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UNIVERSITY OF SAN DIEGO  
Hahn School of Nursing and Health Science  
DOCTOR OF PHILOSOPHY IN NURSING

DEFINING HEALTH AND HEALTH-RELATED BEHAVIORS FOLLOWING A  
NEAR-DEATH EXPERIENCE

by

Suzanne C. Robertson

And A dissertation presented to the  
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE  
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the  
Requirements for the degree  
DOCTOR OF PHILOSOPHY IN NURSING

November, 2006

Dissertation Committee

Dr. Jane Georges, PhD, RN Chair  
Dr. Mary Rose Mueller, PhD, RN  
Dr. Maryanne Garon, DNSc, RN

## Abstract

While broad categories of health and influences on definitions of health have been identified, the process through which adults define and re-define health has not been researched. The purpose of this study was to investigate the process of defining health and appropriate health-related behaviors following a near-death experience (NDE) as an adult and to articulate a grounded theory of decision-making. Five men and 15 women from the United States and United Kingdom were interviewed and the data were analyzed using the constant comparative method.

The basic social process was *I Still Had to Go Through the Process of Understanding*. Understanding involved making sense of the NDE and precipitating event, gaining knowledge and insight, and applying this information in everyday life. This process was comprised of coming back, defining health, the experience of health, and meaning. The latter was a thread which ran through the entire process and was related to both the near-death experience and living one's health.

Coming back involved coming to terms with the physical, emotional, and spiritual consequences of the event, understanding what the NDE was and what it meant, and achieving some level of stabilized health. When their health was stable, participants were able to think about what health was and how it could be achieved or maintained. This typically occurred in three trajectories: the immediate aftermath, a combination of intervals, and over time. Imagery seen or meanings given to the NDE often influenced definitions of health and health

behaviors. The experience of health included thinking about health, living with health issues, and exposure to external sources of health information. Self-management and living well described the two broad philosophies and strategies used to live health.

These findings extend existing views of health, support research identifying multiple definitions of health and patterns of health behaviors, support the need to ask clients about health beliefs and health practices, and have implications for nursing practice, research, and education.

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## CHAPTER 1

### Focus of the Inquiry

Health is socially and personally known but not always articulated, especially if the individual has not been ill. Yet concepts of health guide decision-making regarding health maintenance activities and treatment options when faced with illness. Broad categories of health have been identified as well as components of the process through which individuals make decisions about health care. A missing piece has been the process through which individuals define and re-define health along the life continuum. This research begins to articulate a grounded theory of this process from the perspective of adults who have undergone a near-death experience (NDE) during adulthood.

#### *Background*

The term health comes from the Anglo-Saxon term for wholeness or integrity (Smith, 2002). Health has been identified as an essential element of nursing's metaparadigm or focus of the discipline. Its meanings include health as a conceptual definition, a state, and a nursing practice goal. The concept of health – what constitutes health and what health means – continues to be debated within the profession. This is reflective of both historical and current

discourses about health and the increasingly diverse norms shaping this country (Crawford, 1984, 1994; Pender, Murdaugh, & Parsons, 2002).

Historically, health was believed to be the outcome of living well, divine grace, and ritualistic practices. Enlightenment beliefs in the centrality of science and the Cartesian separation of the mind and soul led to a mechanistic world view in which health became something that could be achieved by scientifically informed practice. As a result, health was placed under the purview of medical practice and social policy (Crawford, 1994). The definition of health became a universal one of absence of disease.

In the West, social forces such as the holistic health movement, cultural diversity, and different models of health care delivery resulted in movement away from a unitary definition to more pluralistic views of health. Responsibility for health was shifted to the individual, or in the best of cases, to a partnership model. Thus, health became an important part of constructing the social self (Crawford, 1994).

Researchers have identified prominent definitions of health used in contemporary Western culture. There is evidence to suggest that factors, such as age, gender, and culture, impact beliefs about health, and that the individual's definition of health may change over the lifespan. What is not known is the process through which beliefs change or the temporal components of change. Models, such as the Health Belief Model, have also been developed to explain health-related behavior. Pender (2002) notes that these models may be useful

for explaining why people engage in disease-specific prevention practices but they do not address how people come to have specific health beliefs.

### *Health Beliefs*

Health beliefs organize our understanding of health and illness and provide justification for health practices (Kleinman, 1988). Health beliefs are central beliefs in that they have extensive connections to other beliefs that one holds. There is considerable literature suggesting that culture or society, significant others, and personal experience are important sources of health beliefs. Sociocultural beliefs, including assumptions about health and illness, are internalized at a young age (Boyle, 1989; Kleinman, 1988; Spector, 1996; Villarruel & Ortiz, 1992). They help the individual classify symptoms, know what is significant, and define what alternatives are available (Mascie-Taylor, 1993). Knowledge from significant others - family, friends, lay sources, and health professionals - is especially important when encountering new health problems or needing health care. Experiential beliefs arise from direct experience and are typically not dependent on social consensus for validation (Rokeach, 1968). Personal experiences may be pivotal in informing one's understanding of health (Bottorff, et al., 1998; Farrales & Chapman, 1999; Pachter, 1994).

Events may occur that cause a cognitive inconsistency, or a questioning of the validity of one's beliefs. Cognitive inconsistency is not an isolated event involving two or more beliefs but occurs in the context of the individual's broader conceptual background (Read & Miller, 1993). Individuals may resolve the

inconsistency through actions ranging from maintaining current beliefs despite “contradictory evidence” to reorganizing their entire belief system.

### *The NDE*

A near-death experience (NDE) appears to be a form of cognitive inconsistency. NDEs are unusual events often reported by people who believe they have survived a state of near-death or clinical death (cardiopulmonary resuscitation). The prototypical NDE as described by Moody (1975) often contains elements such as: a) ineffability, b) feelings of peace and quiet, c) movement through a dark tunnel, d) a sense of being out-of-body, e) meeting others or a being of light, f) life review, g) a border or limit, and h) return to the physical body. Near-death experiencers (NDErs) characterize the event as subjectively real and feel a heightened sense of mental clarity and logic during the event (Ring, 1980; Grey, 1985). The NDE is frequently described as ineffable, not because of inability to depict the event, but because what is known is so different from “normal knowing” (Sutherland, 1992).

NDE research has focused on defining and describing the phenomena, the immediate aftermath, aftereffects, and how the event is integrated into the individual’s life. Studies have indicated that the NDE is frequently a catalyst for profound changes in personal beliefs and behaviors. In fact, many experiencers state the NDE is the most important event to have occurred in their lives (Moody, 1975; Ring, 1980; Sabom & Kreutziger, 1982). The process through which conceptions of health change following the NDE has not been studied.



*Lines of Inquiry*

This study was a beginning investigation of the process of defining health and choosing health-related behaviors over the lifespan. As the literature suggests near-death experiencers often have a sudden and pervasive change in beliefs following the NDE, the population chosen was individuals who had a near-death experience during adulthood. The purpose of this study was to identify the process through which experiencers defined health and appropriate health-related behaviors following a NDE, and to articulate a grounded theory of decision-making related to definitions of health and health-related behaviors.

Questions included:

- a) Do you consider yourself to be healthy or unhealthy? Why?
- b) What does health mean to you? How do you define health?
- c) Is this different from how you defined health prior to your NDE?
- d) How did this come about?
- e) What do you do to stay healthy?

With its emphasis on the social nature of knowledge, grounded theory allows discovery of meanings and behaviors. An individual's interpretation of social reality is not an automatic application of established meanings but is contextual. It is an on-going process operating both to sustain established patterns of behavior and open the behavior to transformation. If interpretations sustaining behavior are disrupted by changed definitions, then the behavior patterns collapse and new interpretations are developed. Grounded theory

methodology traces and studies this evolving process of definition and interpretation by seeing things through the eyes of the participants.

### *Methodology*

Grounded theory was used to generate and analyze data. This research approach captured the process of defining health following a significant life experience and provided a more complete understanding of the ways in which a NDE affected conceptions of health over time. The epistemic root of grounded theory is symbolic interactionism as described by Mead (1934). Mead theorized that definitions of self and others are learned through a process of socialization, that meanings are only derived through interaction with others. Blumer (1969) added that human action is based on the meanings that things - physical, social, or abstract - have for the individual. Rather than being intrinsic, meanings arise from and are continually modified through a process of individual interpretation. The individual decides what things have meaning then interprets the meaning through the use of selection, checking, suspending, regrouping, or transformation in light of the context and direction of action. Interactions are expressed in symbols, of which language is the most symbolic (Annells, 1996).

Interpretation is not an automatic application of established meanings but is contextual, as knowledge is embedded in the social, cultural, and historical reality of the individual (Benoliel, 1996). Interpretation is an on-going process operating both to sustain established patterns of behavior and open the behavior to transformation. If interpretations sustaining behavior are disrupted by changed

definitions, then the behavior patterns collapse and new interpretations are developed.

Grounded theory traces and studies this evolving process of definition and interpretation by seeing things through the eyes of the participants. Theory is developed through simultaneous data gathering, analysis and interpretation. Rather than proving existing theory, the relevant aspects of the phenomenon being studied emerge and provide the core of a substantive theory. (Benoliel, 1996; Strauss & Corbin, 1990).

### *Significance of the Study*

Understanding how beliefs about health and health behaviors vary over time is important to the provision of appropriate and holistic healthcare. Pender, Murdaugh, and Parsons (2002) call for studying ideas of health across the lifespan, including how ideas of health are expressed behaviorally at varying points in the individual's development. Disparities in definitions of health and appropriate health behaviors between care providers and patients can muddle communication and negatively affect care. Kaufman (1996) also indicates that effective health promotion efforts are related, in part, to how the individual defines health.

Holistic nursing care involves caring for all dimensions of the individual. Orne (1992) states that informed nursing practice requires more than technical comprehension, empathy, or identifying with patients, "it requires that the nurse understand the salient features in their day-to-day experiences (p. 25)." An important feature is knowing how patients and caregivers conceptualize health

(Hargrove & Keller, 1993). Just as healthcare providers' concepts of health vary, so do those of patients and caregivers. Concepts of health play an important role in health decision-making; incongruent definitions of health between patients and healthcare workers may lead to failure to follow clinical recommendations (Bauman, 1961; Hargrove & Keller, 1993; Kerns, Meehan, Carr, & Park, 2003). And meanings of health are inextricably linked with health-related behaviors and activities (Jones, 1993).

Another salient feature is knowledge of life experiences that are meaningful to the individual. Research suggests that a NDE can be one of the most significant events in an individual's life (Ring, 1980; Sabom & Kruetziger, 1982). Social support has been identified as being crucial to the experiencer and significant others in the aftermath of a NDE (Hoffman, 1995a; Orne, 1992; Sutherland, 1992). Research suggests experiencers will usually share details of the experience with a nurse rather than other healthcare workers (Oakes, 1981).

Knowledge of the NDE, aftereffects, and its impact on definitions of health provides caregivers with sound theoretical information with which to facilitate healthcare decision-making and activities. Having practical knowledge heightens the nurse's ability to interpret clinical situations and act as a patient advocate.

### *Summary*

Concepts of health are integral to one's self-definition and are used to justify health and illness behaviors. Beliefs about health are learned from sociocultural groups, significant others, and personal experience. Personal experience is often pivotal in informing understandings of health and is typically

not dependent on social consensus for validation. Specific events may cause a cognitive inconsistency that may be resolved in a variety of ways, from maintaining current beliefs to reorganizing one's belief system.

A NDE is a sudden, unforeseen event that has been documented to alter many experiencers' belief systems. This dissertation used grounded theory to conceptualize the process through which definitions of health and associated health behaviors changed for these individuals following a near-death experience.

## CHAPTER 2

### CONTEXT OF THE INQUIRY

Health is “one of those everyday slippery-as-mercury words, the meaning of which seems so obvious and self-evident that we seldom take a few moments to define the term consciously for ourselves” (Mordacci and Sobel, 1998, p. 34). Yet health is socially known. For the lay person it is often taken-for-granted, especially in youth if the individual has not had an experience poor health. For the researcher the concept of health typically carries a traditional meaning.

Until the middle of the 20<sup>th</sup> century health was defined by Western medicine and social policy as the absence of disease. In 1946 the World Health Organization (WHO) (2003) attempted to move the concept of health beyond a disease focus by defining health as not just infirmity, but physical, mental, and social well-being. While it did not change mainstream medicine's focus on the “characteristics and consequences of pathology” (Levin & Browner, 2005, p. 745), there was increasing scholarly and public recognition that health was not a universal concept.

Research about the near-death experience has suggested it can have on-going effects that are outside mainstream ideas of “normal.” When one has a novel experience, it can affect other areas of one's life, including conceptions of health. This is a topic that has not been explored.

This chapter will discuss ideas of health, nursing conceptualizations of health, and lay definitions of health. While health has been conceptualized from individual, group, and population perspectives, the focus of this paper is on individual conceptions of health. Because this research focuses on the process by which near-death experiencers conceptualize health following a NDE, the near-death experience will also be explored to provide a context for later discussion.

### Ideas of Health

Health is variously a goal, an intentional activity, and a direction one moves toward (Engelhardt, 1981). It is a disciplined activity designed to decrease risk factors by protecting or improving the body (Crawford, 1984). Health is often perceived to be elusive in that it is difficult to operationally define. This is due to the division of health into components, such as spiritual and physical components (Larson, 1999), the fact that health is culturally defined and operationalized (Barnes, 1996; Illich, 1976; Kerns, Meehan, Carr, & Park, 2003; Leininger, 2001; Levin & Browner, 2005), gender differences in definitions of health (Ritchie, 1994), and a belief that conceptions of health may change according to the time of one's life (Kass, 1981; Larson, 1999; Pender, Murdaugh, & Parsons, 2006). Another difficulty is knowing where health resides.

Crawford (1984) stated that since the 1970s health had been conceptualized as an expression of bodily experience and that reaching health meant improving or protecting the body. Health was not a given or result of everyday activities, but a goal and the result of intentional action. Other

characteristics included health as a direction one goes toward (Engelhardt, 1981) and as future oriented (Illich, 1976). Crawford (1984) indicated the underlying assumption was that individuals had rational control over their bodies and were thus were able to “manage” their bodies based on social and medical criteria.

In contrast, Dossey (1984) understood health to be “*experience* – a result of a nondual interrelationship between human consciousness and the physical world. Health is a realization, not an acquisition” (p. 34). In this context illness is not an external event – the “I” is not separate from the experience – it is an aspect of health. If the individual accepts life as it is, or is immersed in the experience of health, then he or she is free to act in ways that are accepting of health as lived. Immersion in the experience of health is an ineffable experience, “the domain of pure undivided experience that goes beyond all characterization” (p. 60). This is a harmonic rather than dualistic view of health, embodied versus in-the-body.

Implicit in many views of health is an ethical aspect: it holds connotations about what is good and respectable (Crawford, 1994). It posits not only that the individual has control over the body but that health may have to be sacrificed for other goals, such as job or family. As such, health becomes a metaphor for self-control and will power. Crawford (1984) added that in a “healthist culture, healthy behavior has become a moral duty and illness an individual moral failing” (p. 70).

While health has historically been viewed as a continuum from unhealthy to healthy, the concept of high-level wellness is more recent. Dunn (1973) indicated health had often been viewed as a homogenous rather than dynamic



state, or freedom from illness rather than progress toward an ever-higher level of functioning. Essential characteristics of high-level wellness were being balanced, having a purpose in life; viewing mental, physical, social, and spiritual health as an integrated whole; and progression toward ever-higher potentials of functioning.

Maslow (1968) conceptualized high-level wellness differently. His research on neurosis suggested that it arose from deprivation of one or more basic needs. He described the needs as life, safety and security, belongingness and affection, respect and self-respect, and self-actualization needs. One difference between not-as-healthy and healthy, or actualized individuals was how they were motivated. Not-as-healthy individuals were motivated by deficiency; they depended on external satisfaction of safety, belonging, and affection and respect needs. Conversely, healthy individuals were less dependent on external gratification, more integrated, aware of who they were and what they wanted, and more autonomous.

Scholars have summarized various literatures regarding health and described models or concepts of health. Smith (1983) found four distinctive models of health: a) medical, b) role-performance, c) adaptive, and d) eudaimonistic. The medical model viewed health as absence of disease. It implied health was a flawlessly functioning body fully capable of self-preservation. It assumed a "normal" by which to base evaluations; Smith identified two forms of normal: statistic and ideal. The statistical norm was a population measurement in which central tendency, or conformity was

considered to be health. The ideal norm was optimal efficiency of organs and body systems and optimal was defined empirically through physiological studies. Smith added that within this context, health was evaluational as well as normative; it was a desirable state and implied personal choice.

The role-performance model summarized the work of Parsons, Mechanic, and others. Role was defined as “a social norm or expectation of behavior” (Smith, 1983, p. 48) which included distinct duties and responsibilities. Because individuals could have many roles, health was the ability to effectively perform central or preeminent roles, or roles associated with one’s family life and occupation, over a long period of time. Assumptions were that the individual was motivated to engage in the role and had socialized knowledge regarding role responsibilities. As requirements differed by role, health was variable rather than a fixed set of criterion. Quality of work and well-being were not essential components of this model. Smith indicated this model was generally used along with other ideas of health, such as the medical model.

Based on the writings of Dubos, adaptive health, the third model, was defined as the ability to effectively interact with a constantly changing environment. While health was dynamic, it assumed equilibrium between the individual and environment was possible. Adaptation was comprised of biological and social components. Biological adaptation had physiological and behavior elements; the latter included phenomena such as taboos and religious beliefs. Social adaptation was the ability to maintain successful relationships. Successful

adaptation included the ability to grow by creatively use the intellect, to have the capacity for reflection and analysis and to seek adventure.

The eudaimonistic model, based in large part on Maslow's work, identified health as complete development of one's intrinsic potential. This was further characterized as optimal physiological health, feeling safe in one's environment, experiencing love and affection from both self and others, spontaneity, creativity, and the ability to "perceive reality correctly" (Smith, 1983, p. 73), or to see life as it is instead of through the lens of one's subjective beliefs or fears. It was the ability to trust one's perceptions and accept the self and others as they are. Other characteristics included the ability to deal with life's ambiguities and seek out the hidden aspects of life. Although in an earlier article Smith (1981) delineated the health extremes of this model as "enervation and languishing debility" and exuberant well being, those characterizations were not included in her later work. Smith (1983) stated the models were not mutually exclusive views but could be thought of as a progressive expansion of the concept of health.

Larson (1999) identified four models of health: a) medical, b) WHO, c) wellness, and d) environmental. The medical model, or absence of disease or disability, was identified as the dominant model of health in the United States and the dominant model in medical research worldwide. He indicated the model included mental health in addition to physical health. The WHO definition of health was stated to be the most comprehensive definition of health and most popular definition of health worldwide. Larson indicated that since this definition was published, "medicine has treated individuals as social beings whose health

is affected by social behavior and interaction” (p. 126). The Wellness Model defined health as the strength and ability to overcome illness and having a reserve of health. The model acknowledged the mind-body link and that health could exist when illness was present. The model posited multiple dimensions, including bad health, disease, illness, and high-level wellness. Characteristics of high-level wellness were optimism; integration of body, mind, and spirit; well-being; and energy. The Environmental Model defined health as the individual’s ability to maintain balance within physical, social, and other environments, “with relative freedom from pain, disability, or limitations” (p. 131). The latter was not defined. The ability to perform needed tasks over a lifetime constituted positive health. Key characteristics of the model were growth, function, and the ability to thrive.

Edlin and Golanty (1999) identified medical, environmental, and holistic models of health. The medical model identified health as the absence of “the 5 Ds:” disease, death, discomfort, disability, and dissatisfaction. They stated mental health was integrated into this model “only with difficulty” (p. 5). The environmental model defined health as an individual’s ability to adapt to a changing environment. It included the effects of socio-economic status and education and conditions external to the individual, such as air quality, social relationships, and exposure to toxins. Illness was defined as disharmony between the individual and environment. The holistic or wellness model – the terms were used interchangeably – encompassed physical, mental, social, spiritual, and environmental aspects of health. Health was viewed as a dynamic

process. The model focused on optimal health, disease prevention, and a positive emotional state. High-level wellness, or optimal health, was the integrated functioning of the a) emotional, b) spiritual, c) intellectual, d) occupational, e) social, and f) physical dimensions. The emotional dimension was one's ability to cope while the spiritual dimension was harmony with self and others and the ability to balance inner needs with external commitments and demands. The intellectual dimension entailed openness to new ideas, experiences, and challenges. Ability to enjoy one's job and contribute to society was occupational role health whereas social health was the ability to perform social roles without harming others. Physical health included making informed and responsible decisions about health practices, maintaining a healthy body, and avoiding harmful habits.

Arnold and Breen (1998) had a slightly different view of health. They presented nine "clusters" of health: a) antithesis of disease, b) a balanced state, c) growth, d) functionality, e) goodness of fit, f) wholeness, g) sense of well-being, h) transcendence, and i) empowerment. Health as the antithesis of disease viewed health and disease as opposite states. Good health was set by medical and social norms and those who did not meet these expectations, such as persons with AIDS, were socially ostracized. Health as a balanced state was an epidemiological measurement of population aggregates. Health was a balance of host, potential agent, and environment; disease was disequilibrium, health was equilibrium. Cultural beliefs and traditions, such as yin and yang influenced this balance. Health as growth was based on developmental theory.

