

Models of the Out-of-Body Experience: A New Multi-Etiological Phenomenological Approach

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Abstract

This paper compares several models of out-of-body experience (OBE) leading a new proposed multi-etiological model. Broadly the unitary hypotheses propose several single broad causes and explanations, though each of these recognizes that any specific explanation may not be all encompassing. These are best divided into four groups: Psychological, Brain, Psychopathology, and Experiential. The psychological models of Blackmore (reality distortion), Palmer (body concept) and Irwin (absorption) are followed by the brain empirical descriptions of Penfield, Blanke, and the cerebral explanations of Persinger (vectorial hemisphericity), Wettach (midbrain near-death experiences), and Nelson (REM-intrusion in near death experiences [NDEs]). Additionally, there is the psychopathological psychiatric perspective, plus the spontaneous and induced OBEs that occur in subjective paranormal experiences, which appear phenomenologically quite different. OBE research has generally been based on single questions without detailed qualitative differentiation of the OBE. This creates the erroneous situation of potentially misinterpreting diverse experiences under a single etiological umbrella. Optimally, OBE evaluations require detailed screening for OBEs so that "like" is classified with "like" not "unlike." The author motivates for a detailed phenomenological analysis model which could accommodate the multiplicity of causes and the different subpopulations. This shifts the model from the unitary etiological hypotheses to Neppe's Multi-etiological Phenomenological Approach. Detailed phenomenological analyses may demonstrate separate distinct kinds of out-of-body experience and therefore ensure that OBEs are appropriately phenomenologically classified in the context of the population samples being examined. This approach facilitates analyzing form, content, circumstance, and predisposed populations using a predominantly biopsychofamiliosociocultural approach and differentiating five possible legitimate hypothetical groups: 1. subjective paranormal experience (SPE) out-of-body experiences, 2. OBEs in SPE- non-experients who may have psychological experiences, 3. seizure and brain linked OBEs, 4. psychopathology interpreted as OBEs, 5. the non-OBE population.

Key Words: absorption, cerebral stimulation, déjà vu, near-death experiences, out-of-body experience, reality distortion, seizures

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Introduction

I am defining the term "out-of-body experience" (OBE) as *the subjective awareness that part or all of one's conscious awareness is in a special location outside the physical body*. This definition is more inclusive than most as it includes

experiences that may have a dual consciousness in and out of the physical body, as well as the sense of self still being located in the body, plus distortions of experience where only the sense of parts of the physical body are felt located outside. OBEs are usually experienced quite spontaneously; but they can be induced either by some kind of stimulating procedure (physical or psychological) or by achieving a deliberate condition of consciousness (for example, via a meditative or contemplative technique) that allows the experient to

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induce his or her own OBE state.

This paper compares and contrasts several diverse models of out-of-body experience (OBE). I suggest a new classification here: All the previous models were “unitary” recognizing one specific possible mechanism; the new model is the multi-etiological phenomenological model.

Unitary hypotheses

The unitary hypotheses attempt a single broad cause and explanation, though recognizing that this may not be all encompassing.

Several unitary models of out-of-body experience exist in the literature. I subdivide them into the “psychological” models, the “cerebral models, the “psychopathological” models and the “experiential” ones.

- The psychological models include those of Blackmore (1984), Palmer (1978a; 1978b; Palmer and Lieberman, 1975) and Irwin (2000). Alvarado has linked OBEs to psi (parapsychological) conduciveness (Alvarado, 1982).
- The brain stimulation empirical models follow Penfield (1958) and latterly the work of Blanke, Ortigue, Landis, and Seeck (2002) and others (De Ridder *et al.*, 2007) and the physiological brain models such as Persinger’s hemispheric model (1999) and Wettach’s midbrain hypothesis (Wettach, 2000).
- Neppe has pointed out a psychiatric terminology perspective (Neppe, 1982).
- The largest ever sample is a mystical one coming from Michael Whiteman (2006) suggesting a psi or parapsychological model.

