

The Near-Death Experience as a Focus of Clinical Attention

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Near-death experiences (NDEs) often produce profound changes in attitudes and behavior that can lead to psychosocial and psychospiritual problems. The diagnostic label of religious or spiritual problem, included in DSM-IV under the category of other conditions that may be a focus of clinical attention, was originally proposed to encompass NDEs and their aftereffects. Four cases are discussed in which patients presented with NDE-related problems, and differential diagnosis and current treatment strategies are reviewed. The inclusion of this new diagnostic category in the DSM-IV permits differentiation of NDEs and similar experiences from mental disorders and may lead to research into more effective treatment strategies.

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When some people come close to death, they go through a profound experience in which they believe they leave their bodies and enter some other realm or dimension, transcending the boundaries of the ego and the ordinary confines of time and space. Moody (1975), who named this phenomenon the "near-death experience" (NDE), described it as an ineffable experience that may include feelings of peace, unusual noises, being out of the physical body, movement through a dark tunnel, meeting other spiritual beings, a life review, a border or point of no return, a return to the physical body, and profound changes in attitudes and values. Greyson (1985) later identified discrete types of NDEs dominated by either cognitive elements such as accelerated thought processes and a "life review," affective elements such as peacefulness and joy, or transcendental elements such as apparent encounters with mystical entities or deceased persons. These NDEs, once regarded as meaningless hallucinations, have become the subject of serious study by medical and other researchers in recent years. Once thought to be rare, the NDE has been estimated to be reported by at least a third of people who come close to death (Ring, 1984; Sabom, 1982), or about 5% of the American population (Gallup and Proctor, 1982).

Researchers have yet to find personal traits or variables that can predict who will have an NDE or what kind of NDE a person may have. Retrospective studies of near-death experiencers (NDErs) have shown them to be psychologically healthy individuals, who do not differ from control groups in age,

gender, race, religion, religiosity, or mental health (Gabbard and Twemlow, 1984; Greyson, 1991; Irwin, 1985; Locke and Shontz, 1983). Several psychodynamic models have been posited to explain near-death phenomena (Greyson, 1983b) as well as neurobiological models that invoke the role of endorphins or various neurotransmitters and neuroanatomical models that link NDEs to specific sites in the brain (Jansen, 1990; Morse, et al., 1989; Saavedra-Aguilar and Gómez-Jeria, 1989). Although correlating NDEs with physical structures or chemicals in the brain would not necessarily tell us what causes NDEs, it would potentially open up new tools and techniques for investigating the mechanisms and aftereffects of these experiences.

Regardless of their cause, these transcendent NDEs can permanently and dramatically alter the individual experiencer's attitudes, beliefs, and values. The growing literature on the aftereffects of NDEs has focused on the beneficial personal transformations that often follow. Aftereffects typically reported include increases in spirituality, concern for others, and appreciation of life, and decreases in fear of death, materialism, and competitiveness (Bauer, 1985; Flynn, 1986; Noyes, 1980; Sabom, 1982). These profound changes in attitudes and in behavior have been corroborated in long-term studies of NDErs, in interviews with their significant others, and in research comparing NDErs with survivors of close brushes with death who do not recall NDEs (Greyson, 1983a; Ring, 1984).

Problems Precipitated by NDEs

Despite the prevalence of NDEs and considerable research into their positive aftereffects, little has been written about the psychosocial and psychospiritual problems that often follow NDEs. Although

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NDErs sometimes feel distress if the NDE conflicts with their previously held beliefs and attitudes, the emphasis in the popular media on the positive benefits of NDEs inhibits those who are having problems from seeking help. Sometimes people who have had a totally unexpected NDE may doubt their sanity, yet they are often afraid of rejection or ridicule if they discuss this fear with friends or professionals. Too often, NDErs do receive negative reactions from professionals when they describe their experiences, which discourages them even further from seeking help in understanding the experience. Most NDErs gradually adjust on their own, without any help, to their experience and its effects. However, that adjustment often requires them to adopt new values, attitudes, and interests. Family and friends may then find it difficult to understand the NDEr's new beliefs and behavior. On the one hand, family and friends may avoid the NDEr, who they feel has come under some unwelcomed influence. On the other hand, family and friends influenced by the popular publicity about the positive effects of NDEs may place the experiencer on a pedestal and expect unrealistic changes. Sometimes, friends expect superhuman patience and forgiveness from the NDEr or miraculous healing and prophetic powers; they may then become bitter and reject the NDEr who does not live up to these unrealistic expectations.