Individuals were viewed as having the capacity to grow continuously throughout the lifespan. Health was the ability to maintain a lifestyle in which the specific tasks of each life stage could be completed successfully. Tasks included cognitive, physical, and psychological competencies. Health as functionality was the ability to successfully fulfill social, physical, and psychological functions. Health as goodness of fit related to how lifestyle choices, biology, environment, and healthcare intersected. While it recognizes that biological factors could be beyond individual control, environmental factors were often negotiated at the level of public policy, and healthcare availability and adequacy might vary, health was considered to be integrity of system function.

Based on systems theory, health as wholeness was integrity of system function with characteristics similar to the eudaimonistic model articulated by Smith (1983). Health as a sense of well-being described the subjective aspect of health as experienced. They indicated well-being could not be formally defined and contained no clear guidelines because it was constructed and interpreted by the individual. Health as transcendence was a process of self-discovery, not confined by body and mind, integrating emotional and spiritual factors to achieve deeper meaning. It was the potential to alter health through mind-body-spirit connection and the possibility of transcending one's immediate circumstances. Health as empowerment linked individual and community sense of empowerment and the level of health experienced. Health was possible if the individual, then community had "a fully engaged sense of self" (p. 10). From this point health could be envisioned and worked toward. An individual alone could reach health

but the process was maximized with the community at large became mobilized. This model acknowledged the wide variety of forces affecting individual and community's choices. These clusters were not discrete models, per se, but as a way to stimulate a re-visioning of the concept of health.

As definitions of health have expanded over the past several decades there has been corresponding change in how Western medicine thought of health. Sullivan (2003) cited an ongoing transformation from a focus on bodies to a focus on patient's lives. He indicated that subjective information and patient-defined quality of life were becoming as important as objective data. Evidence of this change included increased patient autonomy in decision-making, emphasis on patient outcomes, and empirical evidence that patients consider health and disease to coexist. Mold (1995) added that a deficit reduction model was a pessimistic view of health, led to depersonalization of care, and thus was not useful for geriatric patients. He believed that to be useful, a model should be optimistic and achievable and it should value variation. He indicated the functional model of health met these goals by a) allowing for health improvement through life, in terms of personal growth and development, even when physical function was declining, b) changing the orientation from what was "normal" to helping the person achieve individualized goals; and c) changing the focus of assessment from impairments to values, goals, beliefs, strengths, and resources. He also noted that the concept of compliance was not meaningful in this model as treatments can fail or goals may be overoptimistic. His views are similar to those of many nurses.

*Nursing Concepts of Health*

Meleis (1990) stated that while many disciplines may be interested in health, the focus of nursing was different than that of other disciplines. A review of the literature from the past three decades indicated nursing moved from a view of health as absence of disease to more pluralistic definitions of health. Although research on health continues to focus on physical parameters, there is more research considering health as an individual pattern. For example, the perception of individuals as having parts, such as biological, social, and physical, has evolved to a belief that people are wholes with many dimensions that cannot be separated (Corbin, 2003). And there is recognition that some dimensions of health can not be measured empirically (Huch, 1991). A more recent change is recognition that spirit or meaning is an essential part of health. This has been reflected in depictions of health by nursing's grand theories, which are thought to represent the dominant world views of the discipline,

Several theorists' views of health were based on Bertalaneffy's concept of health as having two dimensions: dynamic balance and adaptability (Taboada, 2002). Dynamic balance was the ability of the system to maintain a "steady state" over time and adaptability was the ability to respond positively and creatively to change. King (1981) defined health as the dynamic life experience of the individual and "continuous adjustment to stressors in the internal and external environment through optimum use of one's resources" (p. 5). She later added that it was the ability to achieve harmony and balance in the environment (King, 1990). Similarly, Neuman (1990) spoke of health as the level of wellness at a



given point in time on a continuum from optimal wellness to death. Health, or system stability, was based on one's level of adjustment to stressors. Wellness was characterized as both an energy that empowered and regulated systems and a harmony and balance of body, mind, spirit, and environment. Roy (1984) defined health as a process of becoming integrated and lack of health as lack of integration. Health was a reflection of the individual's interaction with, and successful adaptation to a changing environment (Andrews & Roy, 1991). Adaptation was defined as behavior leading to survival, growth, reproduction, and mastery.

Orem (1991) thought of health as a state of structural and functional wholeness or integrity and absence of health as deviation from normal structure or function. She added a level called "injured and disabled" to indicate transient conditions that did not seriously interfering with integrated functioning.

Watson (1988) stated health was "unity and harmony within the mind, body, and soul" as well as "the degree of congruence between the self as perceived and the self as experienced" (p. 48). She noted her definition was an euda imonistic model of health. Rogers (1990) defined unitary human health as "an irreducible human field manifestation" (p. 10) that could not be empirically measured. Health and illness were not dichotomous but expressions of human patterning. In a later panel discussion Rogers stated that health was a value term and, as such, it was relative and infinite (Huch, 1991). Newman (1994, 2005) also defined health as the expression of unitary pattern of the whole, encompassing disease and non-disease. It was a process of expanding

consciousness or connected-ness with wholeness. Within this process disease could be a way of getting in touch with one's pattern or a way to facilitate growth. Parse (1990) identified connectedness with one's world as an element of health. Health, or the process of becoming, was a nonlinear unfolding, co-created through human-environment interrelationship and "lived in rhythmical patterns of relating that incarnate the meaning that the human being gives to situations" (p. 137). Integral to the model was health as a personal responsibility or commitment. The individual was the source of her or his experience by continually choosing from options.

Leininger (2001) brought the concept of culture into nursing beliefs about health. She defined health as a culturally defined and practiced state of well-being. It included the ability to perform role activities as culturally defined and expressed. (1974), Orlando , and Boykin and Schoenhofer (2001), did not define the concept of health.

While many nurses have advocated for pluralistic definitions of health (Bauman, 1961; Tripp-Reimer, 1984; Meleis, 1990; Kerns, Meehan, Carr, & Park, 2003), Pender, Murdaugh, and Parsons (2006) suggested an integrated, although expansive view of health as mental, social, spiritual, and physical dimensions. This model was considered to be holistic, but more importantly, it was easily integrated with biomedical and public health models. They believed this model would allow clinicians "to work with health and disease together rather than separating the concepts" (p. 25). When comparing how nursing and other scholars define health, two differences are apparent. First, although there is

acknowledgement that definitions of health are influenced by factors such as social construction, culture, age, and gender, scholars continue to define what health should be. This may be due to the hegemony the medical model definition of health has had and reliance on quantitative measures whose tools require definitions. The second difference is the nursing concept of human patterning not seen in other accounts of health. Perhaps this is because nurses, through their extensive interaction with clients, better perceive the extent to which health is dynamic and contextual.

### *Lay Definitions of Health*

Hwu, Coates, and Boore (2001) reviewed articles about health published in four major nursing research journals between 1988 and 1998. Articles were limited to quantitative research in which health was defined as either a dependent or independent variable. They found four trends. First, they noted there were three times as many articles about health than were found in an earlier review of the same literature. The second trend was that the concept of health changed from a traditional perspective to a process of growth and becoming, and that both patients and researchers understood health as a dynamic and subjective process. While parts were more easily measured, it was understood they were manifestations of the whole. A third trend was that the spiritual dimension was often missing from research definitions of health, although they did acknowledge the difficulty in measuring that dimension of health. The fourth was a trend toward using triangulation to combine objective and subjective health perspectives. They concluded that a holistic view of health

was more widely accepted in nursing, multidimensional measures of health had become more widely used in research, and that researchers needed to focus on increasing nursing knowledge of the spiritual domain. An analysis of research indicated concepts of health have been addressed from five perspectives: a) mixed gender groups of varying ages, b) mixed gender elderly; c) women, d) individuals with chronic diseases, and e) particular ethnic groups. There are some differences between ideas of health among these groups.

Brown, Gubrium, and Ogbonna-Hicks (2004) conducted random telephone surveys of rural residents in North Central Florida. Their sample of 174 adults were predominantly white (74%), female (67%), retired or unemployed, and half were over the age of 55. Thirty-five percent of participants defined health as being in good shape or feelings of well-being (females) and quality of life (males). Participants in other studies also gave this definition (Bauman, 1961; Boyle & Counts, 1988; Ness, 1997) also gave this definition. Characteristics used to describe well-being were feeling good; physical fitness; having energy; being satisfied or happy; a sense of freedom; connection to others, nature, and god; feeling loved and worthwhile; loving others; making a difference; and having a positive outlook. Quality of life included simply living, maintaining health, spending time with family, and "everything." What was unusual about the Brown, Gubrium, and Ogbonna Hicks (2004) study was that over 7% of participants were unsure what health meant to them. This was not found in other studies.

Another frequently espoused description of health was role performance. Kenny (1992), along with faculty members of the Women's Health Research

Group, developed a questionnaire to measure health that was based on categories developed by Woods, et al. (1988). Participants were predominantly female (68%), Caucasian (92%), and had at least attended some college (87%). Kenny (1992) found both genders ranked role performance as one of the top three definitions of health. Although Bauman (1961) did not give information on gender, her participants also defined health as role performance. This was described as being able to meet usual role obligations, being able to do what one liked or wanted to do, and being able to work. Other definitions included a positive self-concept (women) and positive body image (men) and social involvement (Kenny, 1992); absence of symptoms of disease (Bauman, 1961); independence (Boyle & Counts, 1988); and balance of mind and body, self-efficacy, and respect for self and others (Ness, 1997).

Research on women showed the most variation. Women living in poverty defined health as a quest for wholeness and the courage to be whole. Polakoff and Gregory (2002) stated there was an "intimate connection between the idea of health and a sense of spiritual wholeness" (p. 838). The quest for wholeness was the ability to integrate past and present; body, mind, and spirit, a drive to discover and be true to one's identity, and emotional safety. The journey to wholeness began with a conscious decision to be well. The courage to be whole described the strength and determination it took to move beyond everyday forces. The two subthemes were the loss of privacy and public scrutiny that came with being on public assistance, and life contexts that had to be surmounted to be well.

Examples of the latter were lack of support and never having enough to meet their needs.

Younger and middle-aged women described health as avoiding disease or illness and practicing healthy lifeways. While avoiding disease was the absence of illness for the Wood's et. al. (1988) participants, for Hargrove's and Keller's (1993) participants it was both internal and spiritual and environmental, or avoiding drugs, drive-by shootings, and other events. There were several differences in definitions between the two groups. Hargrove and Keller (1993) found black women defined health by body weight. While it was acceptable to be thin as a young woman, older women were not considered healthy if thin. Wood's, et. al. (1988) participants, who were Caucasian (64%), African-American (18%), Asian (14%), and other (4%), identified many more ideas of health. This included the ability to perform activities of daily life at one's expected level, cope with stress, actualizing oneself, a positive self-concept and body image, social relationships, thinking rationally and creatively, and spiritual wholeness.

McCarthy, Ruiz, Gale, Karam, and Moore (2004) conducted focus groups with older Anglo and Latino women. Anglo women identified health as a personal construct. They characterized health as needing to be in control, something one worked toward, and the presence of physical well-being. Relationships and spirituality were not found to be essential elements of day-to-day health. In contrast, Latino women defined health as the good life. Health was integrated, a intimate aspect of the self, part of life. It consisted of acceptance, relaxing, closeness to family and God, a sense of humor, and enjoyment and appreciation

of life. The researchers found that Latino women were less likely to seek professional healthcare whereas Anglo women viewed medical practitioners as partners in health. Maddox's (1999) participants were white (88%) and black (12%). Participants gave five defining characteristics of health: a) interactions with a being higher than themselves, b) self-acceptance, c) humor, d) flexibility, and e) being other-centered. Maddox commented that several of these definitions were expected as almost half of participants were nuns.

Individuals with cystic fibrosis described four types of health (Lowton & Gabe, 2003). The "normal state" was characterized as not requiring hospitalization, not needing more sick leave than healthy people, leading an active social life, and participating in sports. This was similar to definitions reported by Long and Weinert (1992) and Stuifbergen, Becker, Ingalsbe, and Sands (1990). Their participants gave descriptions such as the ability to work and function, no sickness or pain, being active and energetic, functioning well, and ability to adapt. The second level, the "controllable state," was the most frequently cited level by participants (Lowton and Gabe, 2003). It was an attitude about health versus a physical control of the body. Participants cited maintaining a positive attitude helped them influence outcomes of treatments but they also acknowledged the loss of spontaneity in everyday life, such as social situations. This level of health signified the beginning of decline. The lowest level was the distressing state in which there was daily disruption of activities, difficulty in controlling or maintaining health, an increased risk for health problems, such as diabetes, and a loss of spontaneity, or the ability to act without planning. The last

definition of health was particular to this group. Health as release was the definition of the few participants who had successful transplants. Health was feeling well, no longer experiencing breathlessness, and regaining spontaneity.

Research on the elderly of both genders suggested more variation in definitions of health. Viverais-Dresler's and Richardson's (1991) convenience sample was elder individuals who lived independently. The majority of participants (71%) were women and 43% had at least one year of college. They found participants defined health as biopsychosocial, or feeling good, enjoying life, able to do important activities; biophysical, or doing what one wanted to do; psychosocial, or having a sound mind and feeling good about oneself; and a combination of psychosocial and process context, or contentment with life, being yourself, and living morally. Averill's (2002) participants were comprised of two groups: miners and miner's widow who had lived in rural New Mexico for 40 or more years and newer residents who had lived in the area 20 years or less. Her findings suggested that definitions of health varied with socioeconomic status. Miners and miner's widows defined health as avoiding contact with the healthcare system and practicing spirituality whereas newer residents, who had higher incomes, defined health as proper diet, exercise, regular exams and spiritual connections.

Bryant, Corbett, and Kutner (2001) and Kaufman (1996) found two similar categories: a) state of mind and b) activity. The former was keeping one's mind active and learning as well as a positive attitude. The latter was doing something meaningful, mental stimulation, and doing what you want when you want.



Kaufman also found participants defined health as absence of impairment or medical attention, taking medicine, and basic functions, such as eating well, sleeping, and breathing without problems.

An ethnographic study of the Ojibwe comprised the last category. Turton (1997) interviewed over 100 Ojibwe people over a seven year period. The Ojibwe consider health to be a gift of the manito, or other-than-human-persons. She described the culturally specific ways in which the Ojibwe came to know about health as stories from the oral tradition, authoritative knowledge of elders, spiritual knowledge, commonsense models of illness and health, and knowing oneself. Oral stories, often called myths or legends, emphasized balance or connectedness to other beings and the earth. Authoritative knowledge of elders included practical knowledge, such as knowledge of herbs, and treatments thought to act by spiritual mechanisms that were obtained through apprenticeship. Spiritual knowledge referred to knowledge obtained from dreams, sweatlodges, or other activities. It was pertinent to the individual and addressed health alterations considered to be spiritual in origin. Commonsense models of health and illness indicated imbalances such as drug abuse or working too much and not attending to family. Knowing oneself was knowing one's purpose in life and doing what one was meant to do.

A thread that ran through these studies was that participants typically gave two or more definitions of health. This exemplifies the complexity of trying to find a single definition of health and supports the need for multiple definitions of

health in the extant nursing literature. The next section will discuss the near-death experience.

### The Near-Death Experience

Although NDEs were reported in early and medieval literature (Zaleski, 1987), the first formal documentation of NDEs was in 1892 by Albert Heim (as cited in Noyes & Kletti, 1972). Early research described the NDE in adult populations, how it was perceived by the experiencer, and attempted to develop tools to measure both the existence and depth of the NDE. The focus has expanded to include different cultural and age groups, how individuals assimilate the experience, how individuals integrate the experience, and long-term effects of the NDE. A number of theoretical explanations have been proposed for the composite experience as well as specific elements. This chapter will summarize this research and briefly describe the most common theoretical explanations.

#### *Adult Near-Death Experiences*

Moody's (1975) informal study portrayed unusual experiences that occurred while his 50 informants were unconscious, from either a cardiopulmonary arrest or an injury or illness in which the person was close to death. Each account was different but there were common elements. Although several events could occur simultaneously, there was a typical order in which the events progressed. Moody reported that the depth of the experience, or number of elements, was greater for those who were physically dead. The length of time the informant was dead also correlated positively with a greater number of

elements experienced. He did not identify how the closeness of death or the amount of time the person was physically dead was verified.

Ring (1980) criticized Moody's work stating his credibility as a philosopher and physician lent a "scientific aura" to his accounts that was not justified. To empirically study the phenomena, Ring interviewed 102 adults who claimed to have been near death as a result of accident, illness, or suicide attempt. Prior to data collection, he constructed a Weighted Core Experience Index (WCEI) based on 11 elements identified by Moody. He arbitrarily established a score of 6 or higher as indicating a NDE, or core experience (range 0-29). A higher score indicated a deeper NDE. Individual scores were established by consensus of three researchers; interrelator reliability ranged from .65 (suicide attempt) to .86 (accident). Structured interviews included eliciting demographic data, a free narrative, and information about aftereffects. Forty-eight percent (N = 49) reported an NDE.

The results indicated that NDEs tended to unfold in a characteristic pattern of five stages, which manifested with decreasing frequency. Stage I was characterized by a sense of peace, well-being, painlessness, and lack of fear. The small number who experienced negative feelings, mainly fear, found that these feelings were transient. In Stage II experiencers felt a subjective sense of separation from the physical body. Some were able to see their physical body but most were not aware of having another body. During Stage III experiencers floated in or moved rapidly through a darkness or tunnel. He described this as a transitional stage between this world and transcendental realms. Stage IV was

marked by the appearance of a brilliant, beautiful light, which was perceived to be restful and comforting. All who experienced it felt drawn to it and some felt enveloped by it. In Stage V experiencers entered the light and found themselves in a world of preternatural beauty. Upon reaching this point, some were greeted by deceased relatives. Over half of respondents reached a point where they had to decide whether or not to return to life. Different individuals experienced this at different stages. The decision was associated with a life review; encountering a presence, which was not seen but sensed, inferred, or intuited; or encountering deceased relatives. Respondents were able to mentally communicate with the presence and relatives. Although the reliability and validity of the WCEI was not reported, Ring included ample qualitative data to describe NDE stages and categories of aftereffects.

Studies in England (Grey, 1985) and Australia (Sutherland, 1992) supported Ring's model and NDE descriptions. However, in her comparative study of 32 British and 9 American NDEs, Grey (1985) noted several variations between groups: 1) British respondents tended to describe a black space and American respondents a tunnel, 2) British experiencers were more apt to move directly from the second stage to the fourth or fifth stage, and 3) there was frequently no dividing line between stages for British participants. For example, several respondents described the events as simultaneous.

Sabom and Kreutziger (1982) interviewed 100 adult survivors of near-fatal encounters which resulted in unconsciousness. Precipitating factors were cardiac arrest, illness, accident, and suicide attempt. Medical status was corroborated

when possible. During structured interviews demographic data, a free narrative, and details regarding aftereffects were obtained. Sixty-one percent of the sample (N = 61) reported NDEs which were categorized as one of three types: autoscopic, transcendental, or a combination of autoscopic and transcendental elements.

Autoscopic experiences were described by 26% (N = 16) of the sample and included a sense of detachment from the body and the ability to observe the physical body and surroundings. A sense of overwhelming peace and calm permeated the episode. The majority, 52% (N = 32), described a transcendental experience, which was more variable but had one recurrent theme. Individuals described passage into a black void or tunnel from which they were lifted or moved to a dimension of bright light and great beauty. Some perceived a border; brilliant white light; and/or deceased relatives, friends, or other entities. Communication was nonverbal and was generally perceived to be a message to return to the physical body. A combination of autoscopic and transcendental elements was reported by 21 % (N = 13) of the sample. Methodological difficulties included nonrandom selection and a lack of qualitative data to support their categories of NDEs.

Greyson (1983) felt previous attempts to measure the NDE had treated it as a unitary phenomena and that this was problematic when trying to explain this complex experience. Citing the lack of a valid screening instrument for the NDE and its components, he developed a 16-item NDE Scale to quantify the experience. Internal consistency (.88), split-half reliability (.92), test-retest

reliability (.92), and criterion validity ( $r = .79$  to  $.90$ ) were reported. Discriminative validity was supported by the lack of correlation to demographic variables and depersonalization symptoms. Construct and predictive validity were not reported. A score of 7, one standard deviation below the mean, was used to delineate presence of an NDE (range 0-32).

Greyson (1983) developed a true-false questionnaire, which contained 40 of the most common NDE elements cited in the near-death research literature. The questionnaire was given to 67 members of the International Association of Near-Death Studies who believed they had had an NDE. Respondents described 74 NDEs, which, for the purposes of the study, were considered to be 74 individual cases. Responses were factor analyzed using Pearson product-moment correlation coefficients. Items having a correlation coefficient of at least .35 with the rest of the questionnaire were grouped into clinically meaningful clusters. Each cluster item had a correlation coefficient of at least .35 with the rest of its cluster. The results indicated a typology comprised of four components: cognitive, affective, paranormal, and transcendental.

