PARANORMAL REPORTS FROM A STUDY OF NEAR-DEATH EXPERIENCE AND A CASE OF AN UNUSUAL NEAR-DEATH VISION

JUSTINE E. OWENS

Much has been written about the near-death experience (NDE) and its possible role in proving immortality. Despite the fact that the vast majority of people who report NDEs also report that the experience is personally convincing of the survival of bodily death, most researchers agree that the typical NDE reports do not constitute convincing evidence for survival. Several possible "paranormal" aspects of the NDE have been noted, however, and these reports require special attention. These cases may provide a unique contribution to the interpretation of the meaning of the NDE.

The purpose of this paper is to review the different kinds of paranormal claims associated with the NDE and to explore the difficulties in investigating these claims. I have grouped cases of NDE in which some paranormal claim is made into four categories, although I do not think that these categories are necessarily *the* four categories of paranormal experience during the NDE. In fact some of the more unique cases do not fit very comfortably within this scheme. However, these groupings do broadly capture the variation I have observed in a large series NDE cases coded for the self-report of paranormal process.

The categories of reports are as follows: (a) knowledge of events occurring out of the range of normal sensory processes, which I will refer to as out-of-body perception (OBP); (b) claimed contact with deceased persons during the NDE; (c) report of telepathic communication or precognition during the NDE and/or an increase of these abilities following the NDE; (d) unusual healing effects associated with the NDE and/or the development of the ability to heal others following the NDE. The first two categories, and sometimes the third, concern the NDE itself, while the fourth category and sometimes the third concern the after-effects of the experience. The first category is explored most fully here, as it is the most frequent of the reports.

The cases I am reporting consist of first person narratives of the experience, questionnaire data concerning the details of the experience,

and information about the life changes reported to follow the NDE. Medical records were obtained for about half of the cases in this sample of 200 cases. The medical conditions of patients reporting NDEs can be reliably rated by independent judges for nearness to death, and the seriousness of medical conditions varies considerably within a group of persons reporting NDEs. The features of the NDE are correlated with the severity of the medical condition, with deeper experiences tending to be reported by persons who were rated to be closer to death (Owens, Stevenson, & Cook, 1990).

Rated nearness to death may be an important factor in evaluating paranormal claims. Sensory processes would be expected to function more normally, in cases where no loss of vital signs occurred and the person is judged to be in a serious medical condition but not near death. In cases where a loss of vital signs occurred, explanations that the person obtained the information through normal sensory processes is less tenable. At this point, however, we simply do not know enough about the state of the brain during near-death conditions. The evaluation of cases such as these clearly depends on a better understanding of mental function during near-death states.

Reports of Out-of-Body Perception (OBP)

The case of Sarah provides a representative example of a report of OBP. Sarah's experience took place in the context of labor and delivery, a medical category comparable in size to cardiac cases, which have received more media attention. (The comparable size of cardiac and labor and delivery cases is based on two samples of self-selected cases.) Sarah's medical records show that she experienced a placental abruption, an abnormal and quick tearing away of the placenta prior to delivery. This resulted in the loss of the baby and hemorrhaging of the mother. Sarah also suffered from untreated toxemia, a dangerous condition in itself, and suffered a cerebral hemorrhage or stroke during her ordeal. Her records reflect a circulatory collapse, requiring cardiac resuscitation, and a lengthy, precarious recovery. Her apparent unconsciousness and lack of responsiveness would lead many to conclude that she was incapable of

cognitive functioning at that time. This is her description of her experience.

"I felt myself swirling away, and next I was at the top of the room. There was a long tunnel, lit brightly with almost blinding white lights. Then I was in the tunnel, narrow at the opening, but wider and wider. I floated in, right to the other end. I hadn't decided to enter, I was just there. I knew complete peace as I was embraced with warmth and love. Beautiful, low voices, chanted, 'Come, Sarah, come. We need you here. We are your guides to heaven, home.' I was ready, and I was going home, where I belonged. Arms beckoned. I saw fingers and wavy white fabric swaying in the breeze of the tunnel. I heard music and I was secure, warm, happy, welcomed and completely at peace. And then...suddenly I was out of the tunnel, at the top of the room. Slowly, I became aware that people in the room were crying. Looking down, I noticed there was a woman on the delivery table who looked a lot like me. Dispassionately, I wondered who it was. I was at the top of the room, just over the operating lights, sort of floating. As I watched the medical team work on that lady a tiny flicker of familiarity surfaced. That lady looked empty. She was dead, I could tell. I knew then, for some reason, that I could make a choice, that there was a choice I needed to make. I chose to go back into the tunnel, hovering back and forth between the two worlds. I still wanted to answer the wonderful, warm, welcoming voices. By then the delivery room was full of people, 20 or 30 of them, all scurrying around. I watched some of them crying, including a man who exactly looked like my father, and slowly I realized they were frantically struggling to save that lady on the table. I remember thinking, 'Forget it. Any one with any intelligence at all can see she's dead.' I saw people's mouths moving, but their words made no sense to me. Yet somehow, I needed to hear and began to struggle to understand their words. Catching one sentence, I heard, 'It's too long. Give it up. There's no chance she'll have anywhere near a normal life.' Someone else asked, 'What about her leg? Is she stitched up?' Up to that point, I was watching with no sense of connection, like looking through a dirty window at a slow motion old movie that had no sound. My mind snapped to alertness like a rubber band striking skin. Something they said felt extremely important to me, but I couldn't grasp yet what it was. 'Her leg ? Whose leg ?' I had to know. Those were the words that abruptly yanked me back, for I thought they were speaking of my child. Pulled me back from my beautiful tunnel, from the warm and bathing light, and

beckoned me to be alert. To pay attention, away from eternal peace and grace.

