Dying: a spiritual experience as shown by Near Death Experiences and Deathbed Visions

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Introduction

In this talk I would like to suggest that dying is a process. First of all, I shall discuss those experiences which occur in the 24 hours or so before death - approaching death experiences - and secondly, the near death experience (NDE), looking at this as a model for death. It can be argued that the near death experience is not a good model for the death process itself, as everyone who has the experience lives to tell of it. However, there are reasons which I shall discuss, as to why this may be the best model that we have. Finally I want to look at some of the prospective NDE studies that have been done, to see whether we can find an explanatory framework for these, and what they can tell us about the spiritual experience of dying.

Approaching death experiences

Several groups of phenomena are reported in the 24 hours before death. The most often reported phenomena are 'take-away' visions - the so-called deathbed visions. These are visions seen by the person who is dying, in which figures are apparently seen who have the express purpose of collecting the dying person and taking them on a journey through physical death.

A further group of reported phenomena are deathbed coincidences. These are coincidences, reported usually by family or friends of the person who is dying, in which they say that the dying person has visited them at the hour of death. Many relatives are reluctant to describe these phenomena, but nevertheless they are frequently reported.

Carers also occasionally report other phenomena just prior to death. They sometimes describe a radiant white light, which envelops the dying person and may spread through the room and involve the carers as well. The quality of the light is described as surrounding those who experience it with love.

Deathbed visions

Deathbed visions are, I think, very common, and certainly they have been reported throughout history and throughout different cultures. The wife of a patient of mine described to me what happened when her husband was dying of a cerebral tumour:

> *'He was going unconscious. When I looked at him, he was looking fixedly at something in front of him. A smile of recognition spread slowly over his face, as if he was greeting someone. Then he relaxed peacefully and died'.*

This case details the main features of the experience. The dying person appears to see and hear the vision and usually responds to it in a

positive way. Often the patient will come out of coma just before having the experience and die almost immediately after it.

Very few scientific studies have been done to classify the phenomenon of deathbed visions. The largest survey was carried out by Osis and Haraldsson (1997) over 20 years ago. In a cross cultural survey they reported that over 70% of death bed visions were 'take away.' In a Western culture dead parents or relatives are most commonly seen; strangers are occasionally seen and children may report seeing living friends. People who have a strong religious faith may see religious figures, and in Eastern cultures the take-away figure is often a 'Yamdoot', the messenger of the God of death. Usually the dying person's response to the vision is one of interest or joy, the figures are welcome and the person is usually ready to leave with them. More rarely the response may be one of fear or a refusal to go.

Typical is this case quoted by Osis and Haraldsson (1977) of a dying 16 year old girl who had just come out of coma.

> *(She said)… 'I can't get up', and she opened her eyes. I raised her up a little and she said 'I see him, I see him, I am coming'. She died immediately afterwards with a radiant face, exulted, elated.*

In an Italian study, Giovetti (1999) reports that 40% of the deathbed visions she collected were 'take-away'. In one such case a wife describes the moment of her husband's death.

> *The gauze over his face moved. I ran to him. 'Adriana my dear, your mother (who had died 3 years before) is helping me to break out of this disgusting body. There is so much light here, so much peace'.*

Houran and Lange (1997) carried out a contextual analysis on 49 accounts of deathbed visions collected by Barrett in 1926 and concluded that these hallucinations were contextual and comforting, that sometimes dead relatives were seen who the dying person did not know had died, and that the authors could not exclude the possibility of survival.

Carers also report that the dying person may tell them that they can move between the room in which they lie and a transcendent world in which they meet those awaiting them after death. Many features of this transcendent state are similar to those of the NDE and contain the light, feelings of love and a wonderful brightly coloured realm. A patient of mine whose 32 year old daughter was dying of breast cancer told me that in the last two or three days of her daughter's life she remained conscious, and told her mother that there seemed to be a dark roof over her head and a bright light. She moved in and out of this 'waiting place', where beings were talking to her. She was quite convinced that this was not a dream, that these were loving beings there to help her through the dying process - her grandfather was amongst them - and that everything would be OK.

There are also many anecdotal reports of people who seem to have a clear intimation of their own impending death. This is an account I was given by someone who told me what happened two days before her mother died.

'Suddenly she looked up at the window and seemed to stare intently up at it… this lasted only minutes but it seemed ages…she suddenly turned to me and said 'Please Pauline, don't ever be afraid of dying. I have seen a beautiful light and I was going towards it, I wanted to go into that light, it was so peaceful I really had to fight to come back'. The next day, when it was time for me to go home, I said 'Bye mum, see you tomorrow'. She looked straight at me and said 'I'm not worried about tomorrow and you mustn't be, promise me'. Sadly she died the next morning...but I knew she had seen something that day which gave her comfort and peace when she knew she had only hours to live'.