I believe the limitations of all these are that they hypothesize one single cause and outcome, whereas out-of-body experiences may have several nosological subtypes, just as the déjà vu phenomenon has, and I also detail this perspective below. I now categorize these models in more detail:

UNITARY HYPOTHESIS MODELS THE PSYCHOLOGICAL MODELS

Three well known psychological models of OBE exist, namely those of Blackmore (1984). John Palmer (1978a; 1978b; Palmer and Lieberman, 1975) and Harvey Irwin

(2000) have somewhat phenomenologically similar ideas.

1. Reality distortion model of Blackmore — no out-of-body experience occurs.

The British Psychologist Susan Blackmore has an approach to OBEs that is the most idiosyncratic of all the OBE models. This model is theoretical only, hypothesizing psychological misinterpretation of what is experienced as a subjective out-of-body experience. The consequence for “OBE” is a coherent psychological cognitive model of reality in which subjective out-of-body experience involves attempts to regain control of one’s external realities. Effectively, the subjective out-of-body experience may have been a misperception that never even subjectively occurred. Additionally, Blackmore discusses sleep related phenomena including REM and NREM sleep, pointing out they are important variables in OBE experiences occurring during sleep.

Blackmore’s model denies even the subjective out-of-body experience; Palmer and Irwin recognize the subjective OBE and attempt to explain it respectively via body concept or dissociation.

2. Body concept OBE model of Palmer

American psychologist John Palmer has proposed a psychological OBE theory (Palmer, 1978a) that relates to changes in body concept. This threatens the self-concept and activates unconscious processes. These, in turn, try to reestablish the sense of psychological identity. His theory deals primarily with the motivation behind the experience, but also employs Freudian descriptors relating to psychodynamics.

According to this theory, the OBE begins with a subtle change in the person’s body concept, instigated by a change in the proprioceptive feedback the person receives from his/her body. The person should only be vaguely aware of the change, if aware of it at all. This alteration in the body concept unconsciously threatens the person’s individual identity and the mind tries to reinstate some concept of the self, using Freudian primary process mechanisms (fantasies or hallucinatory dream-like

experiences). When that process produces an OBE, the self is experienced as a realistic entity outside the body. The OBE then ends when some external stimulus rouses the ego to a secondary process solution. However, the OBE is only one option that may re-establish self identity— another is the lucid dream. The theory predicts that only people who have had spontaneous OBEs can induce them voluntarily, because the memory of the spontaneous experience is needed as a template for the induced one. However, as I see it, this theory focuses on the process and the detailed content. Palmer points out that this model is not empirically tested. However, the existing literature supports its premises about changes in the body concept preceding the OBE, e.g. during anesthesia, relaxed and hypnagogic states, and the voluntarily induced OBEs (Neppe and Palmer, 2005; Tart, 1968) The most consistent finding among all these studies was a reduction or lack of eye movements during the experience. The OBE experient Ingo Swann even reported that he intentionally blocked his eye movements during the experience. This finding is relevant to the theory because the proprioceptive feedback from eye movements can be conceived of as an important vehicle for establishing one's physical identity vis-à-vis the external environment. The high positive correlation between incidence of OBEs and lucid dreams is consistent with the notion from the theory that they have comparable functions. (Palmer, 1979)

3. The Psychological Absorption model of Irwin

Psychologist Harvey Irwin (2000) attempts to either make the out-of-body experience

- a pathological condition correlated with dissociation or
- a non-pathological one correlated with psychological absorption. Irwin emphasizes the experient's capacity for non-pathological dissociative absorption. So-called fantasy proneness (Irwin, 1991), for example, just means that a certain trait or personality phenomenon may correlate with a certain kind of subjective paranormal experience (SPE). It neither confirms nor denies the veridicality of the experience.

Psychological absorption with the strong engrossment in one's mentation involving total attention and full commitment of available perceptual motoric imaginative and ideational resources may lead to a unified representation of the attentional object (Tellegen and Atkinson, 1974). An OBE may be a legitimate example of a representation of an attentional etiology just as Whitlock's depersonalization (Whitlock, 1978) and Spiegel and Cardeña's dissociation (Spiegel and Cardeña, 1991) are. These theories have their origins with the one originally proposed by Pierre Janet (1889) concept. But they do not imply that all out-of-body experiences have that origin. A and B may precede C or D but we cannot directly link C to A and not B or combinations.