From where I was, up at the top of the room, I remember trying to form the thoughts, and then the words, 'Is something wrong with the baby's leg? Why won't it have a normal life?', but no words came out. Years later, thinking back, I do not ever remember seeing a baby in the room. They must have taken her away by then. I had to know. Whose leg? Who wouldn't have a normal life? Who? Even today, 26 years later, I remember how desperate I was to find out, how crucial it felt."

The strong claim in OBP cases is that observing consciousness is physically dissociated from the body and is able to process information in much like normal means, but without being limited to normal sensory channels. Of course, if this is possible, it is a relatively minor step to suppose that consciousness persists after physical death. A weaker claim is that the person is in a state of altered consciousness and has access to information that is normally not available, but this does not involve a physical separation of mind and body. Still weaker is the explanation that these experiences are based partly on available sensory information (auditory and kinesthetic) and partly on general knowledge and the constructive processes of the mind. More dismissive interpretations might say that these recollections were constructions after the fact, that is, after a medical crisis has resolved.

The evaluation of these explanations depends in part on what you believe to be the information processing capacities of the brain during near-death crises. The first three, progressively weaker claims, rest on the assumption that the mind can be quite functional during periods of apparent unconsciousness. Some might find that this assumption itself is inexplicable, even with a paranormal element to it. It certainly defies what many believe to be true of mental processes when the body has been rendered unconscious, or should we say unresponsive. However, many physicians and nurses believe that patients can process auditory information while apparently unconscious due to trauma, or while under general anesthesia, and they caution about the importance of discretion when discussing a patient's condition under those circumstances. While the possibility of information processing during apparent unconsciousness is far from universally acknowledged, there

is some evidence in the medical literature that suggest that an apparently unconscious person can process information (Cheek, 1965; Cherkin & Harroun, 1971; Nastir, 1979; Schnaper, 1990). This is still a relatively uncharted domain, but the ever-growing number of documented NDE reports clearly suggests that persons who are non-responsive, even with a loss of vital signs, should not be presumed unconscious.

Assuming that complex mental functioning can occur during periods of apparent unconsciousness—and I think that this quite extraordinary possibility often gets lost in the rush to get consciousness out of the body—we can move on to evaluating the quality of the information that is reported in cases of OBP. The critical questions here are whether or not the information could have been obtained through auditory or kinesthetic means or if the information could be considered common knowledge, that is, highly probable given the context. If enough evidence were found to indicate information reported in cases of OBP could not have been obtained through these normal channels, then this evidence would lend support to one of the two paranormal hypotheses described above: namely, actual OBP or the somewhat weaker claim that the person is in an altered state with access to information not normally available.

Sarah said that she saw a man that looked like her father and, in fact her father was in the room. Sarah's father was chief of staff at the hospital and was called in when her condition became critical. This is a good example of information that might have been known through normal means, *if* you can accept the idea that people may be able to process information when they appear to be unconscious and unresponsive. Once we accept the possibility of complex mental functioning during near-death states, we must consider the capabilities of an active mind. Sarah's father probably spoke within earshot of Sarah and his voice would be highly recognizable. Even if her father did not speak, Sarah could have inferred his presence given her condition and his position at the hospital.

Sarah's vein had collapsed in her right leg, from an attempt at an emergency IV, and this was a concern of the medical team. The information about something being wrong with Sarah's leg would have been discussed by members of the team. Sarah reported that her

concern about the baby is what snapped her mind to attention. She thought that there was something wrong with the baby's leg, and her need to know more about this, is what she said compelled her to return, away from the warm and comforting peace. Despite Sarah's error in thinking it was her baby's leg being discussed, we are still left with the problem of how Sarah came to know of a difficulty regarding a leg. This would be an example of partially correct information reported in an OBP case.

Sarah's case is a typical example of an NDE in which a person reports obtaining information during the height of a medical crisis. The experiences are quite extraordinary in themselves, but the information obtained is what I would call, for the most part, predictable, or not entirely accurate. As information is quantified in terms of how much uncertainty is resolved, or its unpredictability, the quantity of information reported in cases of this type is often minimal. For example, if a person claimed to observe her doctor tell her husband, during a medical crisis, "We are doing all that we can for her", or something to that effect, this is not particularly convincing because it comes right from the "medical emergency" script. We are all familiar to some degree with the "medical emergency script" and I won't spell out all its common features, characters, and actions, but I can assure you that if a group of people was asked to write out the elements of this script, there would be considerable overlap in the accounts. Cognitive psychologists have conducted just these kinds of studies.