Emotional problems after NDEs include anger and depression at having been returned, perhaps against one's will, to this physical dimension. NDErs often have problems reconciling the experience with their traditional religious beliefs or their previous values and lifestyles. Because the experience seems so central to their sense of self and seems to set them apart from other people around them, NDErs may come to define themselves exclusively as experiencers. Because many of their new attitudes and beliefs are so different from those around them, NDErs can overcome the worry that they are somehow abnormal only by redefining for themselves what is normal. NDErs may feel a sense of distance or separation from people who have not had similar experiences and may fear being ridiculed or rejected by others—sometimes, of course, with good reason. Difficulty reconciling the new attitudes and beliefs with the expectations of family and friends can interfere with maintaining old roles and lifestyle, which no longer have the same meaning. NDErs may find it impossible to communicate to others the meaning and impact of the NDE on their lives. Frequently, having experienced a sense of unconditional love in the NDE, the experiencer cannot accept the conditions and limitations of human relationships.

Above and beyond these problems, which all NDErs may face to one degree or another, people who have had frightening NDEs have additional concerns about why they had that kind of experience and may be troubled by terrifying flashbacks of the experience itself. Similarly, additional problems may follow NDEs that arise out of a suicide attempt or in young children. The way a psychotherapist responds to an NDEr can influence whether the NDE is accepted and becomes a stimulus for further growth or whether it is regarded as a bizarre experience that must not be shared, for fear of being labeled mentally ill.

Flynn noted that the value incongruities between NDErs and their families lead to a relatively high divorce rate among NDErs: "Whereas sociological studies show that many divorces occur because of arguments over not having *enough* money, NDErs' marital breakdowns seem to take place because NDErs no longer share materialistic values with their spouses" (1986, p. 24). Insinger (1991) found that "social death," when the familiar personality of an NDEr dies, can be as disruptive to a family as the physical death of that person. Bush concluded that the price of an NDE "may include long-term depression, broken relationships, disrupted career, feelings of severe alienation, an inability to function in the world, long years of struggling with the keen sense of altered reality" (1991, p. 7). She quoted a divorce rate as high as 75% and noted that although the most disabling aftereffects seem to affect a minority of experiencers, for them the impact is severe and effective interventions hard to find. Wilber, recognizing the difficulties in coping with a transformative experience for which one is unprepared, wrote: "At best, these crises are annoying; at worst, they can be devastating" (1984a, p. 108).

Diagnosing NDE-Related Problems

Wilber (1984b) cautioned against considering all nonordinary states as pathological. He used the term "psychic pathology" to include what he called "split life-goals," the difficulty returning to the state of mind before a spiritual crisis, and also what the 16th-century Spanish mystic St. John of the Cross called the "dark night of the soul," a sense of profound abandonment that results from the inevitable fading of an experience of ecstasy, which can be mistaken for a depressive disorder (Wilber, 1984a). Grof and Grof (1990) argued that the milder forms of spiritual crises should not be diagnosed or treated as mental disorders but rather as developmental crises that can result in long-term improvement in overall well-being and functioning.

The DSM-IV warned against misinterpreting as mental disorders "certain religious practices or beliefs (*e.g.*, hearing or seeing a deceased relative during bereavement)" American Psychiatric Association, 1994, p. xxiv). The DSM-IV distinguished from mental disorders a category of problems labeled "other conditions that may be a focus of clinical attention." These "other conditions" may occur in individuals who have no mental disorder, in individuals who have a mental disorder to which the other condition is unrelated, or in relation to a mental disorder but sufficiently severe to warrant attention independent of the mental disorder. Lukoff et al. (1992) suggested that this category should include a diagnosis of "religious or spiritual problem" to offset the tendency of mental health professionals to ignore or pathologize religious and spiritual issues, creating iatrogenic harm.