The cognitive component encompassed features related to changes in thought processes: distortion in one's sense of time, acceleration of thoughts, life review, and a sense of sudden understanding. Affective features were associated with changes in emotional state such as feelings of peace, or unity or an encounter with a loving being of light. Paranormal features consisted of hyperacute physical senses, apparent extrasensory perception, precognitive visions, and an out-of-body experience. The transcendental component included

travel to an unearthly realm, encounters with a mystical being, visible spirits of deceased or religious figures, and a barrier beyond which one could not return to physical life (Greyson, 1993). Methodological difficulties included nonrandom selection, lack of verification of medical status, possible sample bias, and lack of demographic information.

Researchers have questioned whether NDEs are unique to individuals who are near death. Stevenson, Cook, and McClean-Rice (1989) attempted to verify the accuracy of reported physiological status. Of 109 NDEs reported to these researchers, they were able to obtain the medical records of 40 individuals. After each researcher reviewed all records, consensus of ratings was attained. 35% of patients were rated as having no serious illness or injury, 20% were rated as having a major illness or injury but no danger to life, and 45% were rated as having an illness or injury that would have been life-threatening without medical intervention. They speculated that because half of the other 67 cases did not warrant hospital admission, the frequency of life-threatening illness would be less in this group. In a later analysis of the NDE elements described by the 109 subjects, Owens, Cook, and Stevenson (1990) concluded the NDEs of individuals who were not near death resembled "in all aspects" NDEs of subjects that were near death.

Gabbard, Twemlow, and Jones (1981) reported that awareness of separation from the physical body was "quite prevalent among persons whose survival is not threatened" and that features of NDEs occurred in accounts of subjects who had out-of-body experiences (OBE) (p. 374). When comparing

NDEs to OBEs, they found that, although there was a statistically significant difference in the frequency of certain reported events, such as traveling through a tunnel, no feature was exclusive to either the NDE or OBE.

### *Negative Near-Death Experiences*

Rawlings (1979) was the first to call attention to the fact that not all NDEs were perceived as positive. He cited patients who reported being in "hell" either during or after the procedure. He hypothesized that negative NDEs were repressed soon after the event so that only pleasant parts of the experience were remembered or the experience was not remembered at all. He concluded that interviewing patients soon after resuscitation might yield more reports of negative NDEs.

Twelve percent (N = 4) of Grey's (1985) sample reported having negative NDEs characterized by extreme anguish, desperation, loneliness, a feeling of being lost or helpless, and desolation. They described the NDE environment as dark, gloomy, hostile, or barren. The NDEs followed a five-stage sequence similar to that described by Ring (1980) but differed in content. Stage I was described as a period of fear and panic. During Stage II they reported an out of the body experience and during Stage III they entered a black void. In Stage IV experiencers sensed or saw evil forces and ultimately, Stage V, entered a hell-like environment.

In contrast, the results of a descriptive study (Greyson & Bush, 1992) of 50 individuals who interpreted their NDE to be negative found three types that differed phenomenologically. The first type of negative NDE shared features of



the prototypically peaceful NDE but the experience was interpreted as terrifying rather than reassuring. Loss of ego control was often identified as the terrifying aspect. Once the individual stopped fighting the experience, it occasionally converted from a negative to a peaceful NDE.

The second type of negative NDE involved a paradoxical sensation of ceasing to exist or of being eternally condemned to a featureless void. Common themes included a feeling of being mocked and “a sense of despair that life as we know it not only no longer exists but in fact never did, that it was all a cruel joke” (Greyson & Bush, 1992, p. 101). Following the event, individuals were left with a pervasive sense of emptiness and despair. The majority of this type occurred during childbirth under anesthesia. A small number reported a third type of negative NDE which included more graphic hellish features such as demons, nightmarish creatures, sounds of torment or falling into a dark pit.

Greyson & Bush (1992) cited special difficulties researching negative NDEs: 1) research instruments, such as the WCEI and NDE Scale, perpetuated a bias against recognizing distressing NDE events as they only included positive elements such as peace and joy, and 2) individuals could be reluctant to report them or others to hear them.

It is difficult to imagine that an experiencer could be indifferent to the cultural assumption that personal merit determines type of experience; that is, that ‘heavenly’ and ‘hellish’ experiences come to those who have earned them...value-laden terminology [positive versus negative] may lead experiencers to believe they will be similarly characterized” (p. 96).

*Multicultural Research*

Pasricha and Stevenson (1986) reported the results of a study in northern India. Ten participants who reported NDEs were personally interviewed, information was elicited from firsthand informants in 5 cases, and from a witness in 1 case. Attempts were made to corroborate the participant's illness from other informants they were able to interview. Respondents typically described themselves as being taken by messengers and brought before a man or woman who was often described as consulting a book. Yamraj, king of the dead, his messengers, called Yamdoots, and Chitragupta are well-known figures in Hinduism. Chitragupta has a book, which contains a record of all individual deeds during this life. After discovering the wrong person had been delivered, the person consulting the book would communicate information such as, "We don't need Chhajju Bania (trader). We had asked for Chhajju Kumhar (potter)" (p. 168). The individual then described being brought back or pushed down into the physical body. Occasionally deceased acquaintances, beings of light, or religious figures were seen. Methodological difficulties included use of secondary informants and limiting discussion of the data to only those features different from Western studies.

Feng and Liu (1992) looked at survivors of the 1976 Tangshan, China, earthquake. Eighty-one randomly selected patients from the Paraplegic Convalescent Hospital in Tangshan completed a demographic questionnaire, the NDE Scale, and the Gueng Yue-Xian's Personality Inventory. Both researchers interviewed each participant; the inter-rater reliability was .95. Forty percent of

participants (N = 32) reported having an NDE. Following Greyson's (1983) typology, Feng and Liu classified 34 % (N = 11) of the NDEs as cognitive, 3% (N = 1) of the NDEs as affective, 13% (N = 4) of the NDEs as paranormal, and 28% (N = 9) of the NDEs as transcendental. They were unable to unequivocally classify the remaining 22% (N = 7) of NDEs. These experiencers reported elements rarely mentioned in other literature, including a sensation of the world ceasing to exist, weightlessness, a feeling of being pulled or squeezed, a feeling of being a different person, ambivalence about death, and unusual scents. Reliability and validity of the Gueng Yue-Xian Personality Inventory was not reported.

#### *Pediatric Near-Death experiences*

The few studies done on children indicate that childhood NDEs exist and may share some similarities with those of adults. Morse, Castillo, Venecia, Milstein and Tyler (1986) reviewed medical records of 202 patients admitted to a pediatric ICU. Forty patients met the study criteria of premorbid good health, illness or trauma characterized by unconsciousness, and a full neuropsychiatric recovery. The interview schedule consisted of open-ended questions about memories of the time the patient was unconscious and directed questions based on the NDE Scale. Any subjective experience the participants described as occurring during the period of unconsciousness was considered to be an NDE. Sixty-four percent (N = 7) of the research group reported a NDE, none of the control group reported subjective experiences.

Morse et al. (1986) concluded that childhood NDEs consisted of being out of the body, viewing one's body, perceiving a darkness, perceiving a tunnel, and return to the body. Significantly absent from the children's descriptions were time alteration, detachment, or life review. A salient feature was that the children's descriptions consisted of concrete fragments versus the detailed narratives given by adults.

Serdahely (1990) interviewed four children who related NDEs following life-threatening cardiac or pulmonary conditions. Variations from the previous research findings included an altered sense of time and movement into the light. The eldest, who was 15 years of age, reported seeing images from the past and had a flash forward indicating how her relatives would feel if she died. He speculated that the life review might be a function of age.

#### *The Aftermath of a Near-Death Experience*

The NDE is reported to have two dimensions: 1) the experience itself and 2) its aftermath. The immediate aftermath of an NDE can be a time of uncertainty and confusion as the individual attempts to come to terms with surviving the experience and place the survival in a meaningful perspective (Orne, 1992). Over time, the experiencer may go through a process of incorporating the event, often noting changes in the self and relationships (Morris, 1998; Sutherland, 1992). This section will describe the aftermath period, or the process of finding meaning. Common aftereffects of the NDE will also be addressed.

*Immediate aftermath*

As part of a hermeneutic study, Orne (1992) interviewed 10 participants who had documented cardiac or pulmonary arrests during their current hospitalization and a score of 7 or greater on the NDE Scale. Participants were interviewed prior to and after discharge from the hospital. Participants' understanding of their survival was shaped by prior life experiences, how the NDE was interpreted, how coming back to life was understood; road blocks, obstacles, and mental hurdles encountered; telling others and holding back; and the support or non-support of others. Three themes characterized this understanding: A Lived Affirmation; An Apprehensive Flight; and Dying is Easy, Living is Hard. Those that felt the experience was affirming saw it as a validation of personal beliefs, an opportunity and challenge, and fulfilled expectations. Participants who were apprehensive about the experience felt overwhelmed, insecure, anxious, threatened, and wary about the future. They looked to others to tell them what survival meant. The third theme embodied a feeling of sadness, disconnectedness, regret, and hardship; the meaning and purpose of the event were elusive.

To develop a conceptual framework reflecting the meaning and significance of the NDE to experiencers and the nurses caring for them, Morris (1998) interviewed 12 survivors, six within 1 month of the event and six within two years, and 19 nurses who had cared for patients who had NDEs. Survivors were defined as those who had a cardiopulmonary arrest, serious illness, or trauma with a period of unconsciousness. Her findings also indicate that the immediate aftermath of the NDE was characterized by confusion, frustration, and

a quest for sanity. Survivors realized something powerful had happened but didn't know how to interpret the experience. Major issues during this period were identifying the meaning of the event and addressing the emotional sequelae. Survivors needed time to talk about the event to resolve these issues. Resolution resulted in a quest to define the purpose of life in both spiritual and life course domains. The spiritual domain related to connectedness with a higher power and beliefs about life and death. The life course domain related to a shift in priorities and relationships with others.

Morris (1998) found the NDE to be a personal awakening for all but one of the nurses caring for experiencers. For many nurses, this was described as the first experience that opened the door of their scientific thinking into a realm beyond what they knew as reality. As a result of their experiences with patients who experienced NDEs and other unusual events, nurses struggled to explain what had happened in logical terms. As they ruled out the numerous possible explanations, nurses came to believe that these experiences were very meaningful to themselves as well as their patients (p. 87). The spiritual domain reflected the nurse's core beliefs and the practice domain reflected emotional growth and how this affected their practice.

#### *Finding meaning in survival*

When Sutherland (1992) asked 50 Australian experiencers about their personal and social life following a NDE, they described a process of integrating the experience, or determining meaning and incorporating the NDE into their life, which could take more than 40 years to complete. Integration was considered to

be complete when the NDE was part of the experiencer's life and congruent with attitudes and actions. Integration was reported to be an ongoing, dynamic process constantly being negotiated and managed by the individual within a particular social, intellectual, and historical context. Sutherland described four trajectories: accelerated, steady, arrested, and blocked. Key variables that appeared to determine the type of trajectory were identified as whether or not the individual chose to return (versus being told to return), acceptance of being back, acceptance of the experience as meaningful, change in context awareness, disclosure, and context adaptation and/or subversion.

Accelerated trajectory was a rapid integration path that could take two forms. The first form, a confirmatory trajectory, was the most rapid and resulted from life experiences that prepared the individual for the NDE. The NDE confirmed and gave depth to existing beliefs. The second form, a standard accelerated trajectory, occurred when individuals considered the NDE to be of primary significance but did not have experiential antecedents to understand the event. This trajectory required more time for integration.

The steady trajectory was characterized by an unhurried but constant rate of change, often achieved without social support. Individuals had no preparation for the NDE or basis with which to judge it but accepted the event as meaningful. They were unable to discuss the event, either from caution or because of prior unfavorable responses. There was a search for meaning and an awareness of differences in their own attitudes. The amount of time needed for this type of

trajectory was reported as ranging from 5 to 20+ years. A variety of triggers could cause an accelerated form of this trajectory.

Integration stopped by contextual conditions was called an arrested trajectory. Individuals valued the experience but did not know what to make of it. There was an inability to share the event with others and lack of confidence to proceed without social support. The possibility of integration remained open but was not pursued. With the proper trigger, experiencers could pass on to a more active trajectory. Sutherland found this trajectory to be common in those with childhood NDEs. A minority of experiencers followed a blocked trajectory characterized by denial of the experiential value or meaning of the NDE and disinterest in integrating the experience. Trajectory patterns appeared to be related to the depth of the NDE. Those with the highest WCEI scores (reflecting a deeper NDE) tended to follow accelerated paths at some stage whereas those with the lowest scores tended to follow an arrested or blocked trajectory.

#### *Long-Term Effects*

How the individual labels the experience often affects the sequela more than the NDE content (Grey, 1985). Whereas a minority of experiencers ignored the event and went on with life as usual, most indicated one or more aftereffects or life changes which were often quite profound. Based on his research, Ring (1980) provided a useful categorization of aftereffects: spiritual/religious changes, personal changes, value changes, and paranormal effects.



*Spiritual/religious changes*

These changes appeared to be the most fundamental and the basis for other life changes/aftereffects. Three aspects of spiritual/religious change were been discussed. The first aspect was a decrease in fear of death and an increase in belief of life after death (Ring, 1980; Sabom & Kreutziger, 1982; Grey, 1985; Sutherland, 1992). Findings of the two studies using control groups indicated that it was the NDE, not the precipitating medical event, which caused the decrease in fear of death (Ring, 1980; Sabom & Kreutziger, 1982).

The second aspect was an increase in spirituality. Many experiencers made a distinction between the terms "spiritual" and "religious". The term religion implied an externally determined set of dogma and rituals whereas the term spiritual implied an internal set of beliefs (Ring, 1980; Sutherland, 1992). Participants cited increased prayerfulness and/or a greater awareness of God's presence, a movement away from theological doctrines to a more contemplative spiritual ideology, a feeling that organized religion might be irrelevant to or interfere with the expression of religiousness, a sense of overall religious tolerance (all religions are expressions of a single truth), and a "cosmic" view of religion for which theological doctrines were not adequate (Grey, 1985; Ring, 1980; Sutherland, 1992). One woman explained:

I now have a very strong view that church and religion are totally divorced from spirituality...[religion] just doesn't help each individual along the path to understanding or spirituality. The only way people do it is by looking in

themselves...and most religions I feel take people away from that  
(Sutherland, 1992, p. 104-105).

The third aspect of spiritual/religious change was manifestation of their beliefs. Love was the central theme, ranging from unconditional love to a greater compassion and caring for others (Ring, 1980; Grey, 1985; Sutherland, 1992). During the NDE, individuals experienced an unconditional, overwhelming, or "absolute pure love"(Grey, 1985). For the majority, this was the gist of the experience. It was this love they tried to manifest in their life.

#### *Personal effects*

Recurring themes in the literature are disclosure, ontological change, and relationships. Many respondents described the difficulty they encountered when trying to discuss the experience with others. Responses ranged from cynicism, dismissal, and threats of psychiatric referral to acceptance and support. To gain more insight on this issue, Hoffman (1995a, 1995b) did an ethnographic study of 50 experiencers regarding their disclosures following the event. NDEs were verified using both the WCEI and NDE Scale. Her results indicated there was a need for recognition of the profound importance of the NDE to the individual, often from a trusted professional. For example, after having received two negative responses from health professionals, one woman was asked why it was so important to again try to discuss the event. She asserted that it "'changed me so much' and she wanted that to be acknowledged." This woman interpreted negative responses to mean that having a NDE was "something to be ashamed of" and wanted others to know "something good came out of it" (1995b, p. 38).

Negative responses have had personally devastating effects and often kept the experiencer from talking about the event for many years (Greyson & Harris, 1987; Sutherland, 1992; Hoffman, 1995a).

Ontological changes were described as an increased appreciation for life, increased self-esteem, increased self-understanding, knowledge-seeking and a sense of life purpose (Ring, 1980, Sutherland, 1992; Grey, 1985). In some cases the NDE was perceived as a purposeful event, a type of self-correction. Many felt they had a deeper understanding of life and could now see meaning in life events, both positive and negative. There was also the experience of having been healed physiologically and/or psychologically (Ring, 1980).

This usually led to different ways of living in the world. For a period after the event, many had difficulty readjusting to day-to-day life (Greyson & Stevenson, 1980). Changes in profession, hobbies and interests were not uncommon and there was often an increased need for solitude and reflection. Family relationships were sometimes affected. Insinger (1991) described this phenomena as a "social death" where the familiar personality died and/or former behavior patterns were changed. In a thematic analysis of the interviews of 11 self-reported experiencers, he discovered three patterns of interaction: family reactions, spousal relationships, and relationships with family members. Other investigators have iterated these findings (Ring, 1980; Sutherland, 1992). Family members often found it difficult to discuss and accept the NDE and its aftereffects, although in some cases there was increased acceptance over time.

Experiencers who confronted this kind of family reaction usually accepted the fact that they could not share this aspect of their life with significant others.

Relationships with spouses were found to be a significant part of the NDEr's link to the family unit. Although some spousal relationships were unchanged or strengthened by the experience, the majority of couples experienced some level of strain. There was often conflict in values and attitudes following the NDE among couples who had shared similar values prior to the experience. For example, one spouse had difficulty dealing with the changes in his wife's personality and values, but his anger primarily resulted from her new independence. Divorce was not unusual if the spouse could not accept changes in the experiencer.

Relationships with family members were often more positive following the event. Experiencers related this to an increased acceptance and compassion toward others, greater openness, and more meaningful interaction. Some family members did have difficulty understanding the experiencer's need to help others, interpreting it as a lack of love for those at home. Insinger (1991) speculated that the love the family expected was a more personal love whereas the NDEr had concern for everyone. Sutherland's (1992) participants reported few disruptive changes in social relationships, particularly if significant others were supportive of the experience. A small number reported a decrease in social relationships, seemingly due to a sense of ontological alienation from others.

Less commonly reported NDE aftereffects were stress, anxiety and depression (Greyson and Harris, 1987). These stemmed from interpersonal

conflicts, a NDE that conflicted with previously held beliefs, fear of rejection and ridicule, or doubts of mental stability. Some experiencers were totally unprepared to face this type of experience and its aftermath.

#### *Value changes*

Changes most often cited were increased love, caring, compassion, and empathy for others; greater acceptance of others; and a shift away from material values (Ring, 1980; Grey, 1985; Insinger, 1991; Sutherland, 1992). This manifested as a desire to help others either through a change in profession, volunteer work, or through more informal activities. It became a major feature and commitment of their lives. They felt better able to deal with family disagreements because they were able to see the other person's perspective. Their shift in material values did not usually reflect a lack of enjoyment of possessions but a decreased attachment to money or material items and a decreased need for external approval. This commitment to others and shift in material values became a source of tension when the individual's family did not share the same commitment or views on the issue of money (Insinger, 1991).

#### *Paranormal effects*

An increased incidence of clairvoyance, telepathy, precognition, out-of-body experiences, the ability to heal, perception of auras and other psychic or paranormal phenomena was reported following the experience (Ring, 1980; Greyson, 1983; Grey, 1985; Sutherland, 1992). These phenomena took place with varied frequency and many experiencers did not have control over their occurrence. Some experiencers accepted these events as normal while others

felt they were disruptive (Sutherland, 1992). Due to the social unacceptability of these events, many discussed them only with selected individuals and some actively tried to suppress them.

### *Explanatory Models*

A number of interpretations have been offered to explain the NDE. This section will provide an overview of the most common interpretations in the near-death literature: a) depersonalization, b) mystical, c) neurobiological, and d) essence models.

Noyes and Kletti (1972; 1976a, 1976b, 1977) and Noyes & Slymen (1984) defined NDEs as a depersonalization syndrome comprised of three defensive maneuvers: resistance, life review and transcendence. Upon perception of the threat of death, the individual's energy is directed toward resisting death through life-saving actions. This maneuver ends when the individual surrenders to death. The second maneuver, a life review, represents the individual's reassessment and integration of life events as life nears its end. The transcendental maneuver is a relinquishing of connections to worldly reality. Mystical consciousness, described as the transcendence of time, space, and individual identity, is the end point of this adaptive process.

Ring (1980, 1981, 1984, 1988) and Pennachio (1986, 1988) characterized NDEs as a form of mystical experience. Each person has a spiritual core that may remain dormant until aroused by a powerful catalyst, such as an NDE. The unfolding of this core may lead to transformation. As such, the NDE represents

an experience of a higher, or transcendental, consciousness that may activate latent spiritual potentials.

The most common interpretation is that the NDE is a neurobiological event (Blackmore, 1993; Gomez-Jeria & Madrid-Aliste, 1996; Morse, Venecia, & Milstein (1989); Saavedra-Aguilar & Gomez-Jeria, 1989; Wettach, 2000).