Another report from the medical emergency script would be, "I saw the doctors and nurses scurrying around, doing their best to save me." This statement is typical of an OBP report and even though it does not provide compelling evidence that paranormal perception has taken place, it does not provide evidence that it has not. Medical personnel move more quickly than usual in a medical emergency, and we would expect this to be true in the context of NDE cases as well. The fact that there are predictable, recurring patterns in life should not be held as evidence against the possibility of OBP. We should expect a preponderance of these predictable reports, independent of which the alternative explanations might be true.

However, because most people have this common knowledge and it is as predictable as it is, reports of OBP that reflect this knowledge are

unconvincing of paranormal explanations and can be explained more parsimoniously. If we are willing to accept the possibility that some people, under some conditions, are able to maintain mental function during near-death states, then we can reasonably account for most of the OBP reports with this assumption alone. A mixture of information obtained through auditory and kinesthetic channels, combined with common knowledge of the medical scenario could be used to construct a convincing representation that matches what "actually occurred". The words actually occurred are in quotes because research tells us that if we were to obtain accounts of what transpired during these crises, from the medical personnel, the family, and friends, there would be both an impressive amount of overlap in the *gist* of these accounts, but sometimes substantive differences in the ways ambiguous statements were interpreted and remembered, and which aspects of the situation were more or less salient and elaborated (Owens, Bower, & Black, 1979).

As we move along the continuum of "very predictable" to "highly unlikely" in evaluating the information value of knowledge obtained during an OBE, the evidence for paranormality also increases. It is not until we hear a report that deviates markedly from the script that our interest is sparked. If good corroboration of that unusual piece of information is available—and this availability is an additional matter of luck—then the case becomes more compelling. It logically follows, however, that the more convincing the case, the less likely it would be to occur.

Despite the difficulties inherent in teasing apart complex mental processes, and the improbability of finding cases indicating paranormal process, some have taken up the challenge of investigating cases of OBP. My criticisms of the work I will now describe are intended to further and not diminish efforts in this complex area of study.

Michael Sabom (1982) investigated the reports of NDE survivors of cardiac arrest, who had what he termed "autoscopic" experiences. These patients reported observing resuscitation procedures during their own cardiac arrests and Sabom obtained detailed accounts of what they "observed". As a cardiologist, he was particularly capable of evaluating the accuracy of these patients' reports. Sabom was interested in studying the possibility that these patients were making "educated

guesses" or relying on "prior general knowledge" in explaining these accounts. For this reason, he conducted a study in which he asked a comparable group of cardiac patients to imagine a resuscitation procedure and report to him what they "saw". Sabom concludes that the imagination control group was less accurate and less detailed in their reports.

Sabom began his investigations with a definite skepticism about NDEs in general, and was much surprised and changed by his investigations. In evaluating alternative explanations for the accuracy of autoscopic details he says, "My own beliefs in this matter are leaning in the direction [of] the out-of-body hypothesis" (Sabom, 1982, p. 184), the idea that there is an actual physical separation of consciousness and the physical body. Sabom quickly points out that his beliefs are based on the detailed analysis of a small number of cases, that more research is needed, and that other explanations may eventually rule out his "out-of body proposal". He then reaffirms his belief that his observations indicate that NDE "cannot be casually dismissed as some mental fabrication" (p. 184).

Sabom's study focused on the critical issues in evaluating OBP claims and he attempted to systematically rule out alternative explanations for OBP namely: (a) accurate portrayal of the near-death crisis event based solely on prior general knowledge, (b) accurate portrayal of the near-death crisis event based on information supplied by an informed observer, and (c) accurate portrayal of the near-death crisis event based on visual and verbal perceptions made during a semi-conscious state.

Before ruling out these alternative explanations, I think it is important to consider the synthesizing processes of the mind and the concept that we normally integrate information from multiple sources in creating a coherent and seamless perceptual flow. The above alternatives need not be considered as independent explanations, as in "accurate portrayal of the near-death crisis event *based solely on* prior general knowledge". Imaging information obtained through other senses is a routine cognitive process, especially for some people.

Sabom did not take into account that persons reporting NDEs are reported to score higher on measures of Mental Absorption (Council &

Greyson, 1985; Twemlow & Gabbard, 1984-1985). According to Tellegen, the author of the Mental Absorption Scale (Tellegen 1982),

> Mental Absorption is interpreted as a disposition for having episodes of "total" attention that fully engage one's representational (i.e., perceptual, enactive, imaginative and ideational) resources. This kind of attentional functioning is believed to result in a heightened sense of the reality of the attentional object, imperviousness to distracting events and an altered sense of reality in general, including an empathically altered sense of self. (Tellegen & Atkinson, 1974, p. 268)

For a better comparison, Sabom's imaginative controls might have been matched on levels of Mental Absorption. In addition, some visualization enhancement procedure or hypnosis for the imaginative controls would have provided a stronger test. Cardiac patients might not have been particularly eager to imagine resuscitation procedures.

The predominant error made by the imagination control subjects was the mention of mouth-to-mouth resuscitation, an inferior method not used in hospital procedures. Mouth-to-mouth resuscitation is apparently a salient feature of the "resuscitation script" as the predominance of this error indicates. It seems plausible to conjecture, however, that the mouth-to-mouth resuscitation feature would have been eliminated during the use of artificial respiration techniques. The patients who were actually resuscitated would have this additional sensory information with which to modify their imagery of what was taking place.