Turner et al. (1995) compared the triggering of religious or spiritual problems by an extremely stressful event, such as an NDE, with uncomplicated bereavement. Just as the diagnosis of a major depressive episode would not be given when depressive symptoms result from a normal reaction to a death, so the characteristic sequelae of an NDE should not be viewed as evidence of a mental disorder but rather as normal reactions to a life-threatening stressor. The DSM-IV Task Force, after much deliberation, did finally include among these problems that are not considered to be mental disorders the diagnosis of religious or spiritual problem. The acceptance by the DSM-IV Task Force of this new category acknowledged that psychological problems of a religious and spiritual nature are not necessarily attributable to a mental disorder nor reducible to a biological explanation and treatment (Turner, et al., 1995).

Whereas Lukoff et al. (1992) had included in their definition of religious or spiritual problem two specific examples—mystical experiences and NDEs—the DSM IV replaced these examples by the less specific phrase "questioning of other spiritual values which may not necessarily be related to an organized church or religious institution" (American Psychiatric Association, 1994, p. 685). Turner et al. (1995) noted that this questioning may involve questioning one's whole way of life, purpose for living, and source for meaning. They argued that scientific research over the past decade has established the NDE as an identifiable psychological phenomenon not attributable to a mental disorder but often precipitating significant intrapsychic and interpersonal difficulties, such as anger, depression, and isolation.

The differential diagnosis of NDE-related problems includes posttraumatic stress disorder (PTSD),

as both conditions involve distress after exposure to a threat of death or serious injury. NDErs, like victims of PTSD, may report recurrent, intrusive recollections of the event and at times a feeling as if reliving the experience. NDErs who have difficulty coping with their experience and its aftereffects may also report the PTSD symptoms of recurrent distressing dreams of the event and psychological distress and physiological reactivity to exposure to cues that symbolize the event. In addition to these common intrusive symptoms, some NDErs also report symptoms of avoidance, such as diminished interest in activities, estrangement from others, restricted range of affect, and a sense of foreshortened future. Rarely they may report efforts to avoid reminders of the experience or difficulty recalling part of the experience.

The NDE itself has been compared with dissociation or, more specifically, depersonalization, both of which are common responses to stress (Greyson, 1996b; Spiegel and Cardeña, 1991). However, dissociative disorder is characterized by persistent, recurrent, or chronic dissociation, whereas NDErs generally show no more dissociative tendencies than control populations (Irwin, 1993). Gabbard and Twemlow (1984) noted that depersonalization differs from the NDE in a number of ways, including age and gender distribution, unpleasant and dream-like quality, and separation of observing self from functioning self.

NDEs have also been confused with autoscopy, which has been documented in association with a variety of brain lesions. However, NDEs differ from autoscopic phenomena in that the observing self or point of perception is experienced as outside the physical body, from which perspective the subject sees his or her own inactive physical body rather than an active apparitional "double" (Gabbard and Twemlow, 1984).

Bates and Stanley (1985) noted superficial similarities between NDEs and psychoactive substance-induced hallucinations but reported that visions in NDEs are more complex than those induced by drugs—and more often endowed with personal meaning. Lukoff (1985) differentiated spiritual experiences such as NDEs from brief psychotic disorders by their acute onset after a stressful precipitant and by the experiencers' good premorbid functioning and positive exploratory attitude toward the experience. The DSM-IV cautioned against confusing symptoms of brief psychotic disorder with religious experiences that are not perceived as being pathological.

Although schizotypal personality disorder can include cognitive and perceptual distortions, it is a

pervasive pattern of interpersonal deficits that is not seen in NDErs (Gabbard and Twemlow, 1984; Irwin, 1985; Locke and Shontz, 1983). Again, the DSM-IV warned that religious beliefs can appear schizotypal to uninformed observers.

A diagnosis of adjustment disorder is not appropriate for cases of NDE-related problems in that it requires emotional or behavioral symptoms in excess of normal reactions to a stressor. The anger, depression, and interpersonal difficulties after an NDE occur so frequently that they must be considered normal and expected responses to a tumultuous situation and should not be regarded as adjustment disorders any more than would normal bereavement (Lukoff et al., 1992). The occurrence of NDEs at virtually any point in the life cycle from childhood to old age argues against its diagnosis as a phase of life problem.