Decreased cerebral blood flow and hypoxia cause release of neuropeptides and neurotransmitters resulting in abnormal excitation of target cells. This epileptiform discharge causes increased stimulation of limbic connections resulting in the perception of elements normally described in NDEs. Concomitantly, the priming mechanism (facilitation of sensory events) functions in a less restricted way, allowing declarative memory processes to access a broader set of representations. These representations are integrated with previous knowledge to form a story the individual believes to be accurate (Gomez-Jeria & Saavedra-Aguilar 1994). Variations in NDEs are constituted by discrete neural configurations, which can be mapped once their elements and order of appearance are known.

Arnette (1992, 1995) proposed a theory of essence, which states that humans have both a physical body and an essence, which is the seat of consciousness and thought. The body and essence have extended electrical fields with a strong attraction to each other. Because it is a form of energy, essence is not bound by the physical laws. It can interact mentally with other essences and those in physical form by exchanging information in the form of

thoughts. At death, it disengages from the physical body to travel to locales imperceptible to those in physical form.

The depersonalization, mystical, neurobiological, and essence models have been criticized for their inability to account for all NDE elements, aftereffects, and paranormal experiences during the event; differentiate between those who have the experience and those who do not; and include all situations in which the event is reported to have occurred (Groth-Marnat & Schumaker, 1989; Kellehear, 1993; Persinger, 1989; Roberts & Owen, 1988; Rodin, 1989; Serdahely, 1996). Lundahl and Gibson (2000) cite the dilemma of science when trying to answer questions of ultimate cause; “how to explain the NDE in terms of physically known factors when spiritual or ‘otherworldly’ factors keep intruding” (p. 147). This author believes current models are different levels of interpretation rather than competing interpretations and agrees with Bush who states that NDEs are a “moving experience, pregnant with spiritual meaning, [which] may be seeded by a physiological mechanism” (Bush, 1991, p. 8).

### *Summary*

Health is a complex concept. This is due to the multiple factors that influence how individuals define health, such as age and culture. While the medical definition of health, absence of disease, has dominated research, nurse theorists have defined health in pluralistic ways. This is consistent with nursing research indicating a richness and variety of lay definitions of health. Many of the definitions cited reflect those described by Smith (1983) as role function, adaptability, and eudaimonistic. While some scholars continue to believe one



definition of health is needed, most scholars understand that a unitary definition would be incongruent with those nurses serve.

An appreciable number of individuals experience NDEs. They are perceived to be authentic, vary in content, and may be defined as positive or negative by the experiencer. Current typologies suggest that the NDE can unfold in a sequential pattern of varying content or it can be perceived as specific content, such as autoscopic, cognitive, or transcendental. It is not clear whether individual typologies are comprised of phenomenologically different contents or whether they label the content differently. For example, is the “darkness” (Ring, 1980) the same as the “tunnel” (Sabom and Kreutziger, 1982)? Sparse research suggests that NDEs may not be experienced the same way by all cultural groups.

The literature describes a variety of aftereffects, both positive and negative. It is clear that the NDE holds a potential for personal transformation. The most consistently mentioned aftereffects are changes in spirituality, personality, values, and paranormal effects. Love for others and for nature is often central to manifesting their beliefs. Individual narratives reflect the profound nature and depth of many experiencers' ontological shift from belief to knowing. After the experience, they often feel at odds with mainstream definitions of the nature of reality. There is a new sense of purpose to their lives. They typically undergo a process of integration in which the meaning of the experience is understood and incorporated into their lives. Integration may not come without hardship, both personal and relational.

## CHAPTER 3

### Methodology

The purpose of this study was to provide theoretical description of the process of defining health and appropriate health behaviors following a near-death experience as an adult. As the process of defining health throughout the lifespan has not been well researched, grounded theory, as described by Strauss and Corbin (1990, 1994, 1998), provides a strong methodological basis for this research. Its strength is that it allows process and meanings to emerge inductively from participant descriptions rather than through application of prescriptive theory. Thus it is well-suited to exploring new facets of social processes.

This chapter will address the research methodology and method and the particulars of doing the research. The sampling method, recruitment of study participants, protection of participants, and data collection and analysis procedures will be described and study participants will be introduced. Methods of maintaining methodological rigor will be described.

#### *Grounded Theory*

Grounded theory is a “methodology for developing theory that is grounded in data systematically gathered and analyzed” (Strauss & Corbin, 1994, p. 273). It is inductive research which traces the evolutionary nature of meaning and

action from the perspective of participants and provides a fuller view of “what is.” The methodological assumptions of grounded theory are: a) meaning forms the basis of human action, b) humans actively define and redefine meanings through social interaction, and c) although human action is complex and variable, the evolutionary process can be articulated by the actors.

Hutchinson (1993) states the researcher’s “task” is to articulate the conceptual essence of the social process. This requires theoretical sensitivity to the interpretive role. Strauss and Corbin (1990) described theoretical sensitivity as “the attribute of having insight, the ability to give meaning to the data, the capacity to understand, and capacity to separate the pertinent from that which isn’t” (p.42). It included the researcher’s professional background, familiarity with literature about the phenomenon being studied, and personal experience. It was a practice of frequently examining assumptions as well as openness and sensitivity to concepts, meanings, and relationships during the analytic process.

Conceptualizing essence is accomplished through the simultaneous use of data gathering, analysis, and interpretation. Strauss & Corbin (1998) indicated analysis was both science and art. Science was the rigorous analysis grounded in the data and art was the creative ability to effectively question, compare, name categories, and integrate information. The hallmark of this process is constant comparison, or a set of procedures guiding the researcher through the process of analysis (Robrecht, 1995). It enables larger patterns of behavior to be uncovered and the relationship between patterns delineated (Eaves, 2001).

### *Sample Selection*

The initial participants were a convenience sample of individuals willing to discuss defining health following a near-death experience. Strauss and Corbin (1994) called this open sampling, or data gathering that allows development of categories while remaining open to possibilities. Selection of subsequent participants was guided by theoretical sampling.

Strauss (1987) identified theoretical sampling as data collection based on “analytical grounds,” or identifying who to interview and for what purpose. While initial sampling is open and “loose,” or asks general questions, theoretical sampling is more systematic. Concomitant theoretical sampling, data analysis, and interviewing are used to “flesh out” and note variations in categories and their dimensions. As interviewing progressed and initial participants were re-interviewed, theoretical sampling focused on obtaining richer description of categories and understanding the relationships between categories. Interviewing progressed until there was saturation of major categories.

The researcher relied on a self-report of a NDE rather than attempting to validate the occurrence. Underlying assumptions were that a) the participant was an adult and responsible for her/his health at the time of the NDE, b) the participant had formed her or his own beliefs or been exposed to cultural beliefs about health prior to the NDE, and c) there had been sufficient time since the NDE for the participant to reflect on the event. Therefore, inclusion criteria were a) a self-reported NDE that occurred during adulthood, and b) an NDE that had occurred at least one year prior to the first interview.

*Protection of Participants*

Prior to beginning the study the researcher obtained approval from the Institutional Review Board (IRB) at the University of San Diego (Appendix A). Both as part of the consent form (Appendix B) and prior to beginning the interview, participants were informed the researcher would stop the interview or audiotaping at her/his request. None of the participants requested this. Respondents were not interviewed until a signed consent was received by the researcher. Participants interviewed by telephone or e-mail were sent a consent form with a stamped, return envelope. Local participants signed their consents prior to beginning the interview.

Due to the potential for anxiety resulting from relating an emotional experience, referrals to local providers were available but not used. Three participants discussed their need to interact with others who had a similar experience. At their request, they were either given information about the local IANDS group or given the IANDS web address.

*Recruitment*

Participants who had a NDE were attracted through personal contact, networking, and advertisements. Although six participants had tentatively agreed to be interviewed in the months leading to the onset of inquiry, only two participants were available when the study commenced. Two potential participants moved, leaving no forwarding addresses; one individual did not respond to several voice messages, and one individual declined to participate. Networking with colleagues and friends in several states resulted in the referral of

seven participants. Advertisements were placed on list serves of a local university and a state-wide health agency, resulting in three participants.

The researcher contacted International Association of Near-Death Studies (IANDS) chapter facilitators. These contacts and an ensuing presentation at a local IANDS meeting attracted three participants. The researcher also placed an advertisement in the research section of the IANDS website and of an IANDS newsletter. This resulted in eight responses and six participants.

Two potential participants approached at an IANDS meeting declined to participate in the study. One man who contacted the researcher by e-mail was interested in participating in a study about aftereffects. He was referred to a researcher known to be conducting a study on that topic. Another individual who contacted the researcher did not meet inclusion criteria. Advertisements placed in a local newspaper serving the African-American community did not elicit participants.

#### *Data Collection Procedure*

Initial contact with participants was by a) telephone (9), b) in person (2), and c) e-mail (9). The purpose and scope of the study was explained and participant's questions were answered. The preparatory phase, or the period from the initial contact to agreement to participate, was often lengthy. The researcher was struck by the level of concern regarding anonymity and the sacredness of the experience expressed by many participants. For example,

Table 1

Participants' Sociodemographic Characteristics, Characteristics are continued on the next page.

<b>Total Sample -- N=20</b>	<b>Sample</b>	<b>Female</b>	<b>Male</b>
<b>Gender</b>		15 Female	5 Male
<b>Age at NDE</b>	19 – 29 N = 11 30 – 29 N = 6 40 – 40 N = 1 50 – 59 N = 2	19-50 years  Mean = 29 years	19-54 years  Mean = 35 years
<b>Elapsed Time Between NDE and Interview</b>	0-10 years N=6 11-20 years N=5 21-30 years N=3 31-40 years N=4 41-50 years N=2	3-50  Mean = 23years	5-34 years  Mean = 18 years
<b>Ethnicity</b>	Caucasian N=18  Hispanic N=2	Caucasien N = 14 Hispanic N = 1	Caucasien N = 4 Hispanic N = 1
<b>Income</b>	0 – \$25,000 N=6 \$25,001 – \$50,000 N=3 \$50,001 – \$75,000 N=4 \$75,001+ N=7	0 – \$25,000 N=5 \$25,001 – \$50,000 N=2 \$50,001 – \$75,000 N=2 \$75,001+ N=6	0 – \$25,000 N=1 \$25,001 – \$50,000 N=1 \$50,001 – \$75,000 N=2 \$75,001+ N=1

Table 1

Participants' Sociodemographic Characteristics. Characteristics are continued on the next page.

Total Sample – N=20	Female	Male
<b>Occupation at Time of Interview</b>	Registered Nurse N=6 Homemaker N=2 Computer Analyst N=1 Physician's Assistant N=1 Chiropractor N=1 Therapist N=1 Secretary N=1 Teacher N=1 Beautician (Retired) N=1	Registered Nurse N=1 U. S. Navy (Retired) N=1 Pilot N=1 Building Engineer N=1 Manager N=1
<b>Spirituality</b>	Christian N=4 Catholic N=1 Catholic/Buddhist N=1 Catholic in Name only N=1 Spiritual N=4 Freelance N=1 Buddhist/Tao N=1 Jewish/Spiritual N=1 Nondenominational N=1	Christian N=2 Spiritual N=3



Table 1

Participants' Sociodemographic Characteristics. Characteristics are continued on the next page.

Total Sample – N=20	Female	Male
<b>Precipitating Event</b>	Motor Vehicle Accident N=2 Respiratory Arrest (asthma) N=3 Pulmonary Embolus N=2 Childbirth N=2 Surgery N=1 Cardiac Arrest N=1 Seizure N=2 Strangulation N=1 Drowning N=1	Motor Vehicle Accident N=2 Cardiac Arrest N=1 Heart Attack N=1 Hypothermia N=1
<b>Highest Level of Education</b>	Postgraduate N=6 College N=5 High School N=4	Postgraduate N=1 College N=3 High School N=1

several participants felt there would be negative professional ramifications if others knew of their NDEs. Participants expressed concern that this research might negate the sacredness of their experience and questioned how their statements would be used.

To address these sensitive issues, the researcher:

1. Discussed her background and interest in this topic.
2. Discussed the purpose of the study and how data would be used, such as using statements to illustrate aspects of categories.
3. Explained how anonymity would be protected, such as use of code names.
4. Asked the participant to select another code name when the name initially selected would potentially identify the participant.

Once participants met inclusion criteria and agreed to participate, they selected a date, time, and setting for the interview.

Nine of eleven local participants chose to be interviewed in-person and two individuals chose telephonic interviews. Other U. S. participants were interviewed by telephone. Interviews ranged from 11-90 minutes in length. Two participants who responded to an advertisement on the IANDS website were from the United Kingdom (U. K.). Both declined telephonic interviews but were agreeable to e-mail interviews. One participant was unable to complete the interview due to health issues.

Interviews were conducted at a time and location requested by the participant. Six interviews were completed in either the participant's or

researcher's home, two interviews were conducted after work hours at the individual's work location, and one participant was interviewed, at his request, in a local restaurant. Eight participants agreed to follow-up interviews to clarify previous statements or gain information regarding topics that emerged in later interviews.

Prior to starting the interview, the interviewer established rapport with the participant through a personal introduction and a short period of general conversation. The interview began when the participant indicated she or he was ready to begin. At the beginning of the interview participants were invited to share their NDEs. All participants gave at least a brief description of their NDEs and the events leading up to it. Questions were asked about the NDE only to clarify information.

Participants were then asked to talk about their current health. A core group of questions were asked of each participant; further questions expanded or clarified concepts or their properties and linkages (Appendix C). As new dimensions emerged, new questions were added to the core list. As some knowledge is emic and not readily apparent, the researcher asked each participant if there were relevant questions that had not been asked. Two dimensions emerged from this line of questioning.

### *Data Management*

Sociodemographic questions were asked at the end of the interview. Swanson (1986) indicated that obtaining demographic data after a relationship is established may feel less intrusive. Income data were obtained

by having the individual indicate a number which designated a range of incomes. UK incomes were converted to US dollars using current exchange rates. Demographic information included gender, age at the time of the NDE, age at the time of the interview, time elapsed since the NDE, ethnicity, income, occupation, the precipitating event, and spirituality.

An interview guide (Appendix C), developed from pilot interviews of two nurse experiencers and guidance from committee members, was used to structure the initial part of the interview and assure essential questions were asked. Subsequent questions were based on participants' responses. The researcher felt it important to structure the interview while remaining open to new data. Eighteen initial interviews and nine second interviews were audiotaped; twelve initial interviews and all second interviews were transcribed by the researcher and six initial interviews were transcribed by a professional transcriptionist. All transcriptions were reviewed line-by-line by the researcher for accuracy. E-mail interviews were printed as received and organized by date. Following interviews the researcher made field notes about the interview and the participant's non-verbal responses. After reading e-mails, the researcher reflected on their meaning and relatedness to interview data prior to asking for clarification or asking for further information. Due to the time between contacts, it was often necessary to review many prior e-mails to maintain a coherent thread and continuity.

*Participant Characteristics*

Fifteen women and five men participated in this study. Eighteen respondents resided in the United States (U.S.) and two resided in the United Kingdom (U.K.). Thirteen of the U.S. participants resided in California. At the time of their interview, the ages ranged from 36 to 73. At the time of the NDE, male participants were aged 19 to 54 and females participants were aged 19 to 50. An average of 21 years had elapsed since the NDE (range 3-50 years). Eighteen participants identified themselves as Caucasian and two as Hispanic. Six participants were single and 14 were married.

Half of participants were employed in healthcare-related occupations at the time of the interview. At the time of the NDE, six of seven nurses were either in nursing school or had completed their nursing program. Other participants employed in healthcare attained professional status following the NDE. Four experiencers changed occupations following their NDE. Two attributed the change to their NDEs, one woman stated the NDE influenced her career change, and one participant made the decision to change careers prior to her NDE.

One-third of experiencers classified themselves as spiritual rather than religious. Six participants identified themselves as Christian or Catholic and one held Christian beliefs without being attached to a particular religious group. Three experiencers identified combined traditions and three identified other classifications, such as "free lance."

At the time of the interview, four participants had completed high school and fifteen had completed college or postgraduate work. One participant stopped his education after his junior year of high school due to illness. At the time of their NDEs, nine participants had completed high school and ten participants had completed one or more years of college.

### *Data Analysis*

Initially, transcripts were coded line-by-line to designate and label data bits. Coding is the process of labeling discrete concepts without assigning value (Kools, McCarthy, Durham, & Robrecht, 1996; Strauss & Corbin 1990). Two types of codes were used: a) existing concepts representing an idea or event, such as "acceptance," and b) in vivo codes, or the words participants used to organize and define ideas. Examples of the latter were "second chance" and "naturally healing."

Like concepts were grouped by category. Categories are higher level concepts used to group like data. Data depict the properties, or characteristics of the category and its dimensions, or the range of variation within the category (Strauss & Corbin, 1998). Categories, properties, and dimensions emerged by constantly comparing and asking questions of the data. As they emerged, analysis moved to axial coding.

Axial coding systematically adds breadth and depth to categories and examines the relationship between categories and subcategories, or what happens, how and why it happens, and the conditions under which it occurs. As axial coding proceeded, new questions were added to the core list of

questions to validate and dimensionalize categories. Memos and theoretical notes were used to document the process of organizing and summarizing concepts, their properties, and their explanatory relevance. Memos and theoretical notes were dated and code names of the transcript(s) under discussion were designated to keep temporal order of the analysis journey. Although the researcher lost most of her early notes as a result of a crashed hard drive, she was able to reconstruct a number of theoretical memos. Adequacy of coding and categorizing was validated by having committee members review selected coding and theoretical notes.

Saturation of core categories, or the point at which no new information is encountered during interviews, was reached after 28 interviews (20 initial and 8 second interviews). Analysis moved to integration of categories for theoretical development, or selective coding. Core categories were auditioned to determine the central or explanatory category. Diagramming helped the researcher to visually sort categories and identify relationships. The central category and theoretical relationships were evaluated to ensure consistency with the data, logical development of the theory, and ability to explain the process of defining health and health related behavior.

### *Methodological Rigor*

Rigor is the way in which researchers establish research legitimacy (Tobin & Begley, 2004). Rigor in quantitative research is established by the “methodological trinity” of reliability, validity, and generalizability. As these criteria are inconsistent with qualitative methodology, other verification

strategies have been articulated. Lincoln and Guba (1985) identified trustworthiness as being the qualitative equivalent to reliability and validity and listed four aspects to this concept: a) credibility, b) dependability, c) confirmability, and d) transferability.

Credibility is the faithfulness of the research to the participants' depictions (Altheide & Johnson, 1994; Chiovitti & Piran, 2003). This is demonstrated through conceptual density, linkages between concepts, attention to process (Strauss & Corbin, 1998), and mutuality. The researcher achieved this through description of the social context in which events took place (Denzin, 1994) and fullness of description. To increase clarity, participants' descriptions were used to illustrate and amplify meanings. The author attempted to convey the fact that categories were not "discrete, self-sufficient entities," rather interdependent, or part of a whole (Horsburgh, 2003, p. 309). Attention to process was attained through identifying phases or increments of thought and action over time.

Dependability and confirmability were increased by accounting for the research process (Denzin, 1994; Emden & Sandelowski, 1998; Slevin & Sines, 1999). One way in which this was done was an audit trail, or field notes; operational notes, such as revising the question list when new dimensions emerged; theoretical notes which tracked the researcher's conceptual ideas; and diagrammatic representations of the emerging theory. Use of verbatim transcripts for analysis, concomitant data collection and



analysis, theoretical sampling, in vivo codes, and saturation of data also enhanced the soundness of findings.

Confirmability was enhanced at various points by obtaining confirmation from participants. During the interview the researcher restated information to make sure she had correctly understood participants' reports. Almost half of participants were interviewed twice. At the beginning of each second interview the researcher summarized her understanding of key information for verification. After the theoretical model was fully articulated, the researcher described the model to two participants: a nurse and an individual with no healthcare background. Both participants related the process was consistent with their experiences.

This research presents the experience of one group of individuals. While transferability of findings to other healthcare consumers was not the goal of this study, providers may find it fruitful to discuss concepts of health at various points along the continuum of care. One of these points may be following a life event that is significant or seminal for the individual.

Ethical conduct is central to credible research. Davies and Dodd (2002) indicated ethical research was trustful, open, honest, respectful, careful, and attentive. The researcher made every effort to embody these characteristics during the research process. Based on previous experience as a research participant, the researcher was aware of participants' need to ascertain trustworthiness of the researcher and understand how data would be used before sharing personal information. And from preliminary

discussions with nurse experiencers, the researcher understood the NDE was very sacred to participants. Therefore, the researcher made it a priority to establish a trusting and caring environment by discussing her interest in the topic, how research findings would be used, and by being attuned to verbal and nonverbal cues regarding information participants were comfortable disclosing. To maintain an ethical environment, participants who so indicated were sent a summary of research findings.

A second aspect of ethical conduct was that of knowledge claims. It is important for the researcher to identify her or his location within the research process. Having been healthy throughout life, the researcher's experiences of health were in the contexts of practice and life experiences. Early in her doctoral program her father was diagnosed with terminal cancer. During the last year of his life, she had the extraordinary experience of watching him become more healthy and happy even as his physical body deteriorated. This began her journey of looking at health as a concept. Therefore, researcher beliefs were: a) one's concept of health may change during one's lifetime, b) health is limited only by the limits one places on it or how one defines it, and c) life experiences, including nonordinary events, can trigger changes in beliefs, including health beliefs.

