Discussion

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ONLY APPROXIMATELY FIVE PERCENT OF individuals who suffer a massive coronary occlusion survive through artificial resuscitation procedures. The authors review some of the literature describing these survivors and report that more than one-third experience a new-found and enduring sudden understanding or insight. The experience often is one of being outside of oneself, observing the frantic scene "below," of light, of vivid review of one's life, and is an ineffable experience of being taken up and held by a gigantic being. The authors have, in addition, interviewed nineteen such individuals, a few of whom have an enduring new-found self-curiosity. To my knowledge, the authors report, for the first time, an instance in which a recovered individual then has sought psychoanalytic treatment. He sought treatment for perhaps the optimal reason: to continue and deepen an experience of intense quest for knowledge, specifically self-knowledge, out of a newly-discovered sense that his pre-cardiac-arrest personality had been encumbered by neurotic illness. This insight, more usually the hard-won result of an effective psychoanalytic treatment, was the motivating factor in seeking analysis. In addition, the authors feel that this patient first grasped the nature of psychoanalytic method during the brush with death.

The literature on death and dying is vast, and yet is remarkable in the relative paucity of attention given to the near-death experi-

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ence (Gabbard *et al,* 1981). Lifton's (1983) extremely thorough and scholarly work, for example, does not mention the phenomenon. However, the authors will find the papers of Noyes (1972) and Noyes and Kletti to confirm many of their observations, and to broaden their data base. Additionally, Noyes and Kletti (1976, 1977) have contributed a scholarly review of earlier writings on the subject of near-death experiences, by Jung, by William James (1982), and by A. Heim, who in 1892 published a study of mountaineers who had experienced nearly fatal falls. I found these latter descriptions comfortingly similar to the account detailed by Raft and Andresen. There are no other accounts, however, as far as I know, of long-term follow-up.

The editor asked me to discuss this paper since I had reported in this journal on my experiences of returning to work while still in the chronic grip of uncertainty regarding my own survival (Silver, 1982). My patients, who for a variety of reasons, had required long-term hospitalization, sensed my dilemma in a very fundamental way, and in various ways rescued me, metaphorically taking me up in their arms. I had not undergone such a near-death experience with such a transformation, although the experience of persistent terror, which very gradually remitted over the years, did change me. I experienced myself as perhaps in my late eighties, with each day as perhaps the last in which I could make the long commute to Chestnut Lodge, seeing the unfolding season for perhaps the last time. As my health became somewhat secure, I then entered my seventies, then my sixties, and so forth, moving back toward my chronologic age, at which I imagine I will arrive in the next five years.

This experience has changed me somewhat in the way the described patients were changed. I have lost my awe of the older generation, since prematurely I had become one of them, and thus have become relatively immune to the disorganizing effects of being spoken to sternly in a parentally disciplining manner. I am no longer apprehensive about displeasing these people in authority, but can more effectively listen to the content of their statements. This seems similar to the authors' description in the first case report, where they quote the patient as having "lost his fearfulness, becoming bold to the point of being, as he put it, 'brazen.' He no longer feared voicing his speculations about scientific problems in his field." Additionally, I am clearer about my per-

sonal motivation for working as I do, and am relatively free of a neurotic need to conform to standards for conformity's sake. But concurrently, I have been in analysis. To credit a physical illness with effecting such personality change would be to discount the intensive work in which my analyst and I have persisted.

The case report stressed the patient's new-found connectedness of mind and body, of feelings and sensations. While I have experienced some such increased integration, I remain astounded that I could have been in such dire straits prior to the diagnosis, without experiencing any hint of morbidity or apprehension. Consciously, I didn't have a clue, although, when I reviewed my diary, I found three descriptions of nightmares which could be seen in retrospect to have been very specific warnings of personal catastrophe.

After the diagnosis and beginning of prolonged treatment, I was similarly unable to accept reassurance that various symptoms were not ominous. I was incapable of monitoring my state of health or illness. If my immune system had malfunctioned under the stress of caring for my dying mother, then I really had become, as she had often proclaimed me, "my own worst enemy." I apparently was intrinsically suicidal, without having awareness of such suicidal intent. Knowledge of such self-inflicted vulnerability then served to intensify my anxiety regarding my attempts at mastering the situation. I subjected myself to surgical procedures so that my surgeon could *see* that I was all right. I required frequent and certain knowing. During that year, self-knowledge was linked inextricably with fate. At the end of that first year of treatment, I underwent exploratory surgery, which would reveal the effectiveness of treatment. I referred to this as the "ultimate final examination." During this time, cathecting long-term goals, which had been so prominent an aspect of my personality, was no longer possible. I mourned the loss of ability to plan, and resented evidence of this ability in others. My sickest patients seemed most empathic, intuitively aware of fluctuations in my levels of apprehension, and helpful in their awareness of my solitary struggle.