The DSM-IV option to diagnose religious or spiritual problems even when they appear related to a mental disorder, provided they are sufficiently severe to warrant independent clinical attention, underlines the importance of diagnostic clarity. Further research is needed to refine diagnostic guidelines, but the lack of definitive differential diagnostic criteria at the present time should not preclude recognizing NDEs as conditions distinct from mental disorders. An intended function of the diagnostic category of religious or spiritual problem was to anchor the nonpathological end of a differential diagnostic spectrum, a goal that would be obviated by subsuming these conditions under the diagnosis of a mental disorder.

Cases

There are few cases in the clinical literature of NDE-related problems. Clark (1984) related a case of a 43-year-old man who, after a blissful NDE precipitated by a cardiac arrest, became enraged at his wife's well-meaning intent to change his diet and activities and take a cardiopulmonary resuscitation course. Declaring that he preferred death, he forbade her to resuscitate him. Clark treated this case with brief couples counseling and, given the wife's intellectualized need to control the process, assigned the wife library research on NDEs to be discussed with her husband. Below are four clinical vignettes from my own practice that illustrate requests for psychiatric intervention for problems secondary to NDEs.

Case 1

Ms. L. was a 26-year-old single woman who sought treatment because of increasing difficulty

reconciling her profession as a television producer with her values, which she felt were derived from her NDE. At the age of 6, she had nearly drowned while playing in the ocean. At that time she had an out-of-body experience; went through a tunnel; felt overwhelming peace; encountered nonphysical beings; felt totally connected to them yet still maintained her individuality; felt she had access to all knowledge, including visions of the future; and was sent back to life against her will.

She stated that that NDE had caused her difficulties for the past 20 years. Her parents had always accepted her NDE and had encouraged her in her spiritual seeking, but she described her childhood as having been "too intense" as a result of the NDE. She described herself as arrogant toward teachers, feeling that she had already transcended everything school could teach her. She felt that she had received the message in her NDE to love herself and life, but she remained angry at God for preventing her from having a normal life that could allow her to do so. She experienced an intense level of perfection in that NDE that she felt she could never recapture once she returned to this life. Her greatest persisting frustration had been that the love she experienced in her NDE could not be replicated in relationships in this world. She therefore felt perpetually unfulfilled and felt she could never bond with anyone else, because she was already attached to the entities she encountered in her NDE. She felt that her success in the mundane world was fraudulent, as it was based on manipulation of others, which she felt was antithetical to her NDE-derived values.

She denied vegetative signs of depression, such as disturbances in sleep, appetite, energy, or concentration; had no diurnal mood variation; and had no suicidal or homicidal ideation. She denied any hallucinations, although she acknowledged unshared sensory experiences of a spiritual nature.

She denied any of the symptoms of PTSD as well as abuse of alcohol or recreational drugs. Ms. L. appeared to be suffering from a religious or spiritual problem related to difficulty reconciling her beliefs and values with the kind of lifestyle and career she has been following. She felt oppressed by an apparent spiritual mandate that she had not been able to follow. She was treated with a combination of brief crisis-oriented psychotherapy directed toward helping her clarify the issues and gain perspective on realistic solutions, and she was referred to a support group of individuals experiencing similar crises. She took a leave of absence from her work while she pondered quitting her profession but eventually discovered a way of using her professional skills and

position that might further the altruistic values she acquired in her NDE.

Case 2

Mr. S. was a 24-year-old graduate student in geology who had had an NDE during a near-drowning incident when he was 17. In the intervening 7 years, he had experienced what appeared to be paranormal phenomena. For example, on a visit to the site of a former Nazi concentration camp in Germany, he had heard the screaming and crying of tormented souls and was quite terrified.

