, talking. I saw the – I didn’t know where the anesthesiologist was, but he came running back in. And I saw all of these Post-its [Post-it® notes] sitting on this TV screen. And what those were, were any call I got, the nurse would write down who called and the phone number and stick it on the monitor, and then the next Post-it would stick to that Post-it, and then I’d have a string of Post-its of phone calls I had to make. He described that. I mean, there is no way he could have described that before the operation, because I didn’t have any calls, right?

MILLIGAN: And he’s sitting, he’s lying on the [gestures to indicate surgical table] – so he must have been floating?

RUDY: He was up there. He described the scene, things that there is no way he knew. I mean, he didn’t wake up in the operating room and see all this. [Milligan: No.] I mean he was out [Milligan: Right], and was out for, I don’t know, even a day or two while we recovered him in the intensive care unit. So what does that tell you? Was that his soul up there?

MILLIGAN: It’s hard to know, but certainly brings that possibility into play.

RUDY: It always makes me very emotional.

After Milligan uploaded this video clip onto YouTube, in October, 2011, psychiatrist and NDE researcher Bruce Greyson brought the interview to the attention of researcher Jan Holden; suggested that she, as Editor of this Journal, send Rudy a letter inviting him to submit the case for publication as a case study; and gave her Rudy’s address. She received no reply, and in subsequent correspondence with researcher Chris Carter, she learned that Rudy had died in April, 2012. Simultaneously, the case had aroused our own interest, and co-author Titus Rivas had also tried to reach Rudy by email.

In the meantime, Milligan’s entire interview with Rudy was uploaded onto the AAOSH-website (http://aaoshconnect.org/issue/march-20122013/article/aaosh-video-interviews). For this reason, co-author Rivas approached Milligan to ask him for more details. Milligan sent the following reply:
I met Dr. Rudy during an AAOSH meeting in Chicago in June, 2011, and had dinner with him where he told me about these experiences. I asked him to video them as I felt many people would be interested – I told him very few people would have the perspective he had, being a cardiac surgeon, etc. He reluctantly agreed, and we did the videos the next day. He was a wonderful and gracious man, and a pleasure to be with. Sadly, Dr. Rudy has passed away since we did the videos. (M. Milligan, personal communication, November 8, 2012)

Milligan also suggested two people who might have more information about the case, but when Rivas contacted them, unfortunately they did not.

In January 2013, a correspondent from the UK alerted co-author Smit to an online comment Roberto Amado-Cattaneo, M.D., had made to Milligan’s YouTube clip. Amado-Cattaneo was the physician Rudy had referred to in his interview as his assistant cardiac surgeon, “Dr. Cattaneo.” At the time of his comment, Amado-Cattaneo was connected to CardioWest Cardiothoracic Surgery in Great Falls, Montana. The comment, dated January 23, 2013, was:

Everything that Dr. Lloyd Rudy explained in this video is absolutely true. I was there with him doing this surgery. The patient fully recovered and what he said to us after the surgery is what he experienced.
– Dr. Roberto Amado-Cattaneo, cardiac surgeon, Great Falls, Montana.

On January 28, 2013, co-author Titus Rivas contacted Amado-Cattaneo by email, and Amado-Cattaneo agreed to answer a few questions, also by email. Here are his replies:

This case happened some time late 1990’s early 2000’s.

I do not know the patient’s identity anymore. Neither do I think we can find out, unfortunately. It has been too long and I do not have any records of that case anymore. My role was that of assistant surgeon. I was in the case from beginning to end. I did witness the entire case and everything that my partner Dr. Rudy explained in the video. I do not have a rational scientific explanation to explain this phenomenon. I do know that this happened. This patient had close to 20 minutes or more of no life, no physiologic life, no heart beat, no blood pressure, no respiratory function whatsoever and then he came back to life and told us what you heard on the video. He recovered fully.

I do not think there was something wrong with the monitoring devices. The reason is that there are different types of monitors and they were left on. We could see a flat line, the monitor was on but not recording electrical activity in the heart. When he started coming back, we could see at first a slow beat that eventually evolved into something real closer to normal. The same with the ultrasound scan placed inside the esophagus, we saw no heart activity for the 20 minutes or
so, machine still on, and then it started showing muscle movement, that is, contractility of the heart muscle that eventually turned into close to normal function, able to generate a blood pressure and life. The reason we saw him coming back is that fact, that the monitors were on and so we saw him regaining life, when this happened we restarted full support with drugs, oxygen etc.

This was not a hoax, no way, this was as real as it gets. We were absolutely shocked that he would come back after 20 or more minutes, we had pronounced him dead on the operating room table and told the wife that he had died.

I have seen people recover from profound and prolonged shock, but still having life, in this case there was no life. (R. Amado-Cattaneo, personal communication, January 28 and 30, 2013).

Subsequently, Rivas sent Amado-Cattaneo several additional questions suggested to him by Jan Holden and Bruce Greyson, about the veracity and normal explicability of the patient’s statements and about the location of the monitor with Post-it messages respectively. Amado-Cattaneo replied as follows:

I do not believe he said anything that we questioned as being real, we thought all along his description was quite accurate regarding things he said he saw or heard. Patients’ eyes are always shut during surgery, most of the time they are taped so they do not open since this can cause injury to the corneas. (R. Amado-Cattaneo, personal communication, February 13th 2013).

There are many non sterile equipment in an operating room including monitors. Monitors are close range so surgeons can “monitor different parameters through the case”. The messages to Dr. Rudy I believe were taped to a monitor that sits close to the end of the operating table, up in the air, close enough for anybody to see what it is there, like the patient for example if he was looking at it. (R. Amado-Cattaneo, personal communication, February 15th 2013).

Our UK correspondent also had contacted Amado-Cattaneo who told him the incident took place at the Deaconess Hospital in Spokane, Washington.

Amado-Cattaneo’s testimony is very valuable, as it explicitly confirms Rudy’s account. The evidential value of this case is increased because of the component of the Post-it notes, which involved seemingly out-of-body visual perception of phenomena during documented continuous eyes-closed unconsciousness that was highly unlikely to have been deduced from sensory input such as hearing or from logical deduction. Neither Rudy nor Cattaneo indicated that the patient reported any erroneous content.
This case appears to belong to those most evidential cases of AVP in which perceptions during an NDE were confirmed as completely accurate by objective observers. We believe that the accumulation of such anecdotal evidence is making it increasingly difficult to dismiss this type of case out of hand.

Of course, this case would be complete if the identity of the patient could be established so that medical records could be examined, but unless Amado-Cattaneo recalls his name, such further investigation is not feasible. However, in our view, this imperfection only slightly reduces, but in no way negates, the case as serious evidence for AVP.

References


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