Now, however, I have the knowledge that statistically, I "should" have been dead. (Of those concurrently diagnosed with my condition, at five-year follow-up, only 13% had survived, and a significant percent of these were clearly dying.) Had I died, I would not now be making a fool of myself in whatever venture I happen to be involved. All this has a fundamentally liberating effect, closely

akin to that described in Raft and Andresen's paper. What had been a need to know, as regarded my physical health, has now somehow transformed itself into a pleasure in acquiring knowledge which is not linked to survival issues. In many ways, my experience is more closely akin to that of tuberculosis victims during the 1800's and early 1900's, some of whom acquired during their months of illness a newfound dedication to a particular area of endeavor, pursued for its own sake.

While I can report no "near-death experience" such as reported in Raft and Andresen's paper, I did experience in a mild way something like the described reaction during a powerful but not catastrophic earthquake in Fairbanks, Alaska in 1970. The apartment house seemed suddenly to be a boat knocking into a dock. Traffic signals, which I fascinatedly watched through the window, bobbed around as if someone were tugging at the support poles. I was not alarmed, but intrigued, almost gleeful. After what seemed like a few minutes, I remembered that my children were sleeping in the back room; I ought to get them outside, in case the building collapsed. I made my way, with unsteady footing, down the short corridor, feeling guilty that I hadn't considered their danger immediately. The quake stopped, and it was only then, after feeling deep disappointment that this novel experience had ceased, that it occurred to me that I, too, had been in jeopardy. This reaction of happy fascination, I learned recently, is typical for one's first experience of an earthquake.

On reading Raft and Andresen's paper, it seemed to me that the authors were conveying their affects of gratitude and envy, without labeling them. In this scientific and technologic age, it is far more common for individuals to be terrified by fantasies of their own dying than by their fantasies of possible eternal existences. The comfort of religious and poetic ritual is less accessible than formerly, and is often demeaned as somehow silly or primitive in these technologically advanced times. Patients such as the ones described by Raft and Andresen serve somewhat as modern potential saints, as they tell us of the moment of death, rescued from it by the technologic advances we have come to cherish. They describe in person what T. S. Eliot depicted in *Four Quartets; Burnt Norton, II,* (p. 119):

> The inner freedom from the practical desire,
> The release from action and suffering, release from the inner

> And the outer compulsion, yet surrounded
> By a grace of sense, a white light still and moving,
> *Erhebung* without motion, concentration
> Without elimination, both a new world
> And the old made explicit, understood
> In the completion of its partial ecstasy,
> The resolution of its partial horror.

I envied the authors their opportunity to work with such "saints," and speculated that a powerful feature of work with such patients would be to integrate one's feelings of personal envy and of gratitude for the personal enhancement which must inevitably result from work with patients who have consciously experienced dying. These patients must necessarily help their analyst or therapist to better tolerate his or her terror of the experience of dying. The analyst, in empathically imagining him/herself in the situation described by the patient would imagine his own near-death and then his own arrival finally at the sort of temperament toward which his life's work has been dedicated. Such a patient would quite fundamentally illustrate Searles' (1975) notion of "the patient as therapist to his analyst," in which he states that "the more ill a patient is, the more does his successful treatment require that he become, and be implicitly acknowledged as having become, a therapist to his officially designated therapist, the analyst." While Searles is discussing patients with mental illness, I feel his ideas are relevant to those who are integrating the aftermath of near-death.

The reader's envy of these patients may tempt him or her to turn away, with the feeling expressed again by T. S. Eliot, *Four Quartets, East Coker, II,* (p. 125):

> Do not let me hear
> Of the wisdom of old men, but rather of their folly,
> Their fear of fear and frenzy, their fear of possession,
> Of belonging to another, or to others, or to God.

The authors perhaps have glorified the experiences of these patients, in a way similar to the glorification of psychotic experiences which was characteristic of some of the early analytic work with these patients. Deliniation of narcissistic reactions seems necessary for an understanding of both groups of patients. If one has confronted death, the narcissistic skirmishes of daily competitive life lose their sting, and one is less distracted by them in one's hunger for knowledge, understanding, or communication. Conversely,

fear of one's own time-limitedness, when dealt with by denial is perhaps a universal feature of psychotic decompensation, termed by Freud as "narcissistic neuroses" in contrast to "transference neuroses." Raft and Andresen report that near-death survivors are reluctant to discuss their experiences for fear of ridicule. I speculate that these individuals intuitively recognize that envy contributes heavily to the impulse to ridicule. Those who are struggling with significant narcissistic difficulties would tend towards scornfulness, with which the near-death survivor would have little motivation to enmesh himself.