### *Summary*

This chapter detailed how the study was carried out. Symbolic interactionism methodology and grounded theory were chosen based on their relevance for addressing the social process of defining health and health-

related behaviors, determining meanings, and developing mid-range theory. After IRB approval, 20 participants were recruited and interviewed either in person, telephonically, or by e-mail. Concomitant data collection and data analysis allowed the researcher to identify and develop dimensions. Data collection was terminated when saturation of core categories was achieved. This chapter also defined the steps taken to ensure the trustworthiness of study findings. The next chapter discussed the context of the study, the near-death experience.

## Chapter 4

### PARTICIPANTS' NEAR-DEATH EXPERIENCES

During each interview, participants were asked if they would like to describe their NDE. All participants chose to share at least a portion of the NDE, often the aspects that were most meaningful. Despite the fact that an average of 21 years had elapsed since their NDEs, the majority of participants stated they had no difficulty remembering the event. NDE imagery was also discussed in the context of specific questions. For example, aspects of Dana's NDE specifically related to health. She discussed how this influenced her health maintenance behaviors following the NDE.

It may be helpful to give a context for the data presented in Chapter 5 as the near-death experience may not be "typical" knowledge. This chapter will briefly introduce participants in the order in which they were interviewed, and describe the event that precipitating their NDEs. Then common elements of participants' near-death experiences will be discussed. To further illustrate what the NDE was like for participants, two exemplars will be used to relate the sequence of events encountered during an NDE.

#### Participants

Sonja was a vivacious 43 year-old, referred by a mutual friend. She was a holistic health practitioner, healer, certified hypnotherapist, and certified

massage therapist. Her NDE occurred at age 28. Early one morning, fifteen years prior to the interview, she fell asleep while driving from Los Angeles to San Diego. Her car went over an embankment, rolled over once, and landed upright. Sonja related that her head hit the steering wheel and possibly the windshield; she did not have seatbelts in the car. Another motorist stopped and called for help.

Jaime, an exuberant 73 year-old retired naval officer, was referred by a mutual friend. He had his second myocardial infarction at age 53 while visiting his father at a local hospital. As he was sitting in a waiting area, he began to have chest pain. As he was in visual range of the nurses' station, help was immediately available when he subsequently collapsed. He was taken to the Emergency Department (E. D.) and resuscitated. He later required a six-vessel bypass graft.

Sherry, an intense, thoughtful woman, aged 37, was referred by a mutual acquaintance. Sherry began having asthma symptoms as a child. For most of her life, she had been able to control her symptoms with an occasional use of an inhaler or breathing treatment. Three years prior to the interview, and a year after moving from California to Texas to care for her ailing mother, she began having increasingly severe asthma attacks. During one episode she was intubated for several days until her respiratory status could be stabilized. She remembered being out of her body for the first time, "watching myself with all these people coming around talking to me and figuring out what to do." Two months after this hospitalization, Sherry had an

asthma attack that did not respond to aggressive home treatment.

Fortunately, her mother found her soon after she collapsed and called the paramedics. During transport to the hospital she had a cardiac arrest and was resuscitated. At the time of her telephonic interview, Sherry and her son had moved to a different state and she was supporting her son on income from social security disability. She spent three half days a week volunteering at her son's high school.

Grace, a 45 year-old nurse manger at a large medical center, was a friendly, soft-spoken woman who was quick to smile. The researcher met her in a CPR class. This area of mutual interest was discovered while discussing dissertation topics. Grace spoke of having been raped by several neighborhood acquaintances in the garage of their home. At one point during the assault, one of her attackers used a garden hose in an attempt to strangle her. She was eventually able to evade her attackers and return home. At the time of the interview, Grace was completing the requirements for a doctorate in psychology, with the goal of assisting other victims of violence.

Dawn, also a nurse manager at a large medical center, was an energetic 56 year-old woman referred by another participant. Dawn had a tubal ligation immediately following the birth of her second child. While in the Post Anesthesia Care Unit, she began to hemorrhage.

"[I] started, like bleeding, having severe pain. And then the. I was a critical care nurse at the time; I was 28 years old. And the nurse in the

Recovery Room said, 'We need to call the doctor because her blood pressure is 60/40. And I said, 'Oh, shit.'"

Dawn stated her NDE occurred during this hemorrhagic episode.

Rivkah, one of several IANDS chapter leaders contacted by the researcher, was a thoughtful and articulate 52 year-old woman. At the time of the interview, she had recently retired from the federal government after working for many years as a computer analyst. At age 20, she sustained a skull fracture and extensive skin injuries to one side of her face as the result of a motorcycle accident. Upon discharge from the hospital, and despite intense pain, her physician told her, "We can't prescribe anything [more than aspirin] for your pain because it would be addictive." She related that two weeks following discharge, she felt unable to cope with the situation any longer. She,

"threw myself down on the bed" and told God, "I can't take this; I can't go on.' And it was just like from the heart of my soul. I was just so desperate. It was just so horrible. And that was what triggered it; it was this prayer."

The fact that NDEs occur to individuals not physiologically near death has been documented in the research (Stevenson, Cook, & McClean-Rice, 1989; Owens, Cook, & Stevenson, 1990; Gabbard, Twemlow, and Jones, 1981). Researchers have speculated that the belief that one is near death, versus physiological proximity to death, could be the precipitating factor.

Laura, a 53 year-old nurse clinical specialist, responded to an e-mail on the listserv of her healthcare facility. During the telephonic interview, her answers were generally brief and to the point. Her description of the precipitating event was, "Basically, I was in nurse's training and I had a seizure that lasted close to five minutes."

Amy, 61 years old, faculty at a Southern California nursing program, also responded to an e-mail on a listserv. She was 21 years old when she had "grand mal seizures that they couldn't get stopped." Despite negative tests, she had an exploratory craniotomy to rule out a brain tumor. Following that procedure, she was in a coma for several months.

Joe's wife responded to an ad on the IANDS website. After several unsuccessful attempts, due to required overtime on his job, Joe was finally interviewed by phone. 36 years old, he was an earnest, soft-spoken, and thoughtful speaker, pausing after each question before answering. When he was 19 years old, Joe had surgery around his right eye for a rare form of cancer. While in the Intensive Care Unit following surgery, he had three cardiac arrests. He was unable to give the causative factor for the arrests. At the time of the interview, he worked as a Building Engineer and was raising a family.

Kim, a 50 year-old nurse, contacted the researcher after reading an e-mail on her facility's listserv. She was interviewed by telephone, at her request, due to the frequent travel required by her position. While she was thoughtful and serious, there was a lightness to her speech. Kim related a



history of “chronic, severe asthmatic...since first grade.” At age 21 she had a two month episode of persistent coughing, which she later learned was due to an untreated pneumonia. One evening she began having respiratory distress and was taken to the E. D. A short time later she required resuscitation, intubation, and admission to the Intensive Care Unit.

Skip, an intensely social and personable man, was referred by a mutual friend. At the time of the interview, he was a 59 year-old retired pilot and avid sailor, often sailing his large sailboat. Five years earlier, while walking from the airline terminal to a crew shuttle area, he was hit by a 30-ton fork-lift and dragged across a section of concrete. Due to weather conditions, he could not be evacuated by helicopter. When the paramedics arrived, he was removed from beneath the forklift. His hospital course included resuscitation following a cardiac arrest, a two-month coma, and extensive treatment for burn-type injuries.

Dana, a 46 year-old secretary, was interviewed by telephone. She contacted the researcher after hearing of the study from an IANDS chapter leader. She was a steady and insightful speaker with a good sense of humor. Dana described a history of asthma, typically controlled by inhalers. One evening, nine years previously, her inhalers had been unable to relieve her asthma symptoms. Her father called paramedics, who arrived shortly after she collapsed. During her early hospitalization, she had a cardiopulmonary arrest and required intubation.

Salty, a multi-talented 59 year-old, read about the study in the IANDS newsletter, "Vital Signs." Currently an office manager, he had been a business owner; computer programmer, systems analyst, and marketing representative for several multi-national corporations; and yoga teacher. During his telephonic interview, he related that at age 25, while driving home from work, he swerved to avoid an on-coming car. After hitting the curb, his car went off the road and hit a tree. Residents of nearby homes heard the noise and called 9-1-1. Salty stated he was comatose for two weeks following his resuscitation and surgery for a perforated bowel.

Dolly, a flamboyant 70 year-old, learned of this study through an IANDS chapter leader. She spoke easily and at length about her NDE and subsequent events. She related that her NDE occurred during an illness shortly following the birth of her child. She described a period during which she felt very ill and had daily high fevers. Physicians were unable to diagnose the problem. The problem resolved after several months of various antibiotics. During a later surgery, evidence of a previously ruptured appendix was found. The surgeon speculated that this had been the source of her illness.

Par, a 69 year-old homemaker, contacted the researcher by e-mail after reading of the research project in the IANDS newsletter, "Vital Signs." During her telephone interview, she was upbeat but serious about her experiences. Par stated she had a tubal ligation one week after the birth of her child. The morning following that surgery, "I threw a massive pulmonary embolus," resulting in a lengthy resuscitation effort. She later learned that a

fairly new drug she needed, coumadin, was flown from New York to a nearby city and then brought to the hospital by state police.

Luma, a frank, cheerful, and enthusiastic 64 year-old was referred by a mutual friend. Luma was a retired elementary school teacher and healer, having trained with a curandera as a child and again as an adult. While taking classes for her master's degree, Luma was hospitalized with pneumonia. During a respiratory treatment, she suffered a cardiopulmonary arrest as the result of a pulmonary embolus. She related that she was actually pronounced dead and her body draped with a sheet, awaiting transfer to the morgue. As a technician was cleaning the room in which her body had been placed, she coughed. She remembered that "the doctors and nurses all started flying in."

Sandy, one of two participants from the U. K., was a 40 year-old nurse who learned of this research from the IANDS website. He was interviewed by e-mail at his request. Sandy was an avid hiker with many years experience. Sixteen years earlier, while hiking in Europe, he became lost in inclement weather conditions. Unable to find shelter, he perched on a ledge just below the main path. As the ambient temperature became colder, "I used all I'd been taught and techniques I'd learned to try and reduce the rate of heat loss." A few hours later he had stopped shivering, was unable to feel his extremities, and was drifting in and out of sleep. He stated it was at this point that he experienced his NDE. A number of hours later the weather cleared and he was able to find his way off the mountain.

Tabitha, a 36 year-old Physician's Assistant, learned of the study through a mutual friend. She was an outgoing woman with a bubbly personality. At the time of the interview, she was unable to work full-time due to health problems. Five years previously, Tabitha drove to the hospital after her heart began racing. While in the E. D., she had a cardiac arrest as the result of an arrhythmia that was attributed to an electrolyte imbalance. Approximately one year later, she again had a cardiac arrest in a local E. D. After this episode, she was diagnosed with Torsade de Pointes and placed on the appropriate medication. She stated that her NDE occurred during the latter episode.

Sweetie, a vivacious 57 year-old chiropractor, was referred by another participant. She mentioned having an NDE at age 20 as the result of a car accident. "I was like hurled into the stars, into the light, and then which [sound] back, backwards." She said the experience was quite brief. The NDE she spoke of during the interview occurred when she was 50 years old. While visiting a friend in Hawaii, she had a prolonged period of submersion when she became trapped in a tidal pool.

Rachel, also from the U. K., contacted the researcher via e-mail after learning of the study on the IANDS website. The interview was via e-mail, at her request. She was unable to complete the interview due to complications of a recent surgery. A 45 year-old nurse, Rachel was also a doctoral student at the time of interview. She wrote that following the birth of her stillborn daughter thirteen years earlier, she had experienced "quite a lot of internal

damage.” She stated the NDE occurred in the Intensive Care Unit when the monitor readings “were low and things really looked bad.”

When describing their NDEs, participants typically began by describing what it was like to move out of, or suddenly realize they were no longer in their physical bodies. They then spoke of what they saw, heard, and felt as the NDE progressed. The following section summarizes this information.

#### *Summary of Participant's NDEs*

Although participants related a wide variety of imagery and events, their NDEs were consistent with those described in the literature. While each NDE was different, participants typically described being thrust out of their physical bodies or suddenly realizing they were no longer in their bodies. The latter realization came when they realized they were looking at their physical body from an external point of view. While out of body, they often observed events taking place in the physical environment, such as the activity of the resuscitation team. They related feeling peaceful, calm, and free of pain while out of their bodies. Only two individuals described “hearing” sounds although most reported noticing that people in the physical environment were conversing.

Being out of body was an ontological dilemma for some participants. Salty's description was representative of other participants' narratives:

I was looking down, almost like a second story balcony, at this car crashed into a tree, smoke coming out from under the hood, people running out of the house. And I'm looking at this saying, 'Well, it looks

like my car.' And I focused clearly and I saw this body slumped over the steering wheel. And I thought, 'That's my body. If that's my body then who am I?'

Half of participants described entering or traveling through a tunnel, void, or black space to a place with imagery such as a garden, flowers, buildings, stars, or the earth. The majority of experiencers described seeing or sensing other entities, variously described as a) light beings, b) spirits, c) angels, d) relatives, e) an androgynous form, f) The One, g) Jesus, h) God, i) a white light, and j) hooded figures. Many experiencers spoke of a life review or being given the opportunity to ask questions of one or more entities.

Four experiencers described choosing to return to the physical body. The decision to return was typically to remain with loved ones. Jaime stated:

I'm on the fifth floor and I'm seeing me from [pause] 40 feet up in the air. And so I'm going. And it was a nice; it was comfortable. And it was. The pain was gone and there was maybe a light...I was going down like a tunnel or something. And all of the sudden I thought, "Oh, my god, I can't go. Darlene [his wife]. You know, my dad dying and so on. And somehow, superman [laughing], I. And somehow or another I got turned around.

Other experiencers were either told it was not their time to die or returned to their physical bodies without their permission.

Seven experiencers related having more than one NDE. Joe, Dolly, and Par stated they had three NDEs; the latter two had their first NDEs as

toddlers. Tabitha, Sweetie, Salty, and Luma had two NDEs during adulthood. While Joe and Tabitha described the same imagery each time, Dolly, Par, Salty, and Luma stated each NDE had different imagery.

An aspect not reported in the literature was discussion of stages of death. Luma related this conversation with a being she called the Christ-consciousness:

“When this person came I said, ‘Am I dead?’ They said you’re in-between; you’re dead but you’re not dead, dead. And I never thought of dying in states. And they said, ‘you are what they call on earth clinically dead, but your soul is here with us and a decision has to be made.”

Joe also spoke of being in a large tunnel. Movement toward the end of the tunnel increased in speed as his experience progressed. He described this change in movement as “another stage of, I guess, death” and felt that reaching the end of the tunnel would mean that he had reached the final stage of death. Joe reported he had no control over his movement through the tunnel.

### *Exemplars*

Similar to previous research findings, the “depth,” or number and type of elements encountered during the NDE, varied considerably among participants. To illustrate the range of events and imagery described by participants, two exemplars will be given, one with fewer elements and one

with more elements. Both are representative of the NDEs related by other participants.

Jaime's NDE was an exemplar of a NDE with fewer elements. Jaime was visiting his father at a local hospital. This narrative begins while he is in his father's room. His father had been diagnosed with heart failure and was short of breath due to pulmonary edema. As he was watching physicians perform a thoracentesis on his father,

Jaime: "the old elephant stepped in my chest [each word enunciated separately]. And I'd had a heart attack back in, a subendo myocardial infarction in '78. And so I recognized that it was a problem and so I excused myself."

As Jaime related the following, he "drew" a map on his dining room table with his finger to designate the physical relationship of the different areas he was speaking about.

Jaime: The nurse's station was here and straight across from the nurse's station, all these elevators were here. And so I came out of his room, went by the nurse's station, and went over there [pointing to an area just past the elevators]... And, well, I popped a nitroglycerine.

S: Uh-huh

Jaime: And they. If I remember correctly, they said, 'take one and if it doesn't do anything in a couple of three minutes, or five, some period of time, take another one'. And nothing, really, you know, other than, nothing helped. And some guy came in; he saved my life. He came in



and he said, 'You mind if I smoke?' And I said, 'I don't care if you smoke or not.' And I turned around and walked out. And there was a waiting room with just a chair in it. You know, maybe 50 feet from the nurse's station. The chair was facing right at the nurse's station. So I had taken a second nitro by then and I sat down. It was just like that [pointing to a dining room chair], it was an armchair. And I was in terrible pain, really painful. Hurting. It was no longer elephants, this was pain. And all of the sudden the pain was gone. And I was. I'm on the fifth floor and I'm seeing me from 40 feet up in the air. And I'm going, and it was nice, it was comfortable. And it was. The pain was gone and there was maybe a light. You know, I don't recall exactly, but I was going down like a tunnel or something. And all of the sudden I thought, 'Oh, my God, I can't go. Connie. You know, my dad dying, and so on. And somehow, Superman [laughing somewhat wryly], and somehow or another I got turned around. And as I'm turned around and coming back to the body, I guess, I can see the nurse way over there, 50 feet or whatever, at the nurse's station. And she's looking. I mean, you know, I see the top of her head, I don't see her face. And she's coming toward me, toward my body. And now I'm rushing like crazy to try to get back there before she gets there. And I made it. Because I remember I can see her tapping my hand like that [tapping on the table] from up there somewhere, [voice becoming softer] and I know I've got to hurry. [Voice strong] It was an urgency to

get back, is what I'm trying to explain. And she's talking but I couldn't feel her. You know, I mean, I can see she was doing it to me but I wasn't there yet.

S: Uh-huh.

Jaime: And she came running back with a wheelchair. And so she's going to take me down to Urgent Care, or whatever. Emergency, I guess. And so I'm going down there. I told her I'm in myself again; I'm back. That's how, that's what I refer to it; I'm back. And I said, 'Would you please call my wife and be sure to tell her that it's her husband because she's expecting my dad to die, or to have a heart attack of some other thing....And the next thing I recall is they got me down in the thing and they're shooting stuff straight into my heart, and that kind of thing. And then three or four more days they have me on the back side of intensive care because they figured I was going to die over there.

During his first three days in intensive care, Jaime said he was not allowed visitors, even immediate family members. He did remember "they had a nurse sitting there the whole time." After three days, "they brought me around [to the] the front side [brief laugh]. I'm going to make it."

An example of a deeper experience, or one with more elements, was Luma's NDE. At the time of the event, Luma was working as a teacher and attending her graduate classes in the evening. She had been hospitalized for "respiratory problems" and diagnosed with pneumonia.

Luma: I remember one day after the inhalation therapist came, I was feeling very funny. And then there was a sharp pain in my chest, and I went [sharp, deep inhalation], you know, took, took a deep breath. And then it was as if my whole body were floating in light. I was surrounded by this light. And I realized that I was light, or, you know, was surrounded by this light, and I was moving on. Because when I looked down, I could see me

S: Uh-huh.

Luma: lying in the bed. And they were fussing and doing this, and bells were going off, you know, all that kind of stuff. But it was. But then over in one corner of the room I saw this swirling, like a tunnel. And there was this brilliant, gorgeous light. Now I could still. It still felt like me, but I knew something very different was happening. And there was a tremendous calm. And I remember, you know, intuiting, you know, I was supposed to go through the light. And I did with the greatest of ease. I wasn't frightened, I wasn't anything. It just seemed like a natural, normal thing to do.

As Luma moved through what she called the "tunnel," she said a "light" put a hand around her wrist and told her not to be afraid. As she reached the end of the tunnel,

Luma: I could start to hear, um, like water, waterfall, music, people talking and everything. And I said "where are we?" Well, we went, and, and she said, "you have a decision to make". You're perfectly safe,

you're fine. And we landed in this, it was, was like a garden, but not a garden. And there were buildings over to one side. And they let me stay in the garden: "you rest for a while and we'll come back and get you". Well, I went it. They came back and got me and I went into this building. And at the same time, I knew I wasn't alive anymore. I just knew. And I would look like back over my shoulder. I would still see far, far, far, far away, my body, you know, my me lying in the bed [laughing]. I'm saying "this is very weird".

Luma was told she needed to make a decision whether to stay or return to her physical body. She was told this decision was

Luma: "totally your choice." So, then we go into this room. In this room I see my grandmothers, I see people that I know. I, thought it was a reunion. And then I knew I was not in human form anymore because they were dead. And, and it was a sensation of like, "oh, I really am dead" [laughing]. It was a funny feeling. But very peaceful and everything, and it was like this energy was floating around in my body but it was very calming. And it was like, like helping me adjust to what was going on. So, I'm in this room, I'm kissing and hugging everybody, and so forth. And then this magnificent being that was a male and a female came into the room. And then [pause], what I call Jesus is not what [pause], the energy of Christ consciousness.

S: Uh-huh

Luma: I was very much aware. And greeted me very lovingly and everything else. And he says, "here, come sit down with us". And I drank this. Well the best I can describe it, it was like a cup of sparkling, dancing life, energy, whatever you want to call it. And, and we are sipping and he said, um, you know, "how do you feel that you've done with your life. You've done very well." And it was like he was helping me review. And, and we were also, you know, talking to my lost. Because I was so glad. And I didn't want my grandmother to go away from me. Because it was feeling a little bit different in my body, energy, etheric, whatever you want to call it.