Further examination of OBP cases further illustrates the possibility of the kind of interplay of prior knowledge and constructive visual processes that I am proposing. However, in considering the role of these mental processes in cases of OBP, I am not suggesting a casual dismissal of them as some "mental fabrication" or "just the imagination". Before examining more cases of OBP, I wish to counter this position at the outset.

The fact is that we do not understand what "taking place in the imagination" means. There is a tendency to act as if saying the NDE is just mental fabrication constitutes an explanation, but our current state of knowledge about mental processes does not really justify this.

Advances in cognitive science and mind-body medicine suggest that these attitudes are clearly in need of revisioning. Taking a dismissive position toward perhaps the most complex natural process that we have identified, and that centuries of thoughtful probing has hardly touched, seems unscientific and possibly defensive. I think that this attitude expresses a cultural bias that is slowly in the process of changing.

The status of mental contents is still an unresolved philosophical question. The visual system is engaged in visual perception as well as the visual imagination and it is simplistic to think that one is real and the other is not. The position that one should simply dismiss mental contents as "unreal" if they are not direct representations of a sensory stimulus is hardly tenable. There is no avoiding the fact that perception is inextricably linked with the information processing history—or memory—of the perceiver.

Regardless which explanation for OBP is favored, these reports represent remarkable mental events. OBP reports very often contain testimonials regarding the reality and vividness of these experiences. Unlike most hallucinations, the conviction in the realness of what they "saw" does not diminish over time.

A representative description of the vividness of the imagery and memory for these experiences is given by Lauren who fell into the propeller of a motor boat:

> "I vividly remember looking down on my body from the ceiling, watching everyone running around getting towels to wrap around my bleeding shoulder, but before that I remember looking down and seeing my shoulder cut open and the flesh inside hanging out. I could describe the room to you, even now, three years later. Everyone stated that I absolutely never opened my eyes. They said that I was totally unconscious the entire time."

The strength and consistency of such testimonials address the issue of "realness" and indicate that these reports should be respected, even if they are "just" mental productions. I have tried to caution against taking a dismissive attitude toward mental processes, but this is a position that will fade slowly. In the meantime, we must still address the sources of the information in these reports if we are to investigate the possible involvement of a paranormal process.

Sabom reports a cardiac resuscitation case who described a "shot in the groin". "It appeared to me that they were putting a shot in there" (p. 107). In fact, the medical team drew blood from the man's femoral artery for a blood gas determination. Sabom suggests that this error further supports actual OBP, as the mistake could easily have been made from visual OBP, at a distance. If the man had received this information from overhearing medical personnel, his statements would probably have been more accurate. Sabom does not mention the possibility of kinesthetically sensing this procedure and possibly hearing some verbal reference to a needle, and then representing this visually. We should consider the possibility as well, that Sarah's knowledge that something wrong was with a leg came partially from her kinesthetic awareness of a medical procedure, although her conviction that it was her baby's leg that was in danger complicates this picture.

Sabom says his most striking example of visual perception, outside the visual field of the patient came from a man who reported seeing three of his relatives, his wife, his eldest daughter, and eldest son, in the hospital corridor at the time of his cardiac arrest. He reported that they were talking to a doctor. According to the family's report, they had arrived unexpectedly and the father could not possibly have seen them because of the distance between them and the fact that his head was pointing in the other direction. The father had no reason to expect to see his family that night as he was scheduled to be discharged the following morning. The visit was intended to be a surprise.

This report is similar to a case in my study where a woman named Janet told her husband that she heard the doctor say, "in five more minutes, she would have been gone." The husband did not take Janet's report seriously until she went on to say that she saw her daughter and son-in-law talking to a policeman outside the emergency room. He found this more convincing, but asked her not to discuss it anymore because people would think she was crazy. Incidentally, this last comment represents another consistent aspect of NDE reports—the fear of what other people would think—which may lead to an under-reporting of convincing cases.

Another suggestive case is that of Thomas who reports that he was out of his body looking down on his own brain surgery.

> "I was out of my body looking down at my head. I did not understand what was happening to me but I remember a metal object reflecting much light. Subsequently I learned I was looking at the titanium clip used to clip my artery."

Thomas reported to me that he discussed this experience with his surgeon who appeared surprised at the accuracy of his description. Thomas's medical record is one of the few I have seen which contains a mention of his experience.

> "Mr. B. describes himself as having been dominating and hard driving prior to his aneurysm. Around the time of his surgery, he had an out-of-body experience which profoundly affected his life goals and conduct. He perceives himself now as more mellow, reflective, religious, and concerned about the welfare of others."

This statement does not mention Mr. B.'s in-depth life review and encounter with Christ which may have contributed to his life changes. In any event, long-lasting life changes are often reported following NDEs and are another important indication that these experiences should not be treated in a dismissive way.