The similarity of deathbed visions to NDEs is striking. The peace, love and light are common to both, as is the experience of a journey and an entry into a world dominated by beauty and colour. The experiencing of religious figures and dead relatives together with the method of communication, a sort of mental telepathy, are also similar.

Death bed coincidences

Again, there are many anecdotal reports by relatives who say that they become aware that someone close to them is dead or dying, even though they are often far away and may not know that the person is ill. This may take the form of a 'visit' by the dying person at the time of their death, as though they have come to say goodbye, or simply an experience of interconnectedness with the death - rappings, awakening at the time of death etc.

Gurney, Myers & Podmore (1886) quote the case of General Albert Fytche, who, on getting out of bed, saw an old friend who he greeted warmly and sent to the veranda to order a cup of tea. When he went to join him, the old friend had vanished. Nobody in the house had seen anyone. Two weeks later, Fytche received news that his friend had died 600 miles away at the time he had seen him.

Several people have told me of very similar experiences.

'When I retired to bed I was very restless. I tossed this way and that until suddenly, in the early hours, my father stood by my bed. He had been ill for a long time, but there he was standing in his prime of life. He didn't speak. My restlessness ceased and I fell asleep. In the morning I knew… my father had died late the evening before and had been permitted to visit me on his way into the next life'.

(Personal communication)

The following is an interesting account, as it shows the powerful impression that these experiences can have on those who hear of them.

'Around 1950, a distant relative was in hospital in Inverness. It was a Sunday and my father went to visit John, to be told that he had died that morning at a certain time. The hospital authorities asked Dad if he would inform the next of kin, the deceased's sister Kate and her husband, who were sheep farmers living in a relatively remote part of Easter Ross and not on the telephone. Dad and I drove the 20 or so

miles and up a hill track to the farmhouse, to be met by Kate who said 'I know why you've come - I heard him calling me saying 'Kate, Kate' as he passed over'. She was quite matter of fact about it and gave us the time of death which was exactly the same as that recorded by the hospital. I found it an amazing experience and have never forgotten it, nor will I ever. I was about 17 at the time'.

That deathbed coincidences occur is supported by accounts from different cultures and throughout history. The Giotto paintings at Assisi show just such an experience. A cleric in a different part of Italy who was dying became aware that St. Francis was dying and passing over and cried out '*Wait for me, wait for me St. Francis*, *I am coming, I am coming'* whereupon he died.

The argument against the experiences having a validity beyond coincidence is that feelings of death or severe danger to a loved one are very common and so just by chance alone these feelings will sometimes coincide with an actual death. My own view is that this is unlikely to account for all such accounts and that the idea of an interconnectedness at the time of death remains important.

Experience of light

Other phenomena seem to be associated with the moment of death. Light is often mentioned, and occasionally something interpreted as 'soul' or 'essence' by those who see it is seen leaving the body. A doctor who had seen many patients die told me that he was once playing golf when another player had a heart attack. As he was going to help he saw what he described as a white form, which seemed to rise and separate from the body. Other people have told me of similar experiences.

When I awoke, the room was pitch dark, but above Dad's bed was a flame licking the top of the wall against the ceiling…as I looked... I saw a plume of smoke rising, like the vapour that rises from a snuffed-out candle, but on a bigger scale…it was being thrown off by a single blade of phosphorus light…it hung above Dad's bed, about 18 inches or so long, and was indescribably beautiful…it seemed to express perfect love and peace. Eventually I switched on the light. The light vanished and the room was the same as always on a November morning, cold and cheerless, with no sound of breathing from Dad's bed. His body was still warm'.

(Personal communication)

Suddenly there was the most brilliant light shining from my husband's chest and as this light lifted upwards there was the most beautiful music and singing voices, my own chest seemed filled with infinite joy and my heart felt as if it was lifting to join this light and music. Suddenly there was a hand on my shoulder and a nurse said 'I'm sorry love. He has just gone'. I lost sight of the light and music; I felt so bereft at being left behind."

(Personal communication)

Again I am struck by the similarity between the light and heavenly music of these experiences and those reported from the NDE. Added to this is the experience of something going on a journey, which the carer wishes to accompany and follow into a loving beyond.