Luma said her decision options were clearly explained to her by this entity.

Luma: So then I'm, I'm being pulled very hard by my grandma because I had really missed her. And my grandma gave me a kiss, and she gave me a kiss on the third eye. And it was "whoa" it was just like this electric current through, went through me in a way. And, uh, she says, "go, be quiet. And I will always love you and always be with you. Make up your mind." And so I go back to the garden and I talk. And this Christ-consciousness being, or, I, I felt that it was Jesus, but, you know. He came and found me in the garden and talked and, you know, uh, a beautiful, you what was planned for the cosmos and, you know, different things. And what was going to be happening and not be afraid and so forth. And that I went back, certain gifts would be sharpened up, you know, but the choice was fully mine. And I said, "I hate the

separation, I'd like to be with my grandma." You know, and, the being said, "you're never separated. That's the illusion of earth." Illusion of earth? He said, "you can reach out and you can feel us at any time you want if you just believe that this, your physical form, isn't the reality of what is your energy." Well, that was a jolt. And I said, "really?" He said, "all things." And so he was showing me how the garden, you know. I saw flowers, I saw this, and I saw that. And then he moved his hand and you could just feel this dancing energy. And then he says "and look at me" and there was dancing energy, you know, energy. Just energy and light. And there were tones to it. And I was completely. So then I to, by the waterfall and, and got very quiet. I remember being very quiet, feeling very peaceful, and knowing I was in total. It was ok no matter what I chose.

After some consideration, Luma decided to return to her physical body.

Luma: I said "I think I'm going to go, I would like to go back but is it too late for me to go back?" He says, it's never too late. Whoooooua [a loud, sound on the exhale], just this [another sound]. I, I wish I could explain very accurately. It was a radiance in his face, and everything, and then it was like [exhale] going backwards in a tunnel, very quickly, and yet very lovingly. And all this energy, and kind of like a swoosh of a wind.

S: Uh-huh

Luma: And um, coming down closer. And I could see, I was heading for my body [laughing] but my body was all covered up. They

pronounced me dead, and everything else. And then [clap] this. Not a jolt that was disturbing, but a soft, gentle, and, you know, into your body that I was physically aware, and everything else. "I've got to let them know I'm still alive." And somebody was stirring next to me doing something. So it must have, you know, just happened within. And I, I started to cough; I needed to clear my throat or cough. And I said ohhhh [wavering voice], you know, and everything. And this person got all, uh, excited and everything. And the doctors and nurses all started flying in, and, and, and so forth and everything. Well are you. I said just give me a minute, I feel a little strange. Because it was like [pause] whup you were there and then you were here and this energy just hadn't settled down. And, there, there was a split second, "Oh my god I made the wrong [laughter], I made the wrong decision." And but then the more I got, you know, calmer, I guess, and more acclimated to what had happened to my body, I felt refreshed, I felt wonderful. I said I'm fine. Hon, you can't be fine, you've been dead for I don't know how many minutes. And I says well, I'm here. You know, and the doctors were doing this and everything. And then they asked me a whole bombardment of questions, and everything else, because. They said you were clinically dead for more than four minutes.

Luma related that for several days after the experience she had heightened taste and sensitivity to sounds.

While none of the elements described by Jaime and Luma were unique to these experiencers, the order in which they were encountered and how they were described were varied. It was also interesting to note that, similar to Luma, participants were able to visualize their body at will during the NDE, no matter how far they perceived themselves to be from their physical body.

### *Summary*

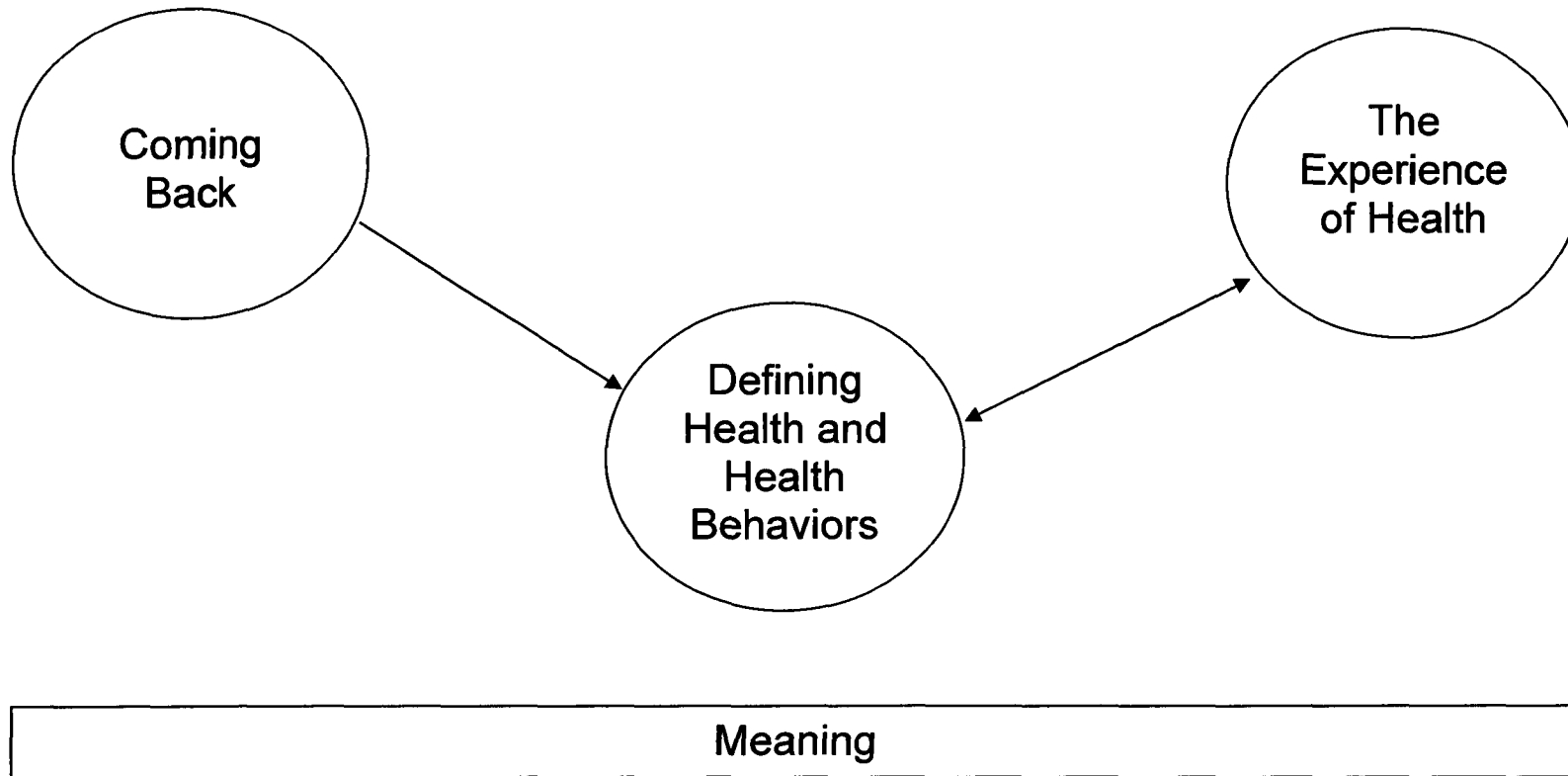
This chapter introduced the twenty participants from this study and spoke of the events which precipitated their NDEs. Precipitating factors included motor vehicle accidents, physical events, such as a myocardial infarction, drowning, hypothermia, and surgery. Key elements of their experiences were summarized. While each NDE was different, the elements described were consistent with NDEs depicted in the literature. Two exemplars representative of participants' NDEs were described in the participant's words to better portray how the experience unfolded and was perceived by the individual.



## CHAPTER 5

### Findings

Participants gave thoughtful, descriptive, and often lengthy answers to questions about the process of defining health and health-related behaviors following their near-death experiences. This chapter presents the grounded theory that emerged from these discussions. The basic social process was one of understanding. Understanding involved making sense of the NDE, gaining knowledge and insight, and applying this information in their everyday lives. They saw themselves as capable of understanding life events and intimately managing their health. Figure 1 outlines the four components of I Still Had to Go Through the Process of Understanding: a) coming back, b) defining health and health behaviors, c) the experience of health, and d) meaning. The category of meaning was not discrete but permeated the other categories. As such, aspects of this category will be addressed as they apply to the actions represented by the other three components. Although the categories are described sequentially, this was not a constant or linear process but a continued negotiation of meaning, understanding, and application. Figure 2 presents the actions/interactions and consequences that comprised this negotiation.



*Figure 1.* I Still Had to Go Through the Process of Understanding. A theoretical model of the process of defining health and health-related behaviors following a near-death experience.

## Coming Back

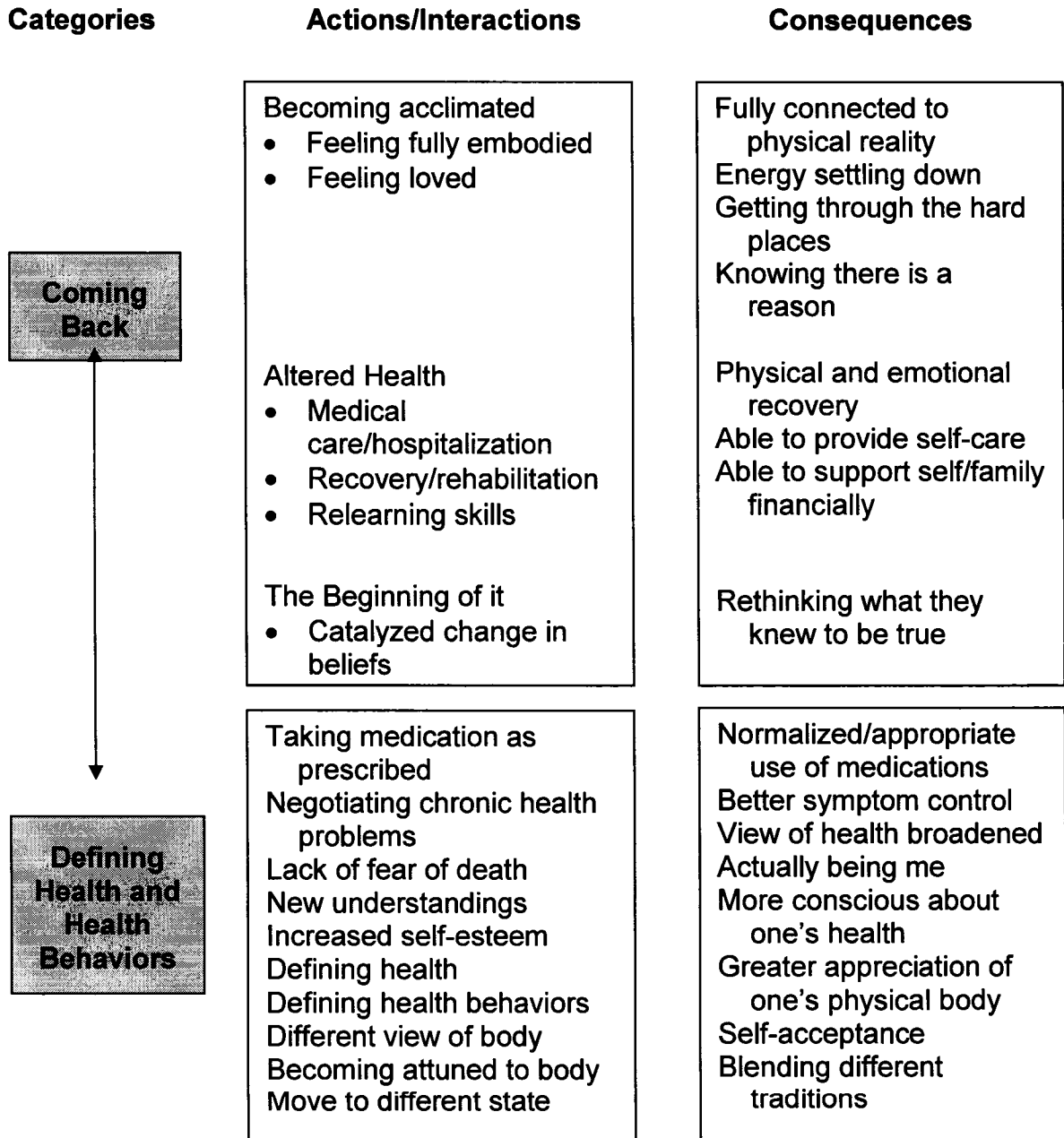
Coming Back began once the individual regained consciousness in her or his physical body following the precipitating event and NDE. Although different in length for each individual, it encompassed coming to terms with the physical, emotional, and spiritual consequences of the precipitating event and the NDE itself. The time it took to negotiate Coming Back was to some extent dependent on the magnitude of the individual's physical and emotional injuries and the time required to reach some level of stabilized health. There were three aspects to coming back: a) Become Acclimated, b) Altered Health, and c) The Beginning of It.

### *Becoming acclimated*

Six participants related that they did not feel fully embodied, or connected to physical reality, for a varied period following the NDE. Jaime stated this lasted for one day and was a source of anxiety for him. He reported being afraid to sleep the night following his NDE due to fear of "taking off again." Becoming acclimated took several days for Luma: "It was like [pause] 'whup' you were there and then you were here, and this energy just hadn't settled down."

Grace, Rivkah, Skip, and Sonya reported this feeling lasted for months. Grace characterized it as a time of feeling "incredibly cherished. Beyond lucky, beyond. I felt so incredibly blessed and so loved." She related that those feelings "helped me get through a lot of the hard places" of her subsequent depression.

**Basic Social Process**  
**I Still Had to Go Through the Process of Learning**



*Figure 2.* First steps in I Still Had to Go Through the Process of Understanding. The process is continued on the next page.

**The Experience of Health**

- Self-management**
- Doing more than 50% of work
  - Understanding health issues not curable
  - Requires help of others
  - Requires time, experience, discipline
  - Co-manage with MD
  - Adjust as needed
- Living Well**
- Understand relationship between beliefs/action
  - Remain open to new ideas
  - Moderation

- Positive attitude**
- Keep going
- Minimize problems
- Enlist support of others
- Know and use resources
- Know when to seek care
- Prevent problems/exacerbations
- Self-care
- Know health you want to create
- Work with health care provider
- Adjust health behaviors based on changes in health status
- Learn from life experiences

**Meaning**

- Finding meaning**
- Seeking knowledge
  - Seeking meaning
  - Validation
- Applying meaning**
- Understand effect of behavior on others
  - Influence of previous beliefs/experiences
  - Meaning of events
  - View of body
- Fluidity of ideas/behaviors

- Knowledge of NDE**
- Understanding meaning of event
- Validation
- Keep S/O informed
- Maintain physical body
- Act on meanings
- Use well-being experienced as benchmark for health
- Understand seriousness of health problems
- Feeling on energetic level
- Understand application of meaning is ongoing

Figure 2. Final steps in I Still Had to Go Through the Process of Understanding.

Rivkah described this period as ecstatic. "The part of me that was back there with the being of light was so much bigger than the part of me that was still in that body." She added,

I was practically being pulled out of my body like all the time. And it was like a, a cosmic orgasm that didn't end. I mean, this went on for months and months that I was in this state of bliss and joy. Um, the other thing, I had this tremendous gift of knowing that there is a reason. That even though we can't see it here, with our limited mind or limited knowledge that, you know, that we're really loved. It is not a random universe; life continues. I mean many. These are just humongous gifts.

Despite faciocranial injuries requiring wet-to-dry dressings, she was pain-free during this time.

Skip was interviewed five years after his accident. He related that for "a year or two" after the NDE, "nothing fazed me." He added:

nothing was important of a physical or here and now nature. It was all. It was just the way it was in that it was unimportant in the real world. The world being larger than the universe. I mean, like I could see things in the future. The further I got away from the accident, the less and less I was open to the energy from the universe. Well see, I've almost re-acclimated.

This was similar to Sonya's description of the year following her NDE and the onset of precognitive episodes. She attributed the latter to the fact that "I may

have been still out of my body somewhat” and stated she had “since gotten control” of them.

### *Altered health*

The majority of participants reported being healthy prior to the NDE. At the time of the precipitating event, eleven participants were in the hospital and one respondent was in an ambulance. Six additional participants received emergency care following the event. Fourteen respondents identified having residual health issues. While a few were able to recover quickly, most stated it was months or years before they were able to fully recover from their physical injuries.

Both Amy and Skip were comatose for several months following the precipitating incident. Amy related,

Well, for the first two or three years I didn't think much about anything except just doing the next indicated thing....This was an hour drive one way, three times a week for speech therapy and occupational therapy and all that. So I really concentrated on relearning everything.

Similar to Amy's experience, Skip was unable to use his hands or arms when he regained consciousness. He related it took a year to regain their use. In addition, he underwent treatment for burn-type injuries, including grafting, partial amputation of a limb, and other surgeries.

Five participants had multiple surgeries following the event. Salty reported the longest period of surgeries at five years. The initial surgery was an intestinal resection to repair abdominal injuries. Over the subsequent

period he had six additional surgeries due to subsequent complications and health problems, such as peritonitis, abscesses, and a pneumothorax. Joe also had multiple surgeries to remove a malignant tumor that threatened his optic nerve.

Tabitha was typical of participants who, while they did not have repeat instances of their precipitating event, took some time to stabilize. She spent approximately a year trying various medication combinations and seeing a number of specialists until it was determined that the cause of her cardiac arrest was the result of an undiagnosed illness intersecting with an electrolyte imbalance.

For some, recovery was physically and emotionally difficult. Sherry spoke of persistent severe asthmatic episodes for several months following her respiratory arrest:

It was so incredibly hard on my body to kick back. And then after that [NDE] happened, I had a succession of seven [severe asthma attacks] in a row; seven within two months. So I never really completely healed before I was hit with the next one.

She later said, "I felt like the machine broke down. And I never planned on that, you know."

While recuperating participants did not report thinking about what health was. Due to the nature of the injuries, their focus was on recovery. Dolly had perhaps the most stark comments about this period. Following the



birth of her child in the early 1950s, Dolly had an infection her physicians were unable to adequately treat.

I could only eat baby food. They kept me on baby food. Because I was in the hospital six months not being given any food and they didn't have intravenous feedings in those days. So when I came back I couldn't even eat more than like 2 tablespoons of anything.

During this time, "I never thought of health at all. I thought of one thing: survival. And if you call that health, that's it." She later added that her goal during that period was to become well enough care for her infant daughter.

#### *The Beginning of It*

Several experiencers reported the NDE catalyzed a change in their beliefs. Sonya stated, "

it was almost as though that NDE was, you know, the beginning of it and then I had to burn off all this stuff, as it were.... It seemed like at that point there was no turning back. But then it was having to go through, you know; hell, I guess you'd call it. Um, and. But where would I turn back to?"

Rivkah "had to look at my whole life and everything I believed in and just start over." Sweetie had a similar description: "I literally had my ideas, my beliefs in reality were changed." She believed her survival was "impossible scientifically....so I had to look at the world in different eyes. That maybe some things were outside of the box of what we consider reality, or I had previously considered reality."

Sweetie, Sonya, and Luma stated the changes were not only in belief systems but also their life work. Sonya said although she knew soon after the event that she could not continue to be a model, she “fought it” for almost a year. During that time she had many experiences she believed guided her and prepared her for her life’s work. Luma, in graduate school at the time, changed her educational focus after “something dormant in me woke up.” As did Sonya, Sandy, and Grace, Luma believed this awakening accelerated her spiritual development.

### Meaning

Meaning was addressed by all participants and the search for meaning often began in the immediate aftermath of the event. Meaning included understanding what the NDE was and what it meant in the participant’s life. Two participants had prior knowledge of NDEs. Dolly had often been told stories about her father’s NDE and Luma, who trained with her curandera grandmother during childhood, was familiar with out-of-body experiences. For others the ease of finding information depended on when the NDE occurred.

Finding information was more difficult if the NDE occurred before media attention was focused on the topic. Par said she

talked to anyone I could find to talk to. I would bring this subject up, probably at inappropriate times, but I wanted to ask anybody that I thought may know anything about this, anything they could tell me. I just had this real bad thirst for knowledge.

It was ten years before her husband heard a radio interview of another experiencer and she was able to contact the International Association of Near-Death Studies for more information.

It was eight years before Amy learned about NDEs.

I was sitting in the beauty shop getting my hair done and reading a magazine....And I picked one up and I started reading about some woman talking about how she had fallen down a tunnel, gone through a tunnel, and she called it a near-death experience. And I went, 'oh my gosh, that's what I did.' Because I had not even told my husband about that. I just thought he would think I was crazy. And here I am reading about it in the beauty shop, fascinated. And everything she was writing about was very similar to what I had experienced but I just didn't know what it was.

She told her husband and they "talked about it a bit, and then we didn't talk about it anymore."