4. The psychological event may be psi conducive

American psychologist Carlos Alvarado proposed an interesting variant (Alvarado, 1982). It does not have the status per se of an OBE model but directly recognizes the role of psi in the psychological experience.

BRAIN PATHOLOGY MODEL

The stimulating brain model empirical approaches

These hypotheses have focused on the brain explanation, for example stimulation of various brain areas producing out-of-body experiences. This is generally a pathological model because of rare reports in which epileptic patients who underwent intracranial stimulation of specific parts of the brain in preparation for surgery reported OBEs. These are rare empirically induced "OBE" descriptions on single epileptic subjects undergoing intracranial brain stimulation pre-surgery. They have produced non-identical loci e.g. Penfield located the "OBE" in the temporal cortex, Blanke in the right *angular gyrus* and De Ridder added to the puzzle inducing phenomena in the parieto-temporal area in an intractable tinnitus case. Occurrence across these different anatomical loci is problematic as are the tiny samples in brain injured individuals, and particularly the absence of state-specific OBEs.

Penfield

In a classic case study, Canadian neurosurgeon, Wilder Penfield (1958) found that a patient reported sensations characteristic of OBEs when the temporal cortex was stimulated.

Blanke

Olaf Blanke and his co-researchers (Blanke *et al.*, 2002) noted that a patient reported seeing part of her body from above, as well as a variety of other somatosensory and vestibular images, while stimulation was applied to the right angular gyrus. The fact that this case and the one reported by Penfield (1958) involved stimulation of different parts of the brain illustrates that it is unlikely we will be able to link OBEs to particular brain loci (Neppe, 2002). On the other hand, as noted above, OBEs are really a range of experiences, and it is possible we might have more success localizing specific qualities of images, such as seeing the body from above.

De Ridder

Dirk De Ridder and his associates described an intractable tinnitus patient (De Ridder *et al.*, 2007). This adds to reports of various parieto-temporal electrical stimulations in epileptics producing these incomplete “subjective out-of-body experiences” (what I call “SOBEs”) (Blanke *et al.*, 2002; Penfield, 1958).

The Phenomenological Question

Phenomenologically, are these even OBEs? Most cogent may be that phenomenologically, these induced SOBEs *variably* produced distorted body-image, depersonalization and derealization, visual perceptions of specific unchangeable loci, and associated other parieto-temporal state or trait features. These descriptions differ markedly from thousands of spontaneously reported SOBEs in ostensibly “normal” individuals. These frequently involve subjectively extracorporeal consciousness with locality dependent perceptual experiences; clear imagery; polymodal perceptions and profound cognitive awareness. (Greyson *et al.*, 2008) These dichotomous epiphenomena of subjectively interpreted “out-of-body

experiences” require careful phenomenological differentiation—the induced SOBE apparently greatly differs from the spontaneous SOBE. Using one term—SOBE—for both endpoint expressions could produce incorrect clustering of entirely different phenomena (e.g., spontaneous SOBE versus complex partial symptoms) or subtypes of SOBE: different origins and etiologies would be inappropriately interpreted as of common basis.

Neppe and Palmer have argued that these physiological theories have problems beyond their speculative nature (Neppe and Palmer, 2005). To establish a link between a certain OBE (and any SPE) component and a particular brain function, we would like two circumstances to be true: (1) that such experiences occur only when that brain function occurs, and (2) that no other types of experience occur when that brain function occurs, i.e., that state specifically produces OBEs. However, the physiological theories of OBEs, for example, frequently occur in various stages of sleep and relaxation when there is no threat of death whatsoever. Drug theories, such as those drawing analogies to ketamine, demonstrate marked phenomenological differences from the classical OBE (and also NDE) (Neppe and Palmer, 2005). OBEs may have multiple causes (Blackmore, 1992) and complex physiological correlates such as REM (Rapid Eye Movement) intrusion have been described in NDEs. However, the same physiological processes can produce different experiences implying our knowledge of these mechanisms is incomplete.