A reductionist explanation of deathbed visions would be that they are simply hallucinations interpretable in terms of a change in brain chemistry, or psychologically derived, confirming expectations or providing comfort as the dying approach their death. A point against this is that occasionally visions of a dead relative appear who the dying person does not know is dead. However, some phenomena surrounding the deathbed are witnessed by carers, and the mechanism for these is clearly different. A reductionist view would be that they are in response to the stress that the carer has had in the months leading up to the death and are probably mediated by a change in affect. Expectation could also play a part, as death always occurs within a culture and in Western culture the concept of soul and a departure to heaven of peace and love is common. However, as we now move towards post-modern science, together with the recognition that as yet neuroscience has no explanation of consciousness (subjective experience), the possibility of transcendent phenomena around the time of death should also be considered.

The Near Death Experience

Probably for as long as man has been aware of the certainty of death he has contemplated the possibility of survival. There is even nothing particularly new about the notion that people can ‘die’ and live to tell the tale. There are written descriptions of such events in myths and legends going back well over 2,000 years. But it was not until the first contemporary accounts of NDEs were collected by Dr. Raymond Moody (1973) that it was recognised that these were worthy of serious scientific study.

Not everybody who comes near death has a NDE and not every NDE is specific to a near-death situation. These experiences also occur as a response to extreme stress or terror or pain, in childbirth, under anaesthesia, spontaneously, and possibly even during sleep. It is unlikely that they are entirely the product of cultural expectations because there are many accounts of children too young to have such expectations, who have had NDEs. A stereotyped chemical explanation, although it might partially explain NDEs in cases of accident or emergency, would not explain those cases that are psychologically induced.

Clearly, NDEs may have different mechanisms in different situations. In order to progress the science behind the NDE, it is necessary to standardise the conditions in which the NDE occurs as much as possible, and to do a prospective study. There are many anecdotal accounts of patients describing these experiences during cardiac arrest. The cardiac arrest model of the NDE fulfils the criteria required for a proper scientific study. In cardiac arrest units, there is a standardised protocol that is carried out by the resuscitation team. The drugs given and the procedures are all standardised, so each patient is essentially treated in the same way. Thus it is reasonable to ask a number of questions relating to NDEs.

First, are NDEs found in a prospective study? Four recent prospective studies suggest that 11-20% of cardiac arrest survivors report such

experiences (Parnia et al. 2001, Van Lommel et al. 2001, Greyson 2003, Schwaninger 2002). These accounts have been standardised against the Greyson scale of near death experiences (Greyson 1983). NDEs are highly structured and in cardiac arrest survivors about 25% begin with an out of body experience (OBE) in which the subject reports leaving his body and looking down at his unconscious body from the ceiling, sometimes having a clear memory of seeing the resuscitation procedure (Van Lommel et al. 2001). This is important, as if definite proof could be obtained by the experiencer that he had indeed been able to view the resuscitation process when his heart had stopped and his brain was not functioning, it would mean that we would have to review our whole concept of consciousness and its relationship to the brain.

The experiencer may then find himself floating down a dark tunnel towards a bright light, always described as peaceful and compassionate. He may report seeing dead friends or relatives, or in our western culture, entering a garden-like area. A few people say that they undergo a 'life review', in which they themselves judge their own past actions. Finally they meet a barrier and realise, or are told, that they have to return. All these experiences are lucid and are rated by the patients as very meaningful. Most patients report a subsequent change in attitude, with less emphasis on the material and more on the spiritual aspects of their lives. These experiences occur in about 10% of patients who recover from cardiac arrest and are well enough to be interviewed before they either leave hospital or die. (The other 90% say they were unconscious for the whole of the arrest episode).

So what distinguishes the 10%? What causes these experiences? Chemical factors would seem to be important, especially as in one study (Van Lommel 2001) it does appear that those who are nearest to death or most severely affected tend to have the NDE. Ketamine, an NMDA agonist, can induce elements of the experience in those who use the drug recreationally (Jansen 1990) and the NMDA receptor (N-methy-D-aspartate) is widely involved in the brain changes in cardiac arrest. But only 10% of patients have the experience, while the NMDA receptor is involved in every cardiac arrest with cerebral ischaemia. These experiences do not appear to be due to changes in serum electrolytes, PaO_2 and $PaCO_2$ (Parnia et al 2001, Van Lommel et al. 2001) or to treatment with sedative agents, as their incidence is less than 2% in intensive care unit patients. Psychological factors are unlikely and religious belief influences the content of the experience but not its occurrence.

The authors of these prospective studies conclude that the occurrence of lucid thought processes, with reasoning and memory formation, and an ability to remember events from the period of resuscitation, is a scientific paradox (Parnia et al 2001,Van Lommel et al. 2001, Greyson 2003, Schwaninger 2002) – paradoxical because studies of cerebral physiology during cardiac arrest suggest that lucid experiences should not occur or be remembered at a time when global cerebral function is severely impaired or absent.