Salty's curiosity led him to seek information early in his recovery. "After the wreck I came back and I tried to talk to people about 'I had this experience.'" He did not believe his physicians when they told him "Oh, it was probably drug-induced hallucinations." He explored multiple sources of information, both secular and religious, before he was able to "come to an understanding of what's it all about."

In contrast, participants with NDEs that occurred after Moody's book was published reported finding it relatively easy to obtain information. At least

seven participants were able to find print media on the subject in a library or local book store or encountered knowledgeable others in their community, such as nurses. The International Association of Near-Death Studies website or local groups was also a source of information for several participants.

Although none of participants reported doubting the event occurred, fifteen participants spoke of disclosing the event to others, often in the immediate aftermath of the experience. Disclosure served to assure the experiencer of her/his sanity and legitimize the event. As Joe stated, "I'm not in question but my mind is." Although his ex-wife "thought I was nuts," his primary nurse "basically believed a lot of what I said...because when her grandmother passed away, she gave the same vision that I gave her." Experiencers told nurses, physicians, family members or selected friends of the event. Three participants reported negative experiences with their first disclosure, one from a physician. Another three experiencers related either positive or "neutral" responses from their physicians. An example of both positive and negative experiences was that of Par. When she told her primary care provider about the experience, she was referred to a psychiatrist. Fortunately the psychiatrist was aware of NDE research and was able to validate her sanity. Neutral responses were described as acknowledgement of the event without willingness to discuss it further.

Two experiencers credited nurses in the Emergency Department and Intensive Care Unit with allaying their fears by telling them the experience was normal. Immediately following her NDE Dana was on a ventilator, unable

to speak. An ICU nurse spoke to her about the possibility of having an NDE during her respiratory crisis. "I didn't realize until that time [nine months later] what a gift this woman had given me within minutes of, probably not minutes, probably within hours of waking up." A number of participants related obtaining copies of their medical records and "my flat line" to "prove" they had been clinically dead.

Once participants had some understanding of the NDE, they considered what the NDE meant in their lives. Meaning was attributed to both the event itself and to what they saw or experienced during the NDE. For example, Kim knew the larger meaning of her NDE soon after the event. As stated earlier, it was eight years before Amy learned what the NDE was and it was another seven years before she believed she understood its meaning. Four experiencers believed the NDE represented a "wake-up call" or "second chance." And approximately one-fourth of experiencers stated understanding the implications of the NDE would be a life-long process.

As respondents' health became stabilized, they felt fully embodied, and had some understanding of the NDE, participants began considering conceptual ideas of health and what was needed to achieve health. The next section describes that dimension of the process.

### Defining Health and Health Behaviors

Participants thought about what it meant to be healthy and the health behaviors required to attain or maintain health as defined. This typically occurred in the context of learning to live with new or chronic health problems.

Thinking and doing had a rhythm for each person. Respondents spoke of three different temporal trajectories: a) the immediate aftermath, b) a combination of intervals, and c) over time. This section will discuss the characteristics of each trajectory.

### *The Immediate Aftermath*

Dana was the only individual who believed the topic of health was addressed during her NDE. “I don’t know that it was like a specific thing, like I was sat down and told, ‘Now look, you’re going to have to do this. But it was [addressed].” She said “an innate knowing” of what was right for her and “doing what I’m supposed to do” came out of the NDE

An example was her use of inhalers. Dana reported hating to take medications prior to the NDE, even though she knew she had a potentially life-threatening disease. Despite this feeling, she characterized herself as being “addicted” to her inhalers. Instead of using Proventil four times daily as ordered, “I was taking it like four times that were in 10 minutes.” From the NDE she learned that taking medication did not “equate with the loss of control.” “When I woke up I knew that this [taking medication] was something I had to do.” Within “days” of the NDE she was able to normalize her inhaler use and has not had a subsequent asthma attack.

The majority of participants reported they no longer feared death following the NDE. For Grace, this led to a “view of health [that] is now broadened to include illness.”

...now that I knew what death was about, my whole idea of 'Oh my goodness, I've got a pain.'...Because always underneath the idea of sickness is the 'oh ho, it could be.' You know, my headache could really be a brain tumor. My, you know, that sort of disasterizing you can so easily do. Which therefore puts a lot of fear around the whole sickness thing. The difference now is...because my view of sickness is now so different, it was then, even especially immediately afterwards, then I guess you could say then by inference that my idea of health is different. I was a lot more accepting of whatever illnesses would come my way.

Grace and three other participants stated their lack of fear of death might also temper what they would do to prolong their lives. Rivkah explained that although many people go to "extraordinary measures to save lives," she believed "we are just here visiting." "I want to get the best life and health that I can for the time that I have, but I have no desire to prolong it." An outcome of her belief was completion of a Durable Power of Attorney for Healthcare, as soon as it was available, because "I didn't ever want to be hooked up to machines."

Joe related two changes following his NDE. The first was a change in his spiritual conception of health:

I was raised in a Christian family and for years I felt like I was pushed into it. And now that I've had this experience, I don't feel like I need to attend to church every single Sunday. Because I have my belief that

what I had was close enough for me to believe that I know who my God is. I don't need to go to church.

He also related change health behavior based on a different level of self-esteem. Prior to the NDE he had been "in the gym for 8 hours" to prove to "everybody else that I could be better and bigger than my older brothers." Afterwards, he reported not feeling "like I need to be somebody else, that I'm actually being me."

#### *Combination of Intervals*

Most participant discussions were reflective of this trajectory. This was a trajectory in which some conceptions changed soon after the event while others changed over a period longer of time, often several years. Following his NDE, Skip understood "we are nothing but pure energy." He reconceptualized health from purely physical to "more of an energy issue, ah, a spiritual issue, an emotional issue than a physical issue," and "physical, the perception of how healthy you are is mental." When asked when that occurred he stated, "well I've kind of been on the edge of thinking that. That as a result of this accident there's no doubt in my mind. Ah, and after watching people in rehab." He related that until his rehabilitation

I did not have a clue as to what extent the mental process and the mental and cognitive, um, consciousness had to do with that [health] on a procedural level. Step by step we have to do this or we have to do this. And I have to follow the best procedures in order to get well. It's



the spiritual/emotional level that underlies that...maybe even changes the chemistry of what goes on in your body.

He continued to learn health behaviors during the months of rehabilitation.

Prior to her NDE Sonja described an unhealthy lifestyle while working as a model.

I wasn't bulimic or anything like that, but I feel that I was borderline anorexia. I was constantly starving myself. I was constantly suffering from headaches, constantly going to doctors to find out what's wrong with me. I had a strange anemia.

She said three ideas changed following the accident. First, soon after the event she became "more conscious about my health." She attributed this to her "feeling about getting a second chance." After the NDE "it was like, ok, we are going to be healthy, we are going to diet, we are going to, you know. We come first." The result was the ability "to be happy at 130 [pounds]." Second, and concomitant to the first change, her understanding that "everything is energy" gave her "a greater appreciation of the physical body and not to abuse it." The third change, which occurred over a number of months, was an acceptance of self.

At that point something triggered where I no longer cared what other people thought of me. I no longer tried to please other people. I no longer felt that I had to live up to. Screw all the others.

She said this last belief was "very scary because I was all by myself" and she feared losing her circle of friends. Within several months, "Strangely enough,

people started gravitating towards me” that shared her new beliefs and lifestyle. Sonja related that over several years she also learned to trust her internal guidance regarding what health behaviors were beneficial.

A slightly different perspective was given by Luma. During childhood she trained with her curandera grandmother in Mexico and later with another well-known curandera in Southern California. As a result of that training, she learned to “go outside my body instead of be in my body and experience in my body.” She later adopted a more traditional Western view of health and believed this was when “kind of a disconnect took place; it wasn’t a balance anymore.” Immediately following the NDE she “knew it on an energetic level....There was an awareness that there had to be a better balance between mind, body, and soul. A huge wake-up call there. And these were things I knew.” She defined this further: “What I’m saying is that it really. Instead of living in different compartments, it was the first time of experiencing my body as an integrated thing.” She related that blending the two traditions “on the practical level” took several years.

Sherry, after a rugged two month recovery period, had to look at how to stop her frequent and severe asthma episodes. It took almost a year to identify that her episodes were due to an allergen common in the state she was residing in. The fact that she was able to only work intermittently impacted her family as she had sole financial responsibility for her son. Once the allergen was known, she made the decision to move to another state that had a less harmful environment and lower cost of living. Although not as

severe or frequent, she continued to have asthma episodes. She learned to avoid triggers and things that would exacerbate an attack. On the advice of her physician, she applied for and was granted permanent disability. One of her realizations during this period, not voiced by other participants, was that aspects of her health were “completely out of my control.”

### *Over Time*

The third trajectory was one in which changes in conceptions occurred over time. Salty characterized his understanding of health as “a whole new relationship” that “evolved over six to seven years.” Prior to the precipitating event, he defined health as freedom from pain. Following the event he defined health as:

Salty: a sense of well-being, the whole sensual change in perspective and perception of my relationship with my body.

S: Can you talk about that a little bit.

Salty: Yeah. Prior to that, of course, I thought I was my body. And it was only by using my body. If anything happened to me, if I get a cold or I had bruises and so forth, it was like I was disabled or at least restricted (unintelligible word). Now I feel like my wellness is an ability to breathe deeply and not feel pain or discomfort, [the] ability to [pause] meet a challenge, to rise to everything.

He later summarized the change as, “the near-death experience opened my mind to the realization that there was more to life than just taking care of my physical self.” “It [the NDE] has molded a lot of who I am today.” Par also said

her view of health was “more or less of a life philosophy since the near-death experience.”

Similar to other participants with chronic health issues, Kim related that over five years she became “more in tune...to when I start to have symptoms,” staying away from triggers, such as people who smoke, and how to effectively treat symptoms when they occurred. Her determination to manage her asthma well was a result of what her physician told her while she was intubated:

She [the physician] had five levels of asthma. And I was at the fifth level so I was ready to go over the end. And I think when she explained all this to me and I realized what had just happened with me, that it made me say, ‘Gee, well you know this really is something serious, this isn’t just asthma that a kid has. And if I’m not careful I can die from it.

Tabitha also learned to be more in tune with her body to decrease the stress that triggered her arrhythmias. She came to understand that health was

a relationship between me and my body. And if it’s a good friendship, if you can use that word, then I’m healthy. And even if I take meds for this and meds for that, I’m still healthy because I’m giving my body what it needs.

She learned to “talk to my body and say, ‘Ok, what are you telling me right now,” seek the support of significant others, and rest when needed.

And although Grace did not report persistent physical problems, she did decide she needed therapy to help her with emotional issues arising from the rape and strangulation.

I went through a period where [pause] it was very, I was very depressed. She But that's a healthy place, to go from empty, like having your emotions frozen, to a place of feeling feelings. And part of that was [pause] that I believe the experience of not feeling alone, the experience of feeling that God was there, that the angels were there, in a very real life here-and-now sense [pause], gave me the courage and the support to go through the pain I had to go through to come out on the other side, to own what had happened.

She reported if it took several years and several types of therapy to "work through" her depression.

### Meaning

Perceptions of health were influenced in multiple ways. For example, Tabitha, Jaime, and Sandy understood their loved ones would suffer if they did not maintain their health and Dolly spoke of childhood beliefs that were influential in how she defined health. Two additional influences identified were meanings attached to the imagery and events during the NDE and the meaning of the precipitating event for the individual. Sandy identified his experience of the NDE as being central to his beliefs. He wrote,

But for me, this is the whole strange thing about my NDE. That I have had such an experience of well-being that felt so indescribable, it

transforms almost all my views, including health. It's really weird, the time I've experienced such a sense of overwhelming well-being and health was when I was 'dead.' I don't understand it and am content to know that I never will...

In a later e-mail he stated his health maintenance behaviors were from "fluid" sources, "the most potent being the NDE."

Several participants encountered "energy" during the NDE. Skip said that after communicating with several entities,

They coalesced into a fist-sized ball of blue-white energy. It wasn't hot and it wasn't cold. There was just blue-white energy. It looked like it was hot as hell. And they just took off.... And what I took home from that, and this may be partly a preconceived belief, but I believed, and I still believe, that we are nothing more than pure energy. That we'll, we'll never die.

The concept of energy became part of his definition of health following the NDE. In another case, Luma recalled being told by the entity she called the Christ-consciousness,

'You're energy.' Well, that was a jolt. And I said, 'Really?' He said, 'all things.'...And then he moved his hand and you could just feel this dancing energy. And then he says, 'And look at me.' And there was dancing energy, you know, energy. Just energy and light.

After this event she spoke of feeling things "on an energetic level."

Jaime said he “paid more attention” to his body following his MI. “I don’t know if it’s because of the out-of-body stuff. It’s just that I know that I can’t survive another heart attack.” Joe’s experiences also influenced his idea of health:

When you have to have someone physically take you to the restroom, brush your teeth, basically have someone run your life for you because you’re not able to, for me to get up in the morning and lay down, that to me, right there, tells me I’m still doing really good.

As this discussion identified, participants used various types of knowledge and experience when conceptualizing health and health behaviors. But once identified, these concepts did not remain static. The next section portrays the dynamic nature of this process.

### The Experience of Health

Participants were interviewed an average of 21 years after the NDE (range, 3-50 years; median 18.5; mode 5, 34). During this period they experienced health: they thought about health, acted on their beliefs through behaviors related to health, had health issues arise, and were exposed to media and other sources of health information. And as Jaime so aptly said, throughout this time “they changed the rules” periodically regarding what was considered to be healthy behaviors. It is within this context that participants discussed their ideas of health and appropriate health behaviors over time. They spoke of two broad aspects: self-management and living well.

### *Self-Management*

Rachel was among participants who identified self-management as the way to achieve a personal sense of well-being. She defined self-management as “not letting the medical team do all the work, self giving 50% (or more), doctor 50%.” Self-management often was difficult in the face of severe health issues. After a number of surgeries, she had been “classified as disabled. The more I do to help myself/improve my life, something else seems to make it a little more difficult. On the whole I try to keep positive and keep going to the best of my ability.”

The idea of self-management was often based on a recognition that “it’s never gonna go away.” Sherry said, “I’m always an asthmatic. They’re not going to be able to cure it. They can treat it, but there are times...you’re going to run into problems. So we’ve minimized the amount of problems.” Self-management was also based on the recognition that managing health issues required the help of others. Kim said, “If my husband wasn’t a nurse, I couldn’t [manage her asthma attacks at home].”

Self-management was a learned skill that took time and discipline to develop. Kim learned to what extent she could treat herself at home before going to the Emergency Department and Tabitha learned how to manage her diabetes. This was based on experience, pharmacological knowledge of medications, and response to home treatment over time. And it required a care provider who was willing to work with the experienter. Kim said her physician “has had to deal with me with things” and knew her well. Sonja



agreed with that saying that she used both nontraditional and allopathic remedies, such as Reiki and routine check-ups. Her primary provider was an allopathic physician “who is also into alternative medicine.” Her method of treating non-urgent problems was to listen to internal guidance and “go to my resource books,” before contacting her physician. “And he’ll say, ‘Ok, Sonja, you know, go ahead and look such and such up.’ So I look up the different remedy or whatever.” “He also respects that fact that I would choose a natural way to do it.”

Self-management behaviors were adjusted as changes in chronic health problems were experienced. Amy discussed making changes as she had new symptoms that required her to spend more time in a prone position. She used this time to grade papers. She also bought a portable jacuzzi to help decrease muscle pain. And part of self-management was knowing when to seek medical or other advice. For non-emergent health issues, Jaime said he would “just give it a chance to get well. And if it doesn’t in a day or two or three, or in a time that I’ve figured out, then I’ll go in.”

Dawn stated she had to learn to “look at all the components” of health. This included limiting physical activities, getting enough rest, remaining stress-free, and being psychologically strong, and taking care of “the inner self and well-being.” She said the inner-self aspect included doing “what Dawn needs to do for Dawn” and the well-being aspect was “positive interactions with people” and “being able to take something negative, turn it into a positive.”

*Living Well*

Living well was both a way of being and doing. While the individual had an understanding of what it mean to live well and what actions were needed to accomplish it, that knowledge was open to change. One example given by participants was a different understanding of the relationship between beliefs and actions and life events following their NDE. Dana learned that “the total picture” was important. She gave the example of “this really crappy job I had taken.” For the first ten months on the job

I was sick. There would be weeks at a time when I couldn't talk or my; I'd be real hoarse or have flu-like symptoms. So it was pretty much the time I was in this job [that] I was sick. Because it wasn't where I was supposed to be. Like that's how things play out for me now....If I do something that would jeopardize my integrity, it comes out as illness for me.

Sweetie said,

We're creating in the invisible at all times. So whatever you're experiencing today, you've already created it. We've already created it. Most of it has to do with things that we're not conscious that we're doing or creating, and we don't. We are not fully aware. I mean, as I live my life day-to-day, I am not in that total awareness all the time of knowing that I am creating my world in the future. But we are, and I know that now. And that has come from that particular experience [NDE].

Ideas of health and health behaviors typically remained, as Sandy called it, “fluid.” Kim attributed this to “maturing and being older and wiser” and Rivkah to life events and interactions with the healthcare system. In a somewhat different vein, Sandy wrote that he took “a pragmatic approach” to health by doing activities in moderation, placing himself in “stimulating situations,” and “maximising my life experiences directed by my Christian faith.” He said his concept of health was “fluid with periods whereby I feel healthier. But those periods – I guess – are relative to my state during the NDE. The closer I come to that ‘state’ the healthier I feel.”

Some participants redefined ideas of health in light of changes in health status. Amy and Dawn were both diagnosed with neuromuscular diseases. As her activity limitations increased, Amy changed her definition of health to include the element of fatigue.

Amy: A good day is having no pain and being able to get out and do things without getting so fatigued that when I get home I have to go to bed.

S: Ok

Amy: So that’s a good day.

S: So it has to do with activity and level of pain.

Amy: Yeah, yeah. And fatigue. Yeah.

Similarly, Dawn added function to her idea of health.

Jaime related that the ineffectiveness of previous health behaviors influenced his current health behavior. When he was told his cholesterol was

quite elevated he “started eating salads and a little of that, you know, the usual low fat diet.”

I still had the dumb heart attack. ‘Well, geez,’ I told him [his physician], I said, ‘This is crap, you know.’ Tell me to quit smoking – I was a smoker. Told me to quit smoking, eat all this rabbit food, and I get the damn, darn thing anyway. I was really angry....And so when I got out of there [hospital], that was it. You know, I just went on about my business. I stayed on the diet somewhat but I didn’t quit smoking.

He said that led him to eat what he wanted but to use moderation as a guide.

### Meaning

Twelve experiencers reported a different view of their physical body following the event. Most identified this was due to the experience of viewing their physical body from a perspective outside the body. While several recognized “the body is just one part of what we are,” one-third of experiencers related this was an ontological dilemma. This is how Salty conveyed it:

And the next moment there was an enormous Bam! [said loudly], like a swinging door hitting you from behind without a word. And I was stunned. And the next thing I knew is I came out of this stunned feeling, I was looking down, almost like a second story balcony, at this car crashed into a tree, smoke coming out from under the hood, people running out of the house. And I’m looking at this saying, ‘Well, it looks like my car.’ And I focused clearly and I saw this body slumped over

the steering wheel and I thought, 'That's my body. If that's my body then who am I?

After describing the rest of his NDE, he was asked,

S: If you saw yourself as not your body, what did that ultimately mean?

Salty: We are so much more than a body or mind. But those are attributes, almost vehicles for experiencing and expressing blessings of the source we come from.

S: How long do you think it took you to get to that point?

Salty: I don't know that I'm there yet [laughing].

S: Ok [laughing with him].

Salty: I'm still learning.

Other participants made comments of a similar nature, most often using the same statement, "I am not my body." While the specific applications varied, they reported the understanding that one had to "maintain our body" and that "when it's our time to go we will go, and if it's not our time we'll be sent back or we just won't go."

### *Summary*

The near-death experience and the health issue precipitating it were unusual and unexpected events which caused participants to think about health. This chapter discussed the grounded theory that was inductively derived from participants' descriptions. Ideas of health and health behaviors began to emerge while coming back, or stabilizing health, becoming acclimated to the physical body, and thinking about the meaning of the

events. Three trajectories of determining new definitions of health and what health behaviors were appropriate were described and the dynamic nature of health beliefs and behavior was discussed. Also addressed was the importance of meaning, both of the precipitating health problem and the NDE, throughout this process. The next chapter addresses findings in relation to the literature and conclusions of the study.

## CHAPTER 6

### Conclusions and Recommendations

A prominent feature of the near-death literature is the aftereffects of an NDE or the degree to which it may pervade the experiencer's life. While three decades of research have documented a number of common changes in beliefs, such as change in attitude about death, and suggested how experiencers may weave the NDE into lives, research has not focused on concepts of health. Therefore, the purpose of this study was to identify how participants negotiated defining health and health-related behaviors following a NDE. Twenty individuals participated in this study, 18 from the United States and two from the United Kingdom. Data were analyzed using the constant comparative method. This chapter provides a theoretical summary, discussion of findings, comparison with the literature, conclusions, study limitations, and recommendations for nursing practice, research, and education.