Again, this stimulation research neither confirms or refutes the validity of any kind of subjective paranormal experience and does not imply this is the sole cause of the experience.

Psychocerebral Explanations

Three “psychocerebral explanations” exist, namely Persinger’s vectorial hemisphericity (Persinger, 1999), Wettach’s midbrain involvement of near-death experiences (Wettach, 2000), and Nelson’s physiological REM intrusion explanation of NDEs are relevant (Nelson *et al.*, 2006). The commonality here is the brain linked with causes but explained through mechanisms of

how the events are subjectively experienced from a psychological perspective.

Persinger's hemispheric model

Canadian psychologist Michael Persinger used another model of the brain's role in OBEs. However, this, as well as other psychocerebral explanations, does not imply brain pathology per se, just a psychological variant of other explanations. His model of the OBE (Persinger, 1999) posits that it is an alteration in the sense of self induced by "vectorial hemisphericity," which he defines as "a right-hemisphere homologue to the left hemisphere sense of self." Specifically, it occurs when left-hemisphere activation accompanies sudden right-hemisphere deactivation. It resembles some of the explanations of hemispheric dissonance found in the déjà vu phenomenon (Neppe, 1981b; 1983b; 2006b; Neppe and Funkhouser, 2006a; 2006b).

Wettach's midbrain model

Physician George Wettach (2000), focused on the floating sensation, attributing the OBE to activity of the midbrain unaccompanied by the orienting information and spatial cues normally supplied by other parts of the nervous system. He felt this was typical and reproducible based on a single diabetic patient with hypoglycemia

Nelson's REM intrusion model

Nelson and his co-researchers (Nelson *et al.*, 2006) presented a well-publicized model for the neurophysiologic basis of the near-death-experience (NDE). I include it here because of the phenomenological component of NDEs conforming to some definitions of them as a subgroup of OBEs. These researchers studied REM state intrusion (a more impressive term than "sleep paralysis") and argued that it contributes to the NDE. They pointed out that REM intrusion during wakefulness is a frequent normal occurrence but can occur in other clinical conditions, such as narcolepsy. They proposed that NDE elements can be explained by REM intrusion because cardiorespiratory afferents evoke REM intrusion, and persons with an NDE may have an arousal system predisposing them to REM intrusion. They presented data indicating that the life-time prevalence of

sleep paralysis as well as sleep-related visual and auditory hallucinations were substantially more common in subjects with an NDE. They posited that REM intrusion could promote subjective aspects of NDE and often associated syncope. Moreover, mechanistically, suppression of an activated locus ceruleus could be central to an arousal system predisposed to REM intrusion and NDEs. However, the researchers used a questionable sample of 55 Internet located respondents compared with age and gender-matched control participants.

Perspective

In all these instances, I have stressed that even when findings on subjective paranormal experiences (SPEs), including OBEs, are referable to specific anomalous brain functioning, they neither confirm nor deny the veridicality of the SPEs (Neppe, 1979; 1983c). Like pathological hallucinations, the SPEs including OBEs may have endogenous origins within the brain; alternatively, a particular brain function pattern may allow experience of an outside, usually covert, reality.

PSYCHOPATHOLOGY MODEL ILLUSTRATING CONVENTIONAL PSYCHIATRY

There is a fourth approach. I have pointed out that psychiatrists can easily enough mislabel any out-of-body experience as, ipso facto, pathological and describe the OBE as extreme ego-splitting with psychological dissociation (Neppe, 1982). As a consequence this may lead to attempts at psychopharmacological modulation. This approach should be utilized with the utmost caution and in fact rethought thoroughly. This interpretation may be inappropriate because, in my opinion, one is not necessarily dealing with psychopathology.

Psychiatric explanations for SPEs implying their abnormality should be viewed very carefully because of the remarkably high incidence of all kinds of SPE in the general population demonstrated in at least six countries. Labeling all such SPEs "pathological" would result in most of the population being regarded as abnormal. I posit that there may sometimes be pathology, as there is with any other

experience, but an OBE is not itself reflecting pathology, per se.