The Paradox

Cerebral localisation studies have indicated that complex subjective experiences are mediated through the activation of a number of different cortical areas, rather than any single area of the brain. A globally disordered

brain would not be expected to support lucid thought processes or the ability to ‘see’, ‘hear’, and remember details of the experience. Any acute alteration in cerebral physiology leads to confusion and impaired higher cerebral function (Marshall et al 2001). Cerebral damage, particularly hippocampal damage, is common after cardiac arrest; thus only confusional and paranoid thinking as is found in intensive care patients should occur. The paradox is that experiences reported by cardiac arrest patients are not confusional. On the contrary, they indicate heightened awareness, attention, and memory at a time when consciousness and memory formation are not expected to be functioning.

An alternative explanation is that the experiences reported after a cardiac arrest may arise while consciousness is either being lost or regained, rather than during the period of cardiac arrest. Any cerebral insult leads to a period of both anterograde and retrograde amnesia, the extent of which is a sensitive indicator of the severity of brain injury. Therefore events that occur just prior to or just after loss of consciousness would not be expected to be recalled. Moreover, recovery following a cerebral insult is confusional, and cerebral function as measured by EEG often does not return to normal until many tens of minutes or even a few hours after successful resuscitation. Thus these experiences could not occur during recovery.

It can still be argued that the some of the subjectively recalled features, such as seeing a bright light, might occur during the recovery phase. However the many anecdotal reports of patients being able to ‘see’ and recall detailed events during the cardiac arrest, which hospital staff later confirmed, cannot be explained in this way. For memory to be laid down, some form of consciousness would need to be present during the cardiac arrest, and for the memory to be recovered after the arrest, brain damage would have to be absent.

One further possibility is that every patient with a cardiac arrest does have an NDE but only those with the least brain damage, and so with relatively intact memories, remember it. The current data does point against this; as mentioned above, the largest prospective study (Van Lommel et al 2001) suggested that these experiences are reported by the most seriously ill and thus the most brain damaged.

The study of the human mind during cardiac arrest provides a unique opportunity to examine the brain/mind identity theory. If the mind is only a product of the activity of neural networks within multiple areas of the brain, then one would expect there to be no activity of the mind or consciousness in the absence of brain function. Apparent lucidity during the period of cardiac arrest (rather than before or after), when there is a lack of cerebral perfusion and the brain has become non-functional, would support the view that mind and brain are not identical, that is, that the brain identity theory must fail. The NDE could be the opportunity to put this theory to test.

The prospective experiment

It is of extreme importance for neuroscience to test whether or not the NDE does occur when the brain is not functioning. Penny Sartori, in a study in an intensive care unit in Morriston Hospital in Wales, has looked at cardiac arrests in a number of patients. Some of her patients have had NDEs and a few have left their body at the beginning of the experience. She was

hoping for this result and had placed on the top of monitors in the intensive care unit a number of cards, which were changed each week and which could only be seen from the vantage point of the ceiling. Thus, those out of their body and 'on the ceiling' should be able to report what was on the cards, but not others in the ICU. Sartori found that those who left their body were simply interested in the resuscitation process and thus none of them looked on top of the monitors. So, using this information we have designed the following experiment, which we hope to carry out:

A liquid crystal display screen will be suspended above the bed and above the resuscitation team, but in such a position that the experiencer, if he has left his body and looks back on himself being resuscitated, would have to look through this screen. Should he wish to see himself, then he must see the symbols on the screen. These symbols would be recorded on a video camera, as would all the details of the resuscitation process. Thus, subjects who reported the resuscitation procedure would have their accounts checked and verified by the video data of the resuscitation, and a correlation with any symbols described with the symbols that were present at the time. (We are awaiting funding before setting up this study!)

In summary, then, the approaching death phenomena seem to indicate that there is a spiritual process to dying, and that love and light are fundamental to the dying experience. They suggest a journey to a place of extreme beauty and intense colour and heavenly music. There is also the inference that mind and brain are not the same, and that consciousness can travel. The near death experience suggests the same place and journey, and also an apparent separation of mind and brain, and even that consciousness may survive death of the body.

However it is likely that we will never know until the time of death arrives, so please remember the Zen parable: A nobleman asked Master Hakuin, 'What happens to the enlightened man at death?' 'Why ask me?' said Hakuin. 'Because you are a Zen master'. 'Yes, but not a dead one'.

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