His NDE included a life review that included many events from his childhood, along with several scenes that he could not recognize, including a funeral at which he saw many relatives and a few people he did not know. Since that time, some of those scenes had come to pass exactly as they had appeared in his life "review." At his mother's funeral when he was 20, he suddenly realized he was in the scene from his life review, with people standing just as they had in that vision. The life review included some very painful scenes that had not yet come to pass, and he was now living in what he felt was the certainty that they were destined to happen to him someday. He sought counseling for his anxiety about these seemingly inevitable events and his despair at loss of control over his fate, but his counselor did not want to discuss his NDE. He and his counselor then sought consultation from me, and a therapeutic plan was developed to help Mr. S. overcome his sense of helplessness and victimization by exploring ways in which his NDE seemed to be tailored to meet his particular psychological needs and the active role he may therefore have played in generating the structure and content of his NDE.

Case 3

At age 14, Mr. V. was electrocuted by a spark apparently jumping from an overhead power line to the tree he was climbing. While his father and brother administered cardiopulmonary resuscitation to his unconscious body, he had an NDE with both heavenly and hellish visions and felt communication from both a deceased grandfather and Christ, in addition to a demonic figure. Before that accident, he had been a good student, quarterback on the junior varsity football team, and guitarist in a rock band. After his experience, he began questioning the value of these activities, felt he had been saved from death by Christ, and sent back with a mission, although he did not know what that might be. He began to evaluate previously enjoyable activities in light of their contribution to his mission and judged them

trivial and distracting from his real work. His grades fell as he found studying meaningless; he decreased participation in sports and music and ceased socializing with peers. He felt confusion over the meaning of life in general, his life in particular, and the implications of his having been saved. He was unable to reconcile his new sense of importance and seriousness of purpose with his daily life as an adolescent. He was unable to talk with others about these feelings and felt estranged from peers, with whom he ceased to share any interests.

After 2 years, he was experiencing unpleasant flashbacks of the accident, both in dreams and while awake; at those times, he would become oblivious to his surroundings. He also began sleeping more with decreased restfulness and experienced anxiety, anhedonia, weight loss, decreased concentration, fatigue, and despair with suicidal ruminations. He had frequent crying spells and on rare occasions had violent outbursts, fighting with peers with little provocation, something he had never done before. After 3 years he began abusing alcohol and then cocaine to avoid the flashbacks and the painful sense of meaninglessness in his life. He was then referred for counseling by his parents for his depression, suicidal ideation, and substance abuse.

Mr. V.'s religious or spiritual problem secondary to the NDE, exemplified by his confusion and turmoil over meaning and purpose, interfered with his normal adolescent struggle to formulate life goals and values. At a time when identity with a peer group wrestling with these common issues is critically important to adult personality development, Mr. V. felt uniquely estranged from his peers and from the usual adolescent activities and developmental tasks. In addition, Mr. V.'s distress met criteria for both major depressive disorder and PTSD. He was treated with individual psychotherapy focused on clarifying his life goals and sense of meaning and purpose; with referral, along with his parents, to a support group for NDErs; and with desipramine. His neurovegetative signs of depression resolved over the course of several weeks. The flashbacks and his subsequent substance abuse abated and ceased after a few months; however, his existential despair continued throughout high school. After graduation, he enrolled in an emergency medical technician course and eventually found satisfaction in the hands-on healing he was able to do with the rescue squad and in lecturing to high school groups on suicide prevention. Although he attended the support group only sporadically, his parents went regularly for about a year and felt it helped them understand what their son was going through.

Case 4

Mr. G. was a 30-year-old policeman when he had a NDE precipitated by postoperative hemorrhaging. He had been sent home after an uneventful herniorrhaphy but then started bleeding. His wife, a registered nurse, rushed him back to the hospital, where he lapsed into apparent unconsciousness and had his NDE. He felt an urgent need to explain to his wife and to others the sense of unconditional love he had felt during his experience and to find some way to share that love with others. His attempts to describe these feelings were frustrating, as he felt unable to verbalize it even to himself, let alone to others. He was able to express some of the affect in poetry and painting but felt misunderstood and frustrated in his attempts to communicate to others.