Essentially, all the above theories can be and have been found wanting (Greyson, 2000; Neppe, 2007a; 2007b) as they may apply to some aspects of the experience and not others.

THE EXPERIENTIAL DESCRIPTIVE SCIENTIFIC SUBJECTIVE PARANORMAL EXPERIENT APPROACH

Michael Whiteman, the remarkable South African mystic, philosopher, mathematician, and musician, documented 10,000 of his own deliberately induced OBEs (Whiteman, 2006). His remarkable and detailed documentation of each experience contributed more than any individual to the varieties of mystical components in OBEs. Whiteman (1980; 2006) documented the progressive stages of his subjective "separative experience" (SE) these range from SE in the body, SE with consciousness both in and out of the body, and SE outside the body. He described these as the different stages of separation of the out-of-body experience, including the sense of being out of the body but, nevertheless, unable to subjectively "see" the physical body. Whiteman also described how in some OBEs, one's consciousness is not necessarily detached, but is both in and out of the body.

Whiteman's conceptualization, therefore, includes states of subjective non-separation of consciousness from the body and separation and non-separation. Moreover, his awareness of OBEs in the context of different phenomenological perceptions of different stages of "separative experiences" Possibly most important was that this centenarian was able to show how a highly functioning and brilliant individual could at will induce OBEs and that these were phenomenologically similar to those typically described by subjective paranormal experients and were quite different from the limited OBE-like experiences described in stimulation of the pathological brain in epileptics or a case of tinnitus.

THE PHENOMENOLOGICAL MULTIDIMENSIONAL MODEL OF NEPPE

The single question model

Several OBE researchers including Irwin, Palmer, Murray and Fox (Murray and Fox, 2005a), Alvarado, and Blackmore have, at times, based empirical data on one single overriding question itself. This is used to screen for the out-of-body experience (Alvarado, 1989; Alvarado and Zingrone, 1998-99; Blackmore, 1996; Irwin, 1985, 2000; Murray and Fox, 2005a; 2005b; Palmer, 1994). The question usually derives from Palmer's original research probe though with slight later variants. Essentially the question that Palmer asked was:

"I have had an experience that I was located outside of or away from my physical body; that is, the feeling that my consciousness, mind or center of awareness, was placed in a different place than my physical body. If in doubt, please answer false."

As single questions go, this is a reasonable screen item. But it limits respondents in that it does not talk about experiences where there are dual localities of consciousness (inside or outside) or when someone is still inside the body though somehow feeling partly outside. It ignores, for example, the partial separative experiences of Whiteman.

Another perspective is Charles Tart's, who argued that the experience must be real in the sense that "consciousness seems completely clear and normal" (Tart, 1975; p. 149). This is very much a phenomenological interpretation but, again, may be too restrictive. There is a question as to what "normal" is and likewise for "clear" particularly as the state of awareness in OBE may be interpreted differently, so that even if it were "clear" in one sense, it may not be so in the subject's interpretation.

Consequently, such limitations within the defining statement may be premature. This is why I have defined OBE above broadly: *the subjective awareness that part or all of one's conscious awareness is in a special location outside the physical body.* This way all experiences that have met the subjective descriptions can be analyzed.

Can this be done with a single question? I have maintained single questions are inadequate to study the key issue of OBEs (Neppe, 2002). This simply may not be

doable by a single screening question because the question must be nuanced for the subject to appreciate any variants they have. I further argue that it is a question of debate whether a single broader defining question on OBE may be adequate when OBEs are only part of the larger picture, for example, when screening for subjective paranormal experiences or exceptional human experiences. I think this may still not be adequate on its own and should include further screening questions or an interview, or requirements to describe in detail such “experiences.” It is critical for “like” to be compared with “like” and not “unlike” (Neppe, 2007a; 2007b; in press, 2009). This is so for several reasons, cited below.