After reviewing hundreds of NDE cases for evidence of paranormal processes, I have concluded that nature rarely provides us with the ideal experiment. That people may be reluctant to report these cases to an investigator only makes the situation more problematic. The scarcity of convincing cases has led some people to propose experiments designed to improve on these circumstances. In order to expose the subject to unlikely information, one could provide visual targets. Or as I have jokingly suggested, one could have information in a room away from the emergency, with signs posted, directing the way: "Out of your body? Please go to room 167." Some have even attempted to carry out experiments exploring the possibility of out-of-body perception, but the practical aspects of conducting such research in a medical setting, make these kinds of studies very difficult.

The final case of reported OBP, the case of Helene, is unusual in a number of ways. I learned of this case very soon after it occurred. Corroborating witnesses were available to be interviewed and

documentation, in the form of police records and medical records, was available. The information that was reported from the NDE was both a highly specific and unlikely occurrence.

Helene, an elderly woman suffering from lung cancer, was in an ICU being treated for an adverse reaction to penicillin. Her priest and her relatives were summoned in the middle of the night. During this vigil, she was in and out of consciousness, and she was able to tell her priest and her two sons of her remarkable near-death experience (NDE).

Helene ascended a marble staircase, with harps playing and flowers of unearthly colors, with a unusually sweet scent. Four black doves flew out and four black horsemen came and shot them down, one at a time. As each black dove fell and was thrown to the side, a white dove came out, each with a band of pearls and glittering diamonds in the tail. Four black doves and four white ones. Helene continued to ascend the steps and saw four rainbows. She saw her sister, who was still living and said goodby. She continued to climb the staircase effortlessly; there was "no pull" resisting her steps. When she reached the fourth rainbow she knew that she must turn back. She then "heard a phone ring"—no phone actually rang in the room—and knew there was a message for her family. She found herself viewing a vehicular accident involving a car and a truck, occurring at an intersection. It was dark and pouring rain. The scene "unravelled like a picture". She could see that there were two young men in the car and one was thrown out of the vehicle and landed in a muddy ditch. She knew that a cousin of her grandchildren, who lived in South Carolina, had been killed. The next day her grandchildren came to see her and she asked them, "Which one of your cousins has been killed?" Her grandson replied, "There's nothing wrong in our family." The grandmother answered with certainty, "Yes, there is, your cousin has been killed." The grandchildren soon learned that their cousin had, in fact, been killed in the night, two states away. The grandmother's medical crisis, as indicated on her medical record, and the fatal accident, according to the police report, coincide in time.

Helene told me that when her priest learned of the accident, he said to her that she must have gone to South Carolina that night. (He is clearly an unusual priest!) Helene seemed somewhat disturbed by his

statement and confided in me that she wondered about him for saying it. Helene has had psychic experiences since she was a child and it was my sense that she believed that this was a strong example of her psychic abilities, perhaps enhanced by her NDE, but that her consciousness had not physically separated from her body.

Physical separation of mind and body is the more extreme of the paranormal explanations, as indicated earlier. The cases that I have studied do not suggest, to me, that this position is supported. Cases such as Helene, however, do support the idea that some paranormal process of obtaining information during an NDE may be involved in some of these cases. I think it is important to study the previous experiences of persons reporting unusual cases, to further understand the role of prior psychic abilities.

Claims of Contact with Deceased Persons

The second category of paranormal claims is the reported encounter with deceased relatives. Many persons come away from the NDE with the conviction they have actually encountered their deceased parents, grandparents, other relatives, or friends. Conversations with these figures most often concern the issue of returning to life and so do not typically contain information with potential for supporting the claim of paranormality. I mention encounters with deceased relatives because there is the possibility of obtaining such information. The deceased relative might convey something highly informative, which only that individual knew, for example, the location of a long-lost valuable object or document. This possibility has been discussed elsewhere with respect to encounters with deceased persons in dreams, apparitions, and NDEs (Myers, 1889-1890; Owens, 1991).

Reports of Psi During or Following the Near-Death Experience

The third category of paranormal claims is the report of telepathic communication or precognition during the NDE and/or an increase of these abilities following the NDE (Ring, 1984). For example, Thomas,

who reported seeing the titanium clip used during his brain surgery also reported a vision of his church congregation:

> "Then I saw several people sitting in a church. And I saw beautiful prayer waves like heat waves rising from a hot asphalt road in the summer coming at me like sound waves from these people. I later learned they had prayed a prayer for me at a Sunday service."

Another person, Monica, reported to me that she saw a vision of her daughter with a black baby (her daughter was white) and her daughter did later have a black child.

Cases which somewhat fit this category are reports that others knew of what was happening to them while it was happening, or felt compelled to go to their assistance at the time of the crisis. For example, a woman reported that she fell off a sailboat and nearly drowned. She was enveloped by a bright light and her husband pulled her to the surface. She was amazed by the presence of her mother when they arrived back at the boat dock. In her words:

> "My mother was driving down the street in my home town, 17 miles away and had what she described as a 'sinking feeling'. She then felt 'drawn' to turn around the drive to the lake. She did not know I was going sailing that day or where I was at all. We had rented the sailboat from one of my girlfriend's co-workers and it was kept at a lake at a private home. My mother did not even know the name of the co-worker or where the family's house was located. She drove directly to the lake and drove without error to the house where the sailboat was kept. She didn't know why, she just followed her instincts. As we docked, I stepped onto the dock and looked up and there was my mother."