For years he considered the experience too personal to share and could not find a way to speak of it. Thinking about his experience would provoke intense affect, and he would not speak without crying. He felt alienated to have experienced something that meant so much to him and had changed his life but that he could not share with anyone else. His family, in their attempt to accept his experience, expected him to show supranormal tolerance and patience, and they became angry and disappointed whenever he became angry or lost his temper. They often reprimanded him when he acted in ways they saw as selfish, insisting that because of his experience he "should know better." He also became intolerant of violence and hypocrisy, which resulted in his inability to watch television or attend movies with his family. After endangering himself and his partner on patrol because he could not fire his gun, he resigned his job as a policeman and retrained as a teacher. Although he found teaching high school fulfilling, he often found himself reprimanded for becoming involved in his students' personal lives.

Fourteen years after his experience, he sought counseling for depression and despair over being unable to communicate his profound feelings to his family. Although he did show depressed mood and affect and some depressive equivalents, he had insufficient symptoms for a diagnosis of major depression or dysthymia and in fact reacted angrily when the possibility of antidepressant medication was raised, insisting that having suffered to transcend earthly pettiness, he did not want to be medicated into "adjusting" to it again.

Because there was no local support group for NDErs in his area, Mr. G. was treated in a time-limited psychotherapy group consisting exclusively of NDErs and in couples therapy. Once his wife realized his problems were neither unique nor due to

his individual psychopathology, she became more interested both in working with him to resolve their problems and in developing nursing interventions for NDErs. Mr. G. and his wife eventually were instrumental in establishing a local NDEr support group.

All four of these cases are appropriately regarded as cases of a religious or spiritual problem, as outlined in the DSM-IV. With the exception of Mr. V., none of them experienced characteristic clinical features of PTSD or major depression. That case illustrates the possibility alluded to in the DSM-IV of a religious or spiritual problem related to a mental disorder and yet of sufficient severity to warrant independent clinical attention. Such cases raise questions not only of differential diagnosis of the comorbid conditions but also of the causal relationship between them: that is, whether NDEs may predispose toward certain mental disorders, and whether certain mental disorders may predispose toward spiritual problems in NDErs.

Treatment

Individual Psychotherapy

Clinicians who have worked with NDErs have developed a consensus of helpful strategies in individual psychotherapy (Greyson, 1996a, 1996b; Greyson and Harris, 1987). It is usually useful to let these patients verbalize their confusion and distress, even when it seems difficult to put into words. Unlike delirious patients, who may become more agitated if allowed to do so, NDErs usually become more frustrated if told not to talk about their experience. Reflection and clarification of the patients' perceptions and emotions are usually more helpful than interpretations, which are often regarded by patients as misinterpretations. Objective information about the frequency and common effects of NDEs often alleviates concern about its implications and consequences, both for patients and for their families.

Regarding the NDEr as a victim is often countertherapeutic, whereas helping patients appreciate their active role in generating the specific details of their experience, and the relevance of those details to the experiencer's unique psychodynamics, may help them resolve problems arising from it. Rosen (1976) noted that a therapeutic aspect of many NDEs is what he called egocide or symbolic suicide, the sacrifice of conflicted parts of the personality that had been a source of suffering for the individual. In such cases, grieving for the loss of those conflicted parts, despite its therapeutic result, may be appropriate. The induction of controlled altered

states through hypnosis or guided imagery, and the use of nonverbal media, such as art, may help patients express conflicts that are experienced as ineffable. A sense of having been "returned" to life for a reason or of having chosen to return is a common source of conflict; regrets, ambivalence, and frustration over the return should be explored.

Changes in values, beliefs, and attitudes may require changes in familial interactions, which in turn can lead to secondary problems. A here-and-now focus in the therapy may help individuals who have difficulty appreciating temporal constraints after an apparently "timeless" experience. Unlike patients with PTSD, NDErs rarely want to eliminate intrusive reminders of their experience. More commonly, they request help integrating the experience and its lessons into their daily lives.

Group Psychotherapy or Support Groups

With an experience as foreign to mundane life as the NDE, exploring problems and solutions with fellow experiencers can reduce the sense of bizarreness. Some experiencers may find it easier to explore issues in a psychotherapy group composed of patients who have had NDEs or similar experiences than with a single therapist who, even if he or she has had an NDE, may legitimately be unwilling to share it with patients to avoid influencing their recollections and interpretations. Most patients will benefit from referral to NDEr support groups, which exist in many cities.² Talking with other NDErs in such a setting can help normalize the experience, although experiencers should be discouraged from identifying and associating only with persons who have shared similar experiencers.