First, a potential distortion of research simply measuring acquiescence to a single subjective question must be recognized (Neppe, 2007a; 2007b). This translates into not obtaining detailed subjective information based on a series of questions both screening for and amplifying subjective out-of-body experiences (Neppe, 2007a; 2007b). This means that the population being analyzed may not necessarily be “subjective out-of-body experiencers” but a population reflecting differentiation of responders and non-responders to a single question that we like to regard as reflecting the construct of “out-of-body experiencers” but it may be an incorrect construct to begin with. If so, this has erroneous implications for research.

Secondly, I argue that when dealing with a specific subjective paranormal experience we need to carefully define what we purport to be measuring subjectively; then we must go to great pains to ensure that we are indeed measuring subjectively what we are purporting to measure. As indicated, this approach is slightly less critical if the phenomenon (e.g., subjective out-of-body experiences) and is only one of a series of criteria measuring, for example, the construct of subjective paranormal experience (SPE), but it is clearly more relevant when the whole research is based on one question because conclusions are as strong as their weakest link.

No matter how well a single question is fashioned it could create both false negatives and false positives due to

misinterpretation. More powerful at least would be a series of questions, for example, on out-of-body experiences, clarifying whether the participants’ experiences conform to operational definitions. Sometimes, the limitation is striking: Murray and Fox used two well recognized questionnaires—the 28 items of the DEQ (Dissociation Experiences Questionnaire) and the 34 items of the TAS (Tellegen Absorption Scale) (Murray and Fox, 2005a; 2005b) to measure dissociation and absorption respectively. If we could divide a single critical subjective phenomenon into several screen questions we may have greater validity and reliability in interpreting results. And it would be illogical then to measure the other arm of their research, as has been done, namely out-of-body experiences using a single screening question.

This fundamental methodology has been empirically tested in my detailed work, *inter alia*, on déjà vu (Neppe, 1981b; 1983b; 2006b; Neppe and Funkhouser, 2006a; 2006b), on possible temporal lobe symptoms, (Neppe, 1978; 1979; 1983c; 1992-1999; 2008; Neppe *et al.*, 1991) on subjective paranormal experiences (Neppe, 1984; 1988a; 1988b; 1990; Neppe and Palmer, 2005), on olfactory hallucinations (Neppe, 1983e; 1983f), on soft organic brain signs (the SOBIN) in questionnaires on narcolepsy (the Neppe Narcolepsy Questionnaire) (Neppe, 2001-2005, with revisions), and in screening for temporal lobe symptomatology (Neppe, 1992; 2001 with revisions). This approach, therefore, has been empirically validated.

This approach has created a significant body of information—in more than one hundred of my publications. For example, I developed a series of eleven screening questions for déjà vu in the original Neppe Déjà Vu Screening Questionnaire (Neppe, 1981a; 2006a; 2007c). I did this because no single item was sufficient to ensure elimination of false negatives.

As a result, I had a series of questions in the Déjà Vu Qualitative Questionnaire to ensure that what was being answered conformed to the definition of déjà vu (Neppe, 2006c; 2006d; Neppe and Funkhouser, 2006a; 2006b). I then added

specific examples to further clarify the measure.

This process added to the higher level of validity of such items, ensuring that what is subjectively measured would be as appropriate a measure of the subjective phenomenon as possible. In fact, I have classified SPEs into “high-score” (meaning a lower level of subjective validity but more frequent events) and “low-score” SPEs (implying fewer SPEs because each has to be subjectively validated at a higher level, e.g. direct description and memory of a specific event, such as writing it down or mentioning it to others). (Neppe, 1979; 1983c; Neppe and Ewart-Smith, 1982).²

There is a major need to classify subjective experiences in as much detail as possible. (Neppe, 1982; 1988a; 1990; Neppe and Ewart-Smith, 1982; Neppe and Palmer, 2005). For subjective out-of-body experiences operationalized as components of being completely outside one's body, seeing one's own body, and/or obtaining information about physical events or places, one can begin to compare “like” cases with each other instead of with heterogeneous experiences.