Some persons report experiences which fit more than one of the categories. The following is a case in which encounters with deceased relatives are described and an increase in psychic abilities are reported as an after-effect. As a side note, Vernon Neppe, who is a neurologist at the University of Washington and who has studied psychic abilities and temporal lobe symptoms, reported to me that the smelling of sweet floral essences with no flowers in sensory range, is a hallmark of a person with psychic abilities. Although smelling sweet smells is an

infrequent feature of the NDE, I *have* found it to be associated with reports of increased or emergent psi abilities following the NDE. The women who reported the following experience reported smelling an unusual sweet essence during her NDE.

> "Suddenly there was darkness then a tunnel that was brilliant white light, on the 'sides' of this tunnel were sparks of blue light, all I remember thinking was 'how beautiful this is'. Before I knew it I saw white light and figures of people, my mother greeted me (she had died a few years earlier) it was then I thought 'I must be dead' but I was happy—very happy to see her, she had her grey hair in braids over her head as she'd always worn it. With her were 'the Grandmothers' two other elderly wise women, one with something in her hand, I don't remember what, one wise one was Native American. All were smiling at me and I felt such a peace, such love, such complete contentment. I could see, hear, feel yet I don't remember that I had a body—don't feel I did but I was there. I could smell a slight scent of flowers. We talked by telepathy. Mom said, 'We are so very happy to see you, we need to decide whether you stay here or return to your body.' I said, 'I've been in so much pain, physically and emotionally I really don't want to return.' My mother and the Grandmothers said, 'You are here to know you *are* loved and watched over, we know you are going through difficult times now but your future will be better we strongly advise you to return to your body. You have things to do yet in your life.' The NDE has greatly changed my life. I no longer fear death. My intuition and ESP has increased."

Reports of Unusual Healing or Healing Abilities after the NDE

Marilyn is a rather unique case, with elements of categories two, three, and four but that really goes beyond all of these. During her medical emergency, a woman reported that her priest was contacted, but no family member was available. Afterwards her priest mentioned to her that he was glad that at least her father had been able to be come for a short while. I will continue the description in her own words:

> "I asked him what my father looked like and he described him as older, with thick white, wavy hair. He was dressed in dark green shirt and pants

(which my father always wore working in the garden) and said he walked hunched over (my father had emphysema). I said it couldn't have been my father. He became irritated with me and told me the man said, 'Well, I am Mary Ann's father but can't stay, I have to leave.' I then told the priest my father had died two years previously. To that, he just said, 'Oh.' I had no doubt that my father was there, since I loved him extremely and we had a very good, loving family and just know that wouldn't be out of line."

Marilyn also reported an increased ability to heal herself of various ailments. She thinks she also has the ability to heal others, but said she lacks the confidence to try. She would not know how to handle a person lacking in faith, which she believes is essential for spiritual healing. She provided a list of the ways her health has improved.

"I have self-healed many things on myself such as: 1. I damaged my knees in an accident and was told I would never ride a bike again. I now ride all the time. 2. I had chronic painful elbow from same accident. I am never bothered by it anymore. 3. I had an ugly wart on my nose which bled often. It is gone. 4. I had a chronic stiff neck and sometimes couldn't turn my head from side to side. My neck is now fine. 5. I had a bone spur in foot and had three removed previously. I refused to go through that again so I got rid of it. 6. I had clogged salivary glands under tongue which caused swelling and pain in glands under ear, now gone forever. 7. My headaches are gone when they just get started. 8. My hair loss - a lot! - stopped. 9. Many years ago, I had viral pneumonia and have a tendency of recurrence. I regularly clear my lungs and chest area while meditating."

Jonathan also represents a claim of unusual healing associated with the NDE. Jonathan was diagnosed with pancreatic and liver cancer prior to his NDE. Recovering from surgery, he had an out-of-body experience which he believes has changed him irrevocably. Part of this change is that he is now nearly four years in complete remission from his cancer.

Conclusion

Much further research needs to be done before any firm conclusions in this area can be drawn. A major difficulty in pursuing this line of investigation is that NDE cases strongly suggestive of paranormal process are quite rare. It would seem that the same factors which make a case convincing with respect to the paranormal would also work to make these cases unusual. Obtaining highly improbable information during an NDE both contributes to the strength of the evidence and makes it unlikely to occur.

Due to the natural scarcity of cases that are strongly convincing of a paranormal element, progress in this area may require either studying very large numbers of cases or providing appropriate targets in medical environments where NDEs are likely to occur. Alternatively, a multi-factorial approach may be a more feasible line of investigation. Studying the relationship of paranormal reports to the medical and psychological factors known to be significant in NDEs may provide greater insight into the nature of these reports. This approach has the important advantage of integrating these studies within the larger body of medical and psychological research.

Working to change the cultural climate surrounding these kinds of reports may also further this research. People might feel more willing to report unusual NDEs in a society which values these kinds of experiences. The funding needed to carry out such studies is more likely to become available if an attitude of openness toward such cases was to prevail.