My own envy became evident to me when reading the discussion section of the paper in which the authors detail these patients' experience of knowing, and the sequellae of their heightened quest for further knowledge. I facetiously thought that if we ever run out of analytic patients we could try killing our obsessionals and narcissists, which would clearly then have to include ourselves, and then could, were we among the survivors, work with the self-inquiring ones of the five percent who survived this maneuver. I had become impatient with the adulation of the patients' accomplishment of attaining to the ultimate wisdom, and felt a frustration akin to my feeling of inadequacy when reading works such as Buber's *I and Thou* (1970), when I really can't get into full empathic communion with, say, a tree. I then feel an urge to prune it. And I felt an urge to prune the paper, with the notion that one be barred from analyzing the near-death experience until one has had one. I want to emphasize that these remarks are included here because they serve to illustrate my own defensive reactions to the material under consideration, defensiveness which I imagine to be essentially universal, and which, if not acknowledged, might lead to reaction formation in the therapists working with such patients. It was only later, in revising an earlier draft of this discussion, that I realized that my gallows humor scenario bore a resemblance to the myth of Odin, as described in Raft and Andresen's paper.

The interconnection of envy, scorn and dread then led me to consider the parallels between fear of death and fear of psychosis. (Bridging these two fears is the fear of mind-altering-drug abuse. The effects of marijuana, LSD and related substances are mentioned frequently in the literature of near-death experiences, perhaps first by W. James (1982), and are relevant to the understanding of psychosis, as well. Further elaboration on this subject

seemed, however, to take me too far afield.) There seems, however, to be a spectrum of reaction to knowledge, with epistemophilia, solitude and creativity at one extreme, and epistomophobia, loneliness and psychosis at the other. Mind-altering drugs seem to intensify these reactions to knowing, and can do so anywhere along this spectrum.

The authors draw heavily from Winnicott's earlier writings, but I think they would find his posthumously published paper (1974), "Fear of breakdown," to be of central relevance. Winnicott's unfinished paper was written during his final and debilitating illness. He begins

> naturally, if what I say has truth in it, this will already have been dealt with by the world's poets, but the flashes of insight that come in poetry cannot absolve us from our painful task of getting step by step away from ignorance towards our goal.

He states his thesis:

> clinical fear of breakdown is *the fear of a breakdown that has already been experienced.* It is a fear of the original agony which caused the defence organization which the patient displays as an illness syndome. . . . There are moments, according to my experience, when a patient needs to be told that the breakdown, a fear of which destroys his or her life, *has already been.* . . . The patient needs to 'remember' this but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to. The only way to 'remember' in this case is for the patient to experience this past thing for the first time in the present, that is to say, in the transference. . . . Little alteration is needed to transfer the general thesis of fear of breakdown to a specific fear of death. This is perhaps a more common fear, and one that is absorbed in the religious teachings about an after-life, as if to deny the fact of death. . . . Again, it is the death that happened but was not experienced that is sought. . . . Death, looked at in this way as something that happened to the patient but which the patient was not mature enough to experience, has the meaning of annihiliation.

He concludes saying, "*only out of non-existence can existence start.*" (Italics are Winnicott's throughout.) For the patient presented in Raft and Andresen's paper, the dreaded thing happened, was experienced with ineffable calm, and thus need never be feared again.

My impression is that the patient who has undergone a near-death experience of the sort illustrated in this paper then becomes a therapist to his analyst, helping the analyst to bring into more

clearly focused recognition his or her personal "deaths" as they occurred in his or her past, before the individual had words or memories for these events. This is not to be confused with losses of objects, but refers to preverbal dissolutions. The analyst then experiences the gratitude of one who has himself been healed, but may be left with feelings of guilt and confusion, which could lead to disruption of the work if not identified as countertransferential features.

Winnicott links fear of death with fear of psychosis. Concurrently, I have found the description of the patient's near-death experience to bear striking similarities to Joanne Greenberg's account of her experience of return of sanity. Greenberg, the author of *I Never Promised You a Rose Garden* (Green, 1964), was interviewed at length by Laurice McAfee (in press), a fellow staff psychiatrist at Chestnut Lodge. The two discussed Greenberg's work with Frieda Fromm-Reichmann. Greenberg described the terror of psychosis as a thousand times more intense than the terror she felt when she was later trapped in a burning building, when working on a rescue squad. She stressed her conviction, too, that creativity and psychosis are *opposites.* She then described a moment of enlightenment, which I felt remarkably parallels the descriptions of ineffability presented in Raft and Andresen's paper. After a year of hospitalization at the Lodge, she was put in a cold wet sheet pack for the first time.