This technique of amplifying detail into a coherent whole is fundamental to the medical history- taking model allowing the more accurate historical elicitation of symptoms. Without such a technique there is the potential to over-interpret, under-interpret, and/or misinterpret complex subjective phenomena (Neppe, 2009). For example, eliciting a single symptom of “dizziness” (one screening question or comment) is insufficient for diagnosis. The clinician then must amplify exactly what the patient means by “dizziness” and its specific quality, context, and content. This again illustrates how the validity of the construct of equating one question with one kind of subjective experience is limiting. Researchers may restrict their potential contributions to new scientific endeavors by over-generalizing or wrongly interpreting based on the single versus multiple question approach.

2. http://www.pni.org/research/anomalous/low-score_spe_criteria.html

Similarly, briefly applying the multiple screening questions technique to out-of-body experiences (or to what some consider the subgroup of OBEs called NDEs) could yield very different results. This could apply to the psychological OBE interpretations of Palmer, Irwin, and Blackmore to the stimulation descriptions of Penfield, Blanke, and De Ridder, to the specific cerebral functioning ideas of Persinger, Wettach, and Nelson, and to the psychiatric interpretations of such experiences as well as to spontaneous OBE phenomena as well as induced OBEs as with Whiteman. To compare them we will have to have sufficient details and these may imply different causes with different interpretations.

Ironically, collaborating extensively as I have with John Palmer in our temporal lobe / subjective paranormal experience (SPE) studies, Palmer has realized the virtues of using multiple measures to more clearly interpret key variables information (Palmer and Neppe, 2003; 2004). Additionally, with respect, having pioneered this area of phenomenology, I realize how information becomes limiting when we do not amplify key items to at least subjectively increase validity (Neppe and Palmer, 2005).

The multi-etiological approach

The multi-question screen approach should also lead to precise definitions of SPEs including OBEs. This is the case because the essential defining characteristics of the OBE can be more appropriately interpreted after adequate research on any given area of study.

The possibility that the OBE experience might be veridical, in the sense that one's consciousness leaves the body during an OBE, has profound implications; hence we must be careful not to regard all epiphenomena as having a common origin. It is logical to propose that we are dealing with multifactorial etiologies. These, in turn, may manifest with different epiphenomena expressed from these several different underlying causal bases and produces separate nosological categories. This means that the four main categories above may produce five legitimate hypothetical groups:

- subjective paranormal experience/out-of-body experience in the group that has come to know as subjective paranormal experients (who report qualitatively distinct subjective paranormal experiences)
- OBEs in SPE non-experients who may have psychological experiences
- patients with brain pathology who may experience distinct special kinds of OBEs; this may include a subpopulation of epileptics who may experience distinct distorted cerebral-linked OBEs as part of their seizure experience or on stimulation.
- patients with psychopathology who interpret their experiences as out-of-body or who have their own special kind of OBE.
- the general population at large who can neither induce such experiences while denying spontaneous OBEs. However, their psychological experiences may be interpreted incorrectly as OBEs as a result of different perceptual inputs.

If this classification is valid, it implies that the phenomenology of the out-of-body experience may well be different and demonstrable by such techniques as multidimensional scaling in N—dimensions or via correspondence analysis. This is attainable; such techniques were applied to my déjà vu research and demonstrated qualitatively distinct subtypes (Neppe, 1983g; Neppe and Bradu, 2006).

Therefore, the sub-classification analyses of SPEs and like events may allow greater evidence distinguishing why there are several different subtypes, one of which may be different enough that the likelihood of it being of parapsychological origin. This may become more cogent with adequate screening. An example is déjà vu. For example, at least four distinct descriptive entities of déjà vu apparently exist and these occur in different diagnostic subtypes. I (Neppe, 1981; 1983b) analyzed déjà vu in different subtypes using fifty-five different parameters and ultimately twenty-two different Euclidean dimensions. I demonstrated that there are at least four phenomenologically distinct subtypes of déjà vu. These four categories are also diagnostically distinct. Moreover, such phenomenological experiences may be used

in subtyping of type, diagnosis, and management—in itself, another descriptive criterion. These manifestations can explain the wide variety of déjà clinical manifestations. Temporal lobe epilepsy déjà vu occurs in some temporal lobe epileptics; associative déjà vu in so-called “normals”; déjà vu in schizophrenics; and, finally, subjective paranormal experience (SPE) déjà vu is characterized by specific anomalous time distortions in SP experients (Neppe, 1983a; 1983g; 1987).