REFERENCES

Cheek, D.B. (1965). Can surgical patients react to what they hear under anesthesia? *Journal of the American Association of Nurse Anesthetists, 33,* 30-38.

Cherkin, A., & Harroun, P. (1971). Anesthesia and memory processes. *Anesthesiology, 34,* 469-474.

Council, J.R., & Greyson, B. (1985, August). Near-death experiences and the "fantasy-prone" personality. Paper presented at the meeting of the American Psychological Association, Los Angeles, CA.

Owens, J.E. (1991, June). The ontological status of characters appearing in dreams and near-death experiences. Paper presented at the meeting of the Association for the Study of Dreams, Charlottesville, VA.

Owens, J.E., Bower, G.H., & Black, J. (1979). The "soap opera" effect in story recall. *Memory & Cognition, 7*, 185-91.

Owens, J.E., Cook, E.W., & Stevenson, I. (1990). Features of "near-death experience" in relation to whether or not patients were near death. *Lancet, 336*, 1175-77.

Myers, F.W.H. (1889-1890). On recognized apparitions occurring more than a year after death. *Proceedings of the Society for Psychical Research, 6*, 13-65.

Nastir, A.M. (1979). Editorial: On being aware. *British Journal of Anaesthesia, 51*, 711-712.

Ring, K. (1984). *Heading toward omega: In search of the near-death experience*. New York: William Morrow & Company.

Sabom, M.B. (1982). *Recollections of death: A medical investigation*. New York: Harper & Row.

Schnaper, N. (1990, August). Research Panel at the International Association of Near-Death Studies (IANDS) Meeting, Washington, D.C.

Tellegen, A. (1982). *The multi-dimensional personality questionnaire*. Minneapolis: University of Minnesota Press.

Tellegen, A., & Atkinson, G. (1974). Openness to absorbing and self-altering experiences ("absorption"), a trait related to hypnotic susceptibility. *Journal of Abnormal Psychology, 53*, 268-277.

Twemlow, S.W., & Gabbard, G.O. (1984-1985). The influence of demographic/psychological factors and preexisting conditions on the near-death experience. *Omega, 15*(3), 223-235.

DISCUSSION

TAYLOR: I would like to see this phenomenon put in more of a context with regard to what else is going on in other disciplines that might somehow have some relation to this.

OWENS: I didn't have time to go into that because I ran out of time.

TAYLOR: I have what may be a more appropriate question for the General Discussion but I am associating something you said that I thought was very interesting. I would like to see the phenomena you have described considered in the context of what we know about physiology across the life span of the individual. In other words, I cannot conceive that we could penetrate much further into any significant understanding of this unless we understood the relation of the death experience to, for example, sexual reproduction. I mean, if you really look at the global picture of human functioning in a scientific way, you see that we are staying right there at the end of death collecting these experiences. And yet, what do they mean with regard to the overall experience of the organism itself? It seems to me it is quite significant with regard to the whole problem of consciousness, to look at the biological grounding of this phenomenon. At the same time the other portion of what you are suggesting to me hints at the obvious ethnographic comparisons of people in different cultures at the moment of death. I'm particularly struck by the fact that civilized Western culture is unique, in that almost every other culture in the world condones communication with the dead. For us to say, "Oh, you know, we found one subject out of 400,000 who saw a dead relative," seems hardly significant. If you go into China, Bali, or any culture that practices ancestor worship, communication with the dead is commonplace. Just because we do not have scientific evidence or we only have one or two cases, we presume that our little discoveries are suggestive of something. It appears to me that your case at the end is quite suggestive. Most people in the world communicate with the dead and our Western view is really the exception rather than the rule. Isn't that also partly based on the problems of scientific epistemology? We have created a worldview which has eliminated that whole iconographic pantheon from our comprehension of human experience.

OWENS: You said, "The case at the end." I'm not sure which one you are talking about.

TAYLOR: The very last comment you made was about the cultural embedding of our understanding of this phenomenon. It seems to me that it is important to consider that, but it is quite a large agenda from the standpoint of our ancestral birth lines, for instance. I am half-Irish and half-Anglo-Saxon. Obviously, if I go back far enough beyond the

scientific influence on the culture that created my parents and their parents, I will discover basic mythic rituals and understandings that were a part of my genetic blood line when this iconography did exist. It has been winnowed out of our collective psyche as far as the Western analytic tradition is concerned. And here we are, trying to bring it back in.

OWENS: One of my favorite topics is the role of cultural contexts in interpretating the meaning of NDEs and cross-cultural studies. I talked more about the paranormal because of this conference. But I agree with you that the larger contexts of NDEs are probably quite important in understanding them.

TAYLOR: I was not saying you should include this in your paper. I was saying that in the general understanding of this phenomenon, we are trying to advocate knowledge of it between the disciplines. It seems to me that there is a lot more information that could be brought to bear on the discussion.

OWENS: When you talk about the developmental aspect, I have been writing some proposals in those terms partly because I've been advised by several federal officials that the Institute on Aging would be the best place to get funding for this. Apparently, in this culture if you're old it's okay to be spiritual.