Psychopharmacologic Treatment

There is no evidence that psychotropic medications will help with problems after an NDE, unless patients meet criteria for comorbid depressive disorder or PTSD, as did Mr. V. In fact, Wilber (1984b) cautioned against medicating individuals with spontaneous spiritual awakening, as that may freeze the process in midcourse and prevent any further reparative developments (Grof, 1975).

Contemplative Disciplines

As an alternative to medication, Wilber advised that the individual in spiritual crisis consciously en-

gage the reparative process by taking up a contemplative discipline. However, if a spiritual awakening involves psychotic-like features, contemplative disciplines, which require a sturdier ego than psychotics or borderlines possess, are contraindicated. Not only is meditation unhelpful for such patients, it can also dismantle what little structure the borderline or psychotic has (Wilber, 1984b). Engler (1983) also regarded meditation as contraindicated for such patients, even though they are often drawn to it as a rationalization for their "nonego" states. Wilber recommended that, for split life-goals problems, the patient should be helped to integrate spiritual practice into daily life and work rather than withdraw, as the path of ascetic withdrawal confuses suppression of earthly life with transcendence of earthly life (1984b). For "dark night of the soul" experiences, Wilber recommended that patients read classical accounts of these experiences and of how others have weathered similar crises.

Psychosocial Rehabilitation

Some form of psychosocial rehabilitation may be helpful when experiencers have difficulty adapting to the daily demands of mundane life that no longer seem relevant to him or her but are still necessary. At times, the NDEr may need to alter external reality to reflect the internal changes brought about by the experience. Individuals who find old careers or relationships irreconcilable with new attitudes and values may need counseling to address the dissolution of the previous lifestyle or the reconstruction of a new, compatible one. Couples or family therapy may be indicated when changes in the NDEr demand complementary changes in close relationships. In three of the four cases presented in this study, career decisions were made based on NDE-related attitudes: Ms. L struggled with her "manipulative" profession and eventually found a way to use her career skills constructively, Mr. V. found the solution to his crisis of meaning in paramedic training, and Mr. G. found he could no longer function as a policeman.

Conclusion

Inclusion in the DSM-IV of the new diagnostic label of religious or spiritual problem allows for the first time differentiation of these problems from adjustment disorders and major mental illnesses. This differentiation has permitted us to begin focusing clinical attention on these problems and ideally will stimulate research into more effective treatment strategies.

² An updated list of near-death experiencer support groups is available from the International Association for Near-Death Studies, P.O. Box 502, East Windsor Hill, Connecticut 06028-0502.

Although near-death and related experiences bear some similarity to symptoms of mental illness, they and their sequelae are readily distinguished from mental illnesses in their phenomenology. It is plausible then to assume that they may also be distinct in their etiology and response to various treatments. Awareness of the new diagnostic label of religious or spiritual problem can guide the clinician to the relevant diagnostic and treatment literature (Turner et al., 1995) and minimize or prevent unnecessary suffering due to misdiagnosis and inappropriate care (Bowers, 1974; Greyson, 1996a; Greyson and Harris, 1987).