#### *Theoretical Summary*

Fifteen women and five men participated in this study. Precipitating events for their NDEs varied from cardiac arrest to drowning. Although an average of 21 years (range 3 – 50 years, mode – 5, 29) had elapsed since the NDE, participants stated they had no difficulty remembering the event.

While each participant's account of the NDE differed, the elements, sequence of events, and imagery were consistent with descriptions in the extant literature. Based on participants' accounts, their NDEs had a logical progression or storyline that made sense to the individual. And relating the experience often carried a depth of feeling or emotion one does not get from reading the literature. While some participants stated it was several years before they understood what the NDE was, no one doubted the event occurred.

The process of defining health and health-related behaviors following the NDE was characterized as: I Still Had to Go Through the Process of Learning. This encompassed making sense, gaining understanding, and applying what was learned. As Sutherland (1992) stated, this did not simply happen, it required management, or work. It was an evolutionary interaction of Coming Back, Defining Health and Health-Related Behaviors, the Experience of Health, and Meaning. The process was mediated by factors such as whether the NDE occurred before information on the topic was readily available and the length of recovery from the precipitating event.

Coming Back meant becoming grounded in everyday life, recovery or stabilization of health status, and determining the nature and meaning of the NDE. Fourteen participants had health problems following the NDE, and for at least four participants, the precipitating event began a cascade of increasingly serious health issues. As their health stabilized, only three participants, who had a previous NDE or out-of-body experience, did not spend time "searching



for answers” about the event. At some point they began incorporating the NDE, or what they believed they had learned from the NDE, into their lives.

Defining health and health behaviors often took place in the context of learning to live with new or chronic health issues. Participants described three temporal trajectories of defining health and health behaviors: a) in the immediate aftermath of the NDE, b) both in the immediate aftermath and over time, or c) over time. Most individuals in the first trajectory identified a decreased fear of death following the NDE as the source of their changed definition; their concepts of health were expanded to include illness. Exceptions were one man whose spiritual concept of health changed and one woman’s whose health was addressed during the NDE resulting in “an innate knowing” of how to effectively maintain her health. This was one of the clearest examples of behavior change as a result of imagery during the NDE.

The majority of participants spoke of a second trajectory in which definitions emerged both in the immediate aftermath of the NDE and over a longer period of time. Some individuals, such as Skip, had a broader view of health after the event but also gained knowledge, or refined their views, through interactions with the healthcare system or other life events. Skip verbalized not fully understanding the role of “the mental process” on “a procedural level,” that one’s mental outlook could shape outcomes and possibly change one’s chemistry, until he observed other patients in rehabilitation. Although individuals describing the second trajectory had a “working definition” soon after the NDE, essential understandings had to

emerge before they could fully know what comprised health or healthy behaviors. The last trajectory, in which conceptions of health and health behaviors were defined over time, often occurred in the presence of a lengthy recovery or the adjustment of living with a more debilitating chronic health issue, such as asthma.

The experience of health included thinking about health, acting on beliefs, evaluating the efficacy of those actions, and experiencing new health issues. For half of participants, the experience of health was also a clinical experience, either as a nurse, chiropractor, therapist, or physician assistant. Participants reported Self-Management and Living Well as the two broad categories of work. Self-Management included responsibility for one's health, learning to manage health issues well, and recognizing the relational nature of managing health. The latter acknowledged the need to work with health providers and an understanding that participants could not maintain their health without help from significant others, through both direct intervention and social support. Living Well was an evolutionary and holistic view of health. It was evolutionary in that ideas of wellness often broadened over time. For example, several participants came to understand that life decisions and actions, such as job changes, had health effects, and that current actions would affect future health.

While meaning was addressed by all participants, for some it was a pervasive thread in their conversations about health and health behaviors. The larger concept of meaning addressed aspects such as: a) the NDE as a

life event, b) the precipitating event, c) imagery during the NDE, d) survival, e) chronic health issues, and f) other life events as they related to health and health behaviors. Some participants determined meaning comparatively easily and quickly but for others it was a continued experience of reflection and interpretation. Some indicated they still lacked understanding of the meaning of the NDE or specific aspects of the event.

### *Discussion of the Findings*

Specific aspects of the theory and research process merit further discussion and expansion. This section will address elements embedded in the processes of conducting this research study and theorizing: a) researcher experiences, b) sources of changed definitions, c) the out-of-body experience, and d) comparison with the literature.

#### *Researcher experiences*

NDE researchers have discussed the difficulty of finding research participants due to their fear that the NDE will be viewed negatively (Ring, 1980, Greyson & Bush, 1992). This researcher had similar experiences, one of which was especially frustrating. She had presented information about the study to a group of four experiencers and was listening to their conversation while organizing her papers. One woman said that following her NDE, she understood “on a cellular level that all is one.” The researcher invited the woman to talk about this. The woman briefly commented that health was not just being able to move easily, it was all her cells working together to be healthy. The researcher found this quite tantalizing and was very

disappointed when the woman declined to discuss the topic further or participate in the study. Participants who were interviewed after this conversation did not have the same understanding. It was an eye-opening experience regarding the “underground” information researchers and professionals may not be privy to. And as other researchers have learned, scholarly believability of the NDE as a “real” event or participant’s interpretations of the event are often “up for grabs.” An example of this was when this researcher asked a colleague, an experienced researcher, to give feedback about the study. After reading the information, the colleague asked, “Where did you get these people from?”

#### *Sources of change*

While the theoretical model describes the larger process of defining health and appropriate health behaviors, the sources of change are not as evident. When participants were asked to identify why they changed their definitions of health or health beliefs, they identified three sources: a) chronic health issues, b) the NDE, and c) life experiences. Half of participants identified more than one source of change.

For eight experiencers, the chronic health issues underlying the precipitating event or subsequent chronic health issues were instrumental in reshaping their definitions of health or appropriate health behaviors. For half these participants, the realization that the health problem was potentially lethal was the source of the change. An example was Kim. She denied a change in the severity of her asthma before and after the NDE, but when her

physician told her how close to dying she had been, she realized, “this really is something serious, this isn’t just asthma a kid has. And if I’m not careful, I can die from it.” Sherry, Tabitha, and Jaime voiced similar comments. The other four participants, who identified themselves as healthy prior to the NDE, indicated complications of the precipitating events – childbirth, seizures, and surgery - were the basis for their changed definitions. They had lengthy and sometimes complicated recovery periods and their health issues became chronic in nature. The latter four participants also voiced the belief that additional health problems which began later in life stemmed from the triggering event.

For this group, health resided in the physical body and was closely tied to one’s ability to meet daily obligations and live well with chronic health conditions. Their definitions of health were similar to the role-performance model, or the ability to meet daily responsibilities, and adaptive model, or the ability to adjust to changing environmental needs, identified by Smith (1983). Health-related behaviors were defined as activities which promoted the best level of well-being possible for the individual and prevented an exacerbation or recurrence of specific symptoms, such as fatigue or wheezing.

Ten participants indicated the NDE was the basis for their changed definitions of health and health behaviors. Sandy described the deepest link between the experience of the NDE and ideas of health. During the NDE he had “such an experience of overwhelming well-being and health” that felt “indescribable.” He later defined this well-being as “such a sense of peace,

joy, love (both giving and receiving) and wonder. I think of it as being craddled (sic) by the divine!!!” How close he came to this feeling was the basis for his perceived level of health on a day-to-day basis. Sandy described well-being as having physical, religious, ethical, social, and moral dimensions. Although he believed his definition of appropriate health behaviors to be pragmatic, all stated dimensions were articulated as behaviors. Luma also experienced her body “as an integrated thing” for the first time during her NDE. She described herself as feeling “lighter,” or having greater awareness following the event, and defined awareness as knowing at “an energetic level.” The experience of feeling integrated helped her realize there was not “a real blending and merging” of her body, mind, and spirit. Thus, she redefined health as unity or harmony and balance and redefined health behaviors, in part, as those things that would help her integrate these aspects.

Sandy's and Luma's descriptions were similar to Dossey's (1984) idea of health-as-experience, or the understanding that “there is no such thing as health.”

No-health is not man's (sic) mind in tune with man's body, but man in tune with nature in an undifferentiated wholeness that goes beyond distinctions such as health and illness, birth and death, mind and body. He indicates this is not something sought, such as freedom from disease, but “it includes everything, for it is the ground from which all our convenient referents and standards of health take their meaning.” The latter appeared to be true for both these participants. Sandy and Luma had more fluid definitions

of health than other participants; their definitions continued to evolve, even years after the event.

Grace was an example of participants who identified specific elements as important to their ideas of health. The experience of “feeling intensely loved” gave her the ability to be more present in her life and helped her “thaw” emotionally. This impacted her definitions of appropriate health behaviors and appeared to have broadened her options for healing. And loss of a fear of death expanded her definition of health to include illness. Rivkah also identified the experience of intense love as important to her self-esteem and definitions of appropriate health behaviors. As previously stated, Dana’s treatment of her asthma was specifically addressed in her NDE. Following the NDE she had a new understanding of health and the knowledge of how to effectively manage her asthma. And based on imagery in their NDEs, Skip, Rivkah, and Sweetie identified a new understanding of health as having an energetic component and redefined health as being more than a physical experience.

Par was an example of those who identified the NDE the source of change but did not relate the change to a particular element. Par indicated that following the NDE her concept of health was a “life philosophy,” or had a broader conceptual definition. Salty and Joe also had more global changes in definitions of both health and health behaviors. Sonya indicated that both the feeling of self-acceptance and a belief she was “getting a second chance” were the bases for redefining health behaviors following her NDE.

Definitions of health voiced by these participants had elements of both the role performance and eudaimonistic models of health identified by Smith (1983). Similarities with the latter model included a holistic view of health and a belief that illness was defined by the individual. Participants appeared to have moved beyond the eudaimonistic perspective to view illness as an aspect of health (not different from or opposite of health), health as energetic in nature, and health as residing both in and out of the physical body. For example, unlike the eudemonistic model, participants did not see illness as a roadblock to reaching one's potential. And Sandy's and Luma's discussion of wholeness had more depth than that described by the model.

Half of participants cited the third source of changed definitions of health and health behaviors: life experiences. Skip and Rivkah indicated interactions with the healthcare system led to an understanding that medical ideas of health and appropriate health behaviors were not always consistent with what was best for the individual. Kim was typical of most when she indicated her changed definitions were related to "maturing and being older and wiser." None of these participants identified life experiences as the sole source of changed definitions.

#### *The out-of-body experience*

An aspect of the NDE that was identified as important was the experience of being out-of-body. There is little information in the scholarly literature about out-of-body experiences (OBE). Murray (2005) defined it as the subjective sensation that the phenomenal self is separate in Cartesian space from the



physical self. It has been described as a side effect of seizures or as a dissociative experience. For many participants, the NDE was the first time they were aware of existing outside their physical bodies. The ramifications were twofold. First, 14 of 20 participants indicated they no longer feared death due to the experience of being out-of-body: they identified knowing when their physical body died, they would still exist. Second, 10 individuals related an increased appreciation for their physical bodies as “a house for my soul” and “receptacle to house the spirit.” This was described an understanding they needed to take care of their physical bodies to achieve their life purposes.

These descriptions may be similar to what Maslow (1976) referred to as experiencing ‘the real self’ and Dossey (1984) characterized as being without the “I”. When discussing transcendent experiences, Maslow (1976) spoke of the self-validating insight of “feeling what it is like to feel really oneself” (p. 75). It gave one a sense of unity with the universe and of one’s place in the whole. As a result, the individual might see reality from a new perspective or gestalt. Dossey (1984) wrote about mystics experiencing “a world around them without exhibiting a strong sense of ‘I’. And, moreover, the experience of health *without* a burdensome sense of ‘I’ is *heightened*, not diminished.” This may be an explanation for Sandy’s comment that the healthiest he had ever felt was while he was “dead.”

#### *Comparison With The Literature*

This study supported aspects of defining health found in the literature. While the process by which adults come to their definitions of health has not

been examined, there is agreement that definitions are influenced by many factors, such as culture and life experiences. For example, Luma discussed being exposed to conflicting cultural definitions of health as a child: the medical model in the United States and a nontraditional model in Mexico. Because she lived in America for most of the year the medical model became her definition of health as a young adult. It was only after her NDE that she embraced a definition that shared similarities with the nontraditional model of her childhood in Mexico. The fact that several participants identified their definitions changed with age and life experiences indicates that definitions of health and health behaviors are dynamic rather than static. And while there is scholarly agreement that the concept of good health is socially understood, this study suggested that young adults may not define the particulars of good health or appropriate health behaviors until they no longer have health. This was true of participants who had an NDE in their late teens or early-to-middle twenties. And although the study population was small, definitions of health did not support the literature indicating definitions vary by gender. Male participants defined health and health behaviors similar to female participants. While they may have labeled the specific action differently (dancing instead of yoga), the type of behavior, reasoning for the behavior, and intended outcome was similar.

Participants' stories and the theoretical model were consistent with the literature regarding health beliefs. They verbalized well thought out and logical stories of defining health and health behaviors. As hypothesized, links

between existential, shared, derived, and experiential beliefs were evident and explained as causal relationships for problem solving (Rokeach, 1968). And participants iterated the potency of experiential beliefs in situations where there was an absence of cultural models or when cultural models no longer fit what was experienced. One example was although some participants were unable to find information about the NDE for a number of years, and were aware of the negative social image of this type of event, they never doubted the event occurred or that it was important. They continued to search for information until they understood the event well enough to establish meaning.

### *Conclusions*

This study suggests that defining health and health-related behaviors is a thoughtful process that is open to re-interpretation and re-definition at various points in one's life. While young adults may have knowledge of societal definitions of health and appropriate health behaviors, they may not have articulated their definitions prior to experiencing an episode of altered health or "non-health." In fact, when younger participants were asked if their definitions were different after the NDE, their initial response was often a variation of "I guess I was healthy" rather than a discussion of differences.

Having an serious health issue that brought them close to death and having an NDE precipitated much internal dialogue regarding the concept of health – what it was and how to achieve and maintain it. Even those who did not have residual health problems appeared to have spent considerable time thinking about health. For these participants, the age at the time of the event

had an effect on that thinking: the older the individual at the time of the NDE, the more depth there was to the facets comprising health and the range of possible behaviors to achieve or maintain health. The latter also appeared to be related to one's definition of health. For example, participants with definitions similar to those of role performance or adaptation (Smith, 1983) rarely identified nontraditional health activities or providers as possible sources of help or healing. Those with more eudaimonistic definitions almost always spoke of using multiple sources of healing and multiple types of health providers. When asked specifically, only one of the former group of participants had tried a nontraditional therapy.

Skip's comment that a large part of defining health is mental was supported by this study. The model clearly indicates that many factors are considered when defining health and that thinking about health is a recursive activity. There are many points of entry into the thought process, such as personal experience, health knowledge, interaction with significant others and care providers, and other life experiences. But defining health and health behaviors also has an active component which includes seeking information, determining meaning, and trying different strategies. And there is a suggestion, most specifically based on Sandy's, Skip's, and Luma's discussions, that health may be an unattainable internal idea that is not easily translated into consensual reality.

### *Study Limitations*

There are four limitations to using the findings of this study in other settings or contexts. First, although some participants stated they were not healthy, all identified a goal of being healthy and verbalized they were working toward that goal. As Clark (1998) and others have reported, not all individuals are interested in enhancing their health. This has unknown consequences on how the individual defines health. A second limitation was that study participants were primarily Caucasian, thus may not reflect health definitions and practices of other cultural groups. A third limitation was that all but two participants had physical and financial independence and all participants had access to health care. Individuals without those assets might define health and healthy behaviors quite differently and relate a different path of arriving at that definition. A fourth limitation may have been the lapse of time since the NDE. Although it allowed time for participants to reflect on meanings and ideas, it may also have obscured participant memory regarding significant events and milestones in their emerging definitions. Despite these limitations, the findings from this study have implications for nursing research, practice, and education.

### *Research Recommendations*

Three research recommendations arise from this study. The first is the process of defining health over the lifespan. This study suggests that for some individuals, beliefs about health and health behaviors are dynamic and fluid. While factors influencing definitions of health and health behaviors have

been identified, there is a lack of knowledge about the relative importance of specific factors and ways in which definitions evolve or change over time.

This knowledge will positively impact health promotion.

The second recommendation would be to study different populations, such as cancer survivors or those with chronic progressive illnesses as well as individuals with no identified health issues. Do they define health and health behaviors differently? Do definitions of health change over time in the absence of health issues?

The third potential area for research would be identifying how different economic and cultural groups define health and health behaviors. Individuals in this study had access to healthcare, food, and other items they considered important for their health. As Polakoff and Gregory (2002) identified, individuals living in poverty often lack basic resources, knowledge of where resources can be found, and social support systems to help them attain or maintain health. How does this lack affect definitions of health and health behaviors? And do other cultures define health differently? Is health redefined throughout life based on growth and wisdom or specific life events?

#### *Implications for Education*

This researcher agrees with Oakes (1981), Orne (1992), and Hicks (1995) that nursing knowledge of the NDEs is essential, especially for nurses working in areas that typically care for trauma or unstable patients, such as critical care or the Emergency Department. Experiencers iterate the value of having the NDE validated and being told by a professional that their

experience does not indicate mental illness. In addition, the response to first disclosure often shapes the ease at which the experiencer can speak to significant others about the event. This information should be part of nursing education and textbooks associated with high risk areas.

Another type of essential nursing knowledge is what health is. There are often disparities in how healthcare providers and clients define health and what they consider to be appropriate ways to promote health. This is compounded by the variety of healing modalities available, about which many nurses are uninformed. This study suggests that health behaviors are intimately related to definitions of health. Therefore it is important for nurses be conversant with broad views of health and health enhancing behaviors typically employed by individuals using those definitions.

#### *Implications for Practice*

Pender (1990) stated that as nursing shifted more towards Rogers' view of unitary human being, questioning what the individual's experience and meanings of health were became pertinent disciplinary questions. This has two aspects. First, healthcare providers, including nurses, have traditionally defined what it means to be healthy and what behaviors will achieve health. The results of this study reinforce the need to understand the client's beliefs about health and health behaviors. Nurses must be knowledgeable about health beliefs and practices common to the populations they work with and be able to incorporate the client's choice of health practices into the overall plan of care. In addition nurses must be accepting of novel health practices. Many

healing practices have been “underground” because of provider reactions to their use. Just as the idea of mind-body interaction was foreign to mainstream thinking 30 years ago, the concept of energy work may be a mainstream form of therapy 30 years in the future. And be open to the unknowable experiences that may illuminate the individual’s life.

A final aspect is the knotty issue of the client’s right to direct and refuse care. As evidenced in this study, many patients are intimately in touch with their health and are practiced in maintaining high-level wellness. The study also suggests that what is considered normal treatment for healthcare providers may be considered extensive or untenable by an individual who has different views of health. Belief in client abilities and openness to working with clients are becoming essential nursing attributes.



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Appendix B

UNIVERSITY OF SAN DIEGO

CONSENT FORM

My name is Sue Robertson and I am a doctoral candidate in the College of Nursing at the University of San Diego, San Diego, California. I am interviewing people who have had a near-death experience (NDE) to explore how a NDE affects one's beliefs about health.

If you agree to participate, there will be an initial interview lasting 30-60 minutes and possibly a follow-up interview lasting the same period of time. The interview will be audiotaped and I will make a written transcript of the recording. Transcripts will be assigned a code number for reference; I will be the only person who has access to the master list of names and code numbers. Members of my dissertation committee may review coded transcripts as part of the mentoring process. Audiotapes will be destroyed following completion of my dissertation. I will be happy to give you a copy of your transcript and a summary of the analysis if you so desire.

Participation is voluntary. I will answer questions you may have prior to or during the interview. If you have later concerns or questions, please contact me at 619-659-3969, or my committee chairperson, Jane Georges at 619-260-4566. At any time you may decline to answer questions, ask that the interview be stopped, or decide not to participate in the study. There is no anticipated risk involved with participating in this interview.

There is no agreement, written or verbal, beyond that expressed in this consent form.

I, the undersigned, understand these statements and I agree to voluntarily participate in this research.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Location

\_\_\_\_\_  
Signature of Principle Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## Appendix C

## Research Questions

1. Tell me about your current health.
2. Tell me about your health prior to your NDE.
3. Do you consider yourself to be healthy or unhealthy? Why?
4. What does health mean to you? How do you define health?
5. Is this different than how you would have defined health prior to your NDE?
6. How did this change come about?
7. What types of practitioners have you seen in the past year [if none, two years or three years]?
8. How do you decide which practitioner to see?
9. Do you tell your provider about your NDE? If so, is this important? Why?
10. What do you do to stay healthy?
11. Is this different than what you did prior to your NDE?
12. How did this change come about?
13. How do you decide what you need to do?
14. Is this different than prior to your NDE?
15. Did you view your body differently following your NDE?
16. How did you come to the meaning of your NDE?
17. What does life mean to you following your NDE?

18. Some individuals state they no longer fear death after their NDE.  
Was this true for you? If so, did that affect how you defined health?
19. Does this affect how you view your health?
20. Is there anything else that you would like to tell me that you feel is important?
21. Are there questions I did not ask but should have asked?