TAYLOR: I'm thinking of other cases, as well. Phantom limb phenomena, for instance, is a part of the physiological literature, but it is really anomalous.

OWENS: The other thing I hesitate to mention, but I'll just throw it out, is some casual anecdotal conversations that some people report marital difficulties after these experiences. When you talk about sex, they report a very different sense of being in the world. I don't have any statistics on the divorce rate; the divorce rate is so high anyway. But it's something to think about. Certainly, I have anecdotal cases of people saying, "It's just not the same."

LAWRENCE: I was just going to support what you said, although I don't have anything about their sexual practices afterwards. But I know that the transformations that have happened to these people and how they relate or don't relate to the family members creates a very large gap in the relationships. The same person I talked about yesterday who wanted to give away his coat to the fellow on the street, talked to

me about his wife referring to the support groups for people who have had near-death experiences as the "spook groups". She really has no idea of what he's been through, how he feels, and why he's doing the things that he's doing. I think this is not an unusual occurrence. Family discord after this is very common even though their intent is to be more loving and more spiritual. The spouses say, "It's not the same person I married" which is true. It does create, I think, a lot of problems.

OWENS: Yes. I have seen very much of that. One case I didn't report was a wife who told her husband about what she had observed in this medical emergency situation, something that had come right from the script. Then she said she saw her daughter and her son-in-law talking to a policeman outside. That had actually occurred. It really shook up the husband and he said, "Well, don't you tell anybody that because they'll think you're crazy." I hear those reports so often. They're afraid to tell. They've been told not to tell. There's one case even more extreme than that at the University of Virginia. I didn't investigate this case; Emily Cook went out to interview the wife because she had reported a near-death experience. The husband wasn't scheduled to be there but he happened to be home at the time. It turned out that he had had one as well, but they were both afraid to tell each other. It's the fear of what people would think. It's so strong. I can't tell you how strong it is. It's something that's just not talked about much. These people live in fear. It's like being in the closet for years with these experiences. They're so strong, and they're so powerful. They're so afraid to talk about them, which I've said is another proof of their psychological health or at least getting a grasp on what's going on. They are very much aware of what the culture thinks. They're definitely in touch with "reality".

TAYLOR: What you're implying is that there would be cases where people might give these descriptions and then be psychiatrically medicated for them.

OWENS: Oh, yes. There are definitely stories about people being medicated.

TAYLOR: Once they make a description of their true experience, the physician makes a decision that, "Well, this person has got paranoid hallucinations. And we have drugs for that, too."

OWENS: It has happened. That is what's not funny about it. It really has happened to these people.

LAWRENCE: I have one woman that I talked to who had a near-death experience when she was having her baby. When she came home, she had as Justine has said, other kinds of psychic phenomena. She had an out-of-body experience where she was standing at the door watching herself feed the baby. It really scared her. She didn't know what was going on. To have that experience, besides having the near-death experience, she was just petrified. So, she went to see a psychiatrist. He said, "You know, don't worry about it, honey, take this Valium, and you'll be all set." A very typical approach is, "This will go away. It's just your mind. Just take the sedative or the tranquilizer, and you'll be fine." That is a lot of what they get from the medical profession and other family members. People don't want to be labeled as "crazy" and this has always been in the realm of "crazy" behavior.

OWENS: It's very consistent advice that people get. "Just put it out of your mind. Forget about it. It will go away." I've gotten this report so many times. But these experiences are very vivid, and they have an unusual persistence in memory, which I think is another feature of the experience. The advice just doesn't work. They don't go away. That is a hallmark of the experience—they don't go away. So, it's a real problem to be faced with this strong advice, and it just doesn't work. Medical professionals saying, "Don't think about it. It'll go away." It doesn't go away.

GROSSO: In listening to this, I'm surprised in the sense that popular culture, which has featured the near-death experience in dozens of movies and talk shows and popular books, hasn't had any impact. I would think that by now it would become almost passé to have a near-death experience and that more and more people would be prepared to accept these experiences as real. I'm surprised at the level of resistance that persists.

TAYLOR: The popular folk culture has an influence at the level of the clinic. It will not have much influence at the level of scientific epistemology where problems are formulated and grant money is dispensed for major research.

GROSSO: I understand that but what I'm hearing is that even in the popular culture—the family, the priest, the husband, the wife, and so forth—that there is a general pervasive resistance. I'm just a bit astonished at that.

OWENS: Well, I've spent a good deal of my life going back and forth between worlds where these things are taken for granted and worlds where they absolutely are not acknowledged. These are big worlds and they exist; both of them.

LAWRENCE: Michael, to respond to you, I think it is now. If you were to interview people now to describe a near-death experience it wouldn't be as threatening psychologically. People would be more open to that. I don't think it's the case with other kinds of phenomena like near-death visits, having people in their room who had died, or the Grim Reaper. Those people say, "Hey, I don't know whether I'm losing it or not. What is this that I'm seeing here?" I think that in some ways there is probably more acceptance of the near-death experience currently. But in some of these cases, you have people who are talking to you about experiences that they had a number of years ago because at that point in time they didn't want to talk about it. Now they are coming to the forefront because it is more acceptable. It is still kind of touchy, I think, for a lot of people.