References

- American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders* (4th ed). Washington, DC: Author.
- Bates BC, Stanley A (1985) The epidemiology and differential diagnosis of near-death experience. *Am J Orthopsychiatry* 55: 542-549.
- Bauer M (1985) Near-death experiences and attitude change. *Anabiosis: J Near-Death Studies* 5(1):39-47.
- Bowers MB (1974) *Retreat from sanity: The structure of emerging psychosis*. New York: Human Sciences Press.
- Bush NE (1991) Is ten years a life review? *J Near-Death Studies* 10:5-9.
- Clark K (1984) Clinical interventions with near-death experiencers. In B Greyson, CP Flynn (Eds), *The near-death experience: Problems, prospects, perspectives* (pp. 242-255). Springfield, IL: Charles C Thomas.
- Engler J (1983) Vicissitudes of the self according to psychoanalysis and Buddhism: A spectrum model of object relations development. *Psychoanal Contemp Thought* 6:29-72.
- Flynn CP (1986) *After the beyond: Human transformation and the near-death experience*. Englewood Cliffs, NJ: Prentice-Hall.
- Gabbarid GO, Twemlow SW (1984) *With the eyes of the mind: An empirical analysis of out-of-body states*. New York: Praeger.
- Gallup G, Proctor W (1982) *Adventures in immortality: A look beyond the threshold of death*. New York: McGraw-Hill.
- Greyson B (1983a) Near-death experiences and personal values. *Am J Psychiatry* 140:618-620.
- Greyson B (1983b) The psychodynamics of near-death experiences. *J Nerv Ment Dis* 171:376-381.
- Greyson B (1985) A typology of near-death experiences. *Am J Psychiatry* 142:967-969.
- Greyson B (1991) Near-death experiences precipitated by suicide attempt: Lack of influence of psychopathology, religion, and expectations. *J Near-Death Studies* 9:183-188.
- Greyson B (1996a) The near-death experience as transpersonal crisis. In BW Scotton, A Chinen, JR Battista (Eds), *Textbook of transpersonal psychiatry and psychology* (pp. 302-315). New York: Basic Books.
- Greyson B (1996b) Near-death narratives. In S Krippner, SM Powers (Eds), *Broken images, broken selves: Dissociative narratives in clinical practice*. New York: Brunner/Mazel.
- Greyson B, Harris B (1987) Clinical approaches to the near-death experiencer. *J Near-Death Studies* 6:41-52.
- Grof S (1975) *Realms of the human unconscious*. New York: Viking.
- Grof S, Grof C (1990) *The stormy search for the self*. Los Angeles: Tarcher.
- Insinger M (1991) The impact of a near-death experience on family relationships. *J Near-Death Studies* 9:141-181.
- Irwin HJ (1985) *Flight of mind: A psychological study of the out-of-body experience*. Metuchen, NJ: Scarecrow Press.
- Irwin HJ (1993) The near-death experience as a dissociative phenomenon: An empirical assessment. *J Near-Death Studies* 12: 95-103.
- Jansen KLR (1990) Neuroscience and the near-death experience: Role for the NMDA-PCP receptor, the sigma receptor and the endopsychosins. *Med Hypotheses* 31:25-29.
- Locke TP, Shontz FC (1983) Personality correlates of the near-death experience: A preliminary study. *J Am Soc Psychical Res* 77:311-318.
- Lukoff D (1985) Diagnosis of mystical experiences with psychotic features. *J Transpersonal Psychol* 17:155-181.
- Lukoff D, Lu F, Turner R (1992) Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems. *J Nerv Ment Dis* 180:673-682.
- Moody RA (1975) *Life after life*. Covington, GA: Mockingbird Press.
- Morse ML, Venecia D, Milstein J (1989) Near-death experiences: A neurophysiological explanatory model. *J Near-Death Studies* 8:45-53.
- Noyes R (1980) Attitude change following near-death experience. *Psychiatry* 43:234-242.
- Ring K (1984) *Heading toward omega: In search of the meaning of the near-death experience*. New York: William Morrow.
- Rosen DH (1976) Suicide survivors: Psychotherapeutic implications of egocide. *Suicide Life Threat Behav* 6:209-215.
- Saavedra-Aguilar JC, Gómez-Jeria JS (1989) A neurobiological model for near-death experiences. *J Near-Death Studies* 7: 205-222.
- Sabom MB (1982) *Recollections of death: A medical investigation*. New York: Harper and Row.
- Spiegel D, Cardena E (1991) Disintegrated experience: The dissociative disorders revisited. *J Abnorm Psychol* 100:366-378.
- Turner RP, Lukoff D, Barnhouse RT, Lu FG (1995) Religious or spiritual problem: A culturally sensitive diagnostic category in the DSM-IV. *J Nerv Ment Dis* 183:435-444.
- Wilber K (1984a) The developmental spectrum and psychopathology: Part I, stages and types of pathology. *J Transpers Psychol* 16:75-118.
- Wilber K (1984b) The developmental spectrum and psychopathology: Part II, treatment modalities. *J Transpers Psychol* 16: 137-166.