> I was on Main IV (then the ward for disturbed women), having a very tough time, and a doctor, I don't remember who, because I often X'ed people out, said, 'I think you need to be in one of these,' So they put me in one. I think it would be a bad idea for anyone who was claustrophobic to be in a cold pack, but for me it was the first time that I was ever able to look down into my mind—to get clear—to *be* clear. Once that happened to someone who had never had that, I think they would do anything on earth to get it again. That kind of stillness and clarity, all of that yelling that went on all of the time inside me, wasn't there, and I was at the end of it: you are not going to hurt you or it or anything. That's all. That is it. You can fight and fight and fight. I knew that the ability to stop dead and look inside myself was what well people have. And I knew that that high feeling was coming from me, not a drug. I learned for the first time that there's a difference between inside and outside, and that inside then became available to me. Once I saw that, once I learned that, I would do anything to promote it.

As in the case of the cardiac resuscitation survivors, her experience

has stood the test of time as well, and similarly left her able to be free of the intimidating influence of authority figures in a fundamental way, similar to the patient described by Raft and Andresen.

The cases discussed by the authors all happen to be men. The experiences mentioned of being held, at that time of near-death, are ones in which the imagined embracing figure is a gigantic woman. I find it interesting that in a study by Greenberger (1965), concerning fantasies of women confronting death, the women all envision Death as masculine, as a male lover, larger than life-size. The descriptions of near-death experiences seem somewhat akin to descriptions of optimal sexual experience, and the sustained relaxation to be akin to the post-orgasmic state called, interestingly, "la petite mort." I wonder whether this experience may be linked with very early oedipal triumphs, in which the baby or young child was picked up and held by the parent of the opposite sex, this experienced guiltlessly, since the child received the attention passively, simply by being himself or herself.

I found the discussion section of Raft and Andresen's paper to be extremely ambitious, attempting to encompass the evolution and vicissitudes of the capacity for knowing, and the features which lead to its development or relative arrest. Sexual and aggressive energies, object relations, and styles of attention are each considered, in a fervent attempt to make the ineffable utterable. I admired their ambition and the degree to which they have succeeded.

One section of the paper which I found especially illuminating is the third-from-last paragraph, in which the authors discuss the ordeal of loss in terms of the individual's loss of the *illusion* of one's capacities to create a world out of one's needs for it. "That aspects of the world survive and refute the fantasies of destruction is critical to the processes by which what is outside one's self changes from being a subjective object (created by projection) to an object known as distinct from the self, including having qualities that are good and enduring. Thus it is the passage through disillusionment which is critical for the finding of the most reliable perceptions of the sustaining goodness of objects." I experienced a strong sense of concurrence, a feeling that this explained aspects of my own experience to me, a bit of new knowledge of self and world, which the authors describe as so sustaining to those having endured near-death experiences.

Just as Winnicott's final paper, interrupted by death, is of central relevance, so, too, is Fromm-Reichmann's unfinished final paper, "On loneliness."

> Loneliness seems to be such a painful, frightening experience that people do practically everything to avoid it. This avoidance seems to include a strange reluctance on the part of psychiatrists to seek scientific clarification of the subject.

She differentiates loneliness from creative aloneness and from the isolation of someone confined with a minor ailment, or the aloneness of grieving for one who has died. She then outlines aspects of infant and child development and the need for empathic parental contact. She then elaborates on the dread-filled sense of being without hope of future human contact, a feeling so intense that the individual fears being able to relate it, and experiences this despair as uniquely his or her own. She then describes therapeutic maneuvers to overcome such profound isolation, and differentiates this state from "anxiety."

Once one has overcome such aloneness, there is a sense of profound inner strenghtening. This, I think, encapsulates the near-death experience, in which "alone" becomes, for some, "no longer alone." Perhaps it is a reliving of the infantile helplessness: alone; mother arrives; one is no longer alone; there is food and playfulness. The ultimate loneliness is the experience of near-death. It seems to have much in common with severe psychosis, which is often experienced as a terrifying deadness, often with ineffable experiences which draw the individual away from human interaction. Raft and Andresen are to be commended for their pioneering efforts to explore the subject with scientific and personal courage.

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