Thus, not only is déjà vu not easily localized, one can distinguish subtypes that likely have entirely different etiologies (Neppe, 1983d). Conversely, these different etiologies can be used to predict these same consistent phenomenological subtypes (Neppe, 1983a). My associates and I have similarly also demonstrated that olfactory hallucinations of a specific kind occur in SP Experients and also that there is a phenomenological link with the temporal lobe and SPEs (Neppe, 1983c). This has not been done yet in OBEs or for that matter in Near Death Experiences, nor has it been demonstrated in almost all other SPE phenomena. Similar research on other psi phenomena needs to be performed to demonstrate that subtypes might exist.

I suggest applying what I call the “Neppe’s phenomenological analysis model.” This requires a multi-etiological phenomenologic screening approach to recognize possible multiple etiologies. This accommodates the multiplicity of causes and different subpopulations. It allows for detailed multi-question OBE screening. “Like” experiences must be classified as “like” and compared to “like.” As indicated, discrete population sample analysis of form, content, circumstance, and predisposed populations is an empirically viable method in many other areas including temporal lobe symptomatology (Palmer and Neppe, 2003; 2004). Additionally, analyses by multidimensional scaling or correspondence analysis may not be attainable by a single screening question on OBEs. Not all epiphenomena have common origins. Multifactorial etiologies and epiphenomena expressed could produce five distinct nosological subtypes based on these descriptors.

Psychiatrists have for many years attempted to detail their diagnosis with other factors that may be relevant. Diagnosis is commonly linked for example with predisposing, precipitating, and perpetuating factors in relation to the illness. The American Psychiatric Association has, in fact, formalized diagnosis into five axes, namely I psychopathology, II personality, III organicity, IV social precipitants, and V recent functionality. Specific diagnostic or operational criteria have been adopted within each axis producing the internationally recognized Diagnostic and Statistical Manual–IV-TM (APA, 2000).

There appears to be an urgent need to subdivide all apparently anomalous experiences with greater detail from the onset. This may allow for creative analyses - human, mathematical, statistical, computerized, or combinations. These, ultimately, will better allow the parapsychological researcher, the phenomenological psychiatrist, or the consciousness researcher greater insight into the presence of homogeneous entities.

Detailed phenomenological analyses may demonstrate distinct kinds of out-of-body experience and therefore ensure that “like” is classified as “like” in the context of the population samples being examined. We should analyze form, content, circumstance, and predisposed populations, e.g., the predominantly biopsychosocial-cultural model of the sick patient in medicine as contrasted with the more sociocultural

model of the normal psychic claimant (or “paragnost”) in parapsychology.

Later, we may be able to apply these lessons to analyzing links with the brain, particularly the temporal and frontal lobes of the brain, geomagnetic approaches, psychological test correlates, and diagnostic patterning. Such work suggests new philosophical standpoints.

The past reinstates future research in these areas. Pioneering initial contributions and provisional interpretations must be replicated, validated, and expanded. This is the future of OBE research and indeed of all of consciousness research in medicine and psychology. A shift of orientation would likely be worthwhile (Neppe and Palmer, 2005) and would benefit the entire field of consciousness studies.

About the author

Based on publications, presentations, consultations and peer-review, Prof. Neppe has achieved an international reputation in several areas including Neuropsychiatry, Behavioral Neurology, Psychopharmacology, Forensics, Psychiatry and Consciousness Research. Amongst his pioneering approaches, has been the development of: new treatments that have impacted millions, new medical conditions, terminology and classifications, new neuropsychiatric tests, plus the demonstrable links of brain function and subjective experience and the development of the discipline of Phenomenological Parapsychology and its extension to consciousness research.

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