Induced After Death Communication (IADC) is a therapy for grief and trauma that has helped thousands of people come to terms with their grief by allowing them the experience of private communication with their departed loved ones.

Botkin, a clinical psychologist, created the therapy while counseling Vietnam War veterans in his work at a Chicago area VA hospital. Botkin recounts his initial—accidental—discovery of IADC during therapy sessions with Sam, a Vietnam vet haunted by the memory of a Vietnamese girl he couldn’t save. During the session, quite unexpectedly, Sam saw a vision of the girl’s spirit, who told him everything was ok; she was at peace now. This single moment surpassed months—years—of therapy and allowed Sam to reconnect with his family.

Since that 1995 discovery, Botkin has used IADC to successfully treat countless patients—the book includes dozens of case examples—and has taught the procedure to therapists around the country. This is the inside story of a revolutionary therapy that will profoundly affect how grief and trauma are understood and treated.

“Dr. Botkin has hit upon a fascinating and powerful new tool that may not only help clients cope with their losses, but also breaks new ground in understanding life and death.”
—Bruce Greyson MD, professor of psychiatric medicine, University of Virginia, School of Medicine

“A Miraculous Therapy for Grief and Loss
ALLAN L. BOTKIN, PsyD
& CRAIG HOGAN
Life after death is not yet a scientific issue, but experiences suggestive of an afterlife have been an important clinical issue for some time. It is well known, for example, that patients who are resuscitated after close calls with death often have inspiring tales of afterlife adventures to tell. So, doctors involved in the care of these patients need to be able to listen empathetically. The survivors of close calls need to be reassured that they are not alone and that several medical studies show that an appreciable percentage of those who return from death’s door tell of leaving their bodies and entering into a bright, comforting light of love. These patients also tell of reunions with loved ones lost to death during these life-changing interludes.

Seeing apparitions of loved ones lost to death, or feeling their presence vividly, is also a surprisingly common experience. So, again, clinicians need to be able to discuss these experiences with patients, who sometimes need counseling to help them integrate such profound spiritual experiences into their everyday lives.

Anyone who works with patients in the throes of grief knows how common apparitions of the deceased are. Grief counselors are also
generally aware that these apparitional encounters greatly promote the healing process. Grief counselors will attest to how often grieving patients say, “If I only had five more minutes.”

The work Dr. Allan Botkin reports in this book takes clinical work with grieving patients to an entirely new level. He reports on his development of a fascinating clinical method for giving people exactly that—five more minutes to say the goodbyes and I love you and other things left unsaid, and to tidy up unfinished business. I will leave it to him to describe his method and results, which he does very thoroughly in this riveting book.

Incredible as it may seem, there is a long history of documented techniques that elicit experiences of the deceased. The ancient Greeks engaged in such practice and it was continued by medical doctors in Europe well into the Middle Ages. So, although Dr. Botkin’s work may raise some eyebrows in twenty-first century America, it is actually just the latest wrinkle in a human tradition that goes back to prehistory. Indeed, we can even say that evocation of the deceased is part of the collective cultural heritage of humankind.

In Ancient Greece, evocation of spirits was practiced in subterranean institutions known as psychomanteums or, as it is often translated, oracles of the dead. These places were built entirely beneath the earth, with the darkness providing ideal conditions of sensory deprivation. By reading ancient Greek texts and combining what I read there with my psychiatric knowledge of grief counseling, I developed a method of preparing subjects for this experience. Basically, it consists simply of getting them to talk and reminisce about a departed loved one they wish to see again. After they bring up their memories of the deceased, they sit in the apparition chamber, relax, and gaze into a mirror in a dimly lit room.

Under those circumstances, about half or more of the subjects have vivid, lifelike encounters with the spirits of the deceased. They see their loved ones in three dimensions, full color, and seeming vibrantly alive. About one-third of the subjects who have experiences report hearing the audible voice of the deceased.
Almost all the rest say that although they heard no audible voice, they had an experience of heart-to-heart communications during which they felt they were in contact with the departed. Most importantly, these subjects say that they feel their experiences brought them closer to resolution of their grief.

Subsequent to my work, other psychologists have re-created my procedure and achieved identical results. All of us who have worked with it agree that the method holds promise as a technique for helping people with grief.

Dr. Allan Botkin has developed a different and very powerful psychological procedure for evoking experiences of the deceased. I was fascinated when I first heard him describe it and I am sure you will be, too.

To his credit, Dr. Botkin does not present his work as “scientific evidence of life after death.” He and I agree that it is too early for science to tackle the biggest of the big questions of existence and humankind’s ultimate mystery. Instead, he is content to put his findings forward in hopes that they may be of clinical benefit to those who have lost loved ones and who are struggling with grief. For this, I commend him and hope that his exciting new method will inspire new research. And I believe that his readers will get as much enjoyment and stimulation from his book as I have.

Raymond A. Moody, Jr., Ph.D., M.D.
The Cases
The cases presented in this book are all real. They occurred in therapists’ offices or, in the case of after-death communications that happened unexpectedly and spontaneously, were reported to the therapists by patients. All details that might identify patients have been changed to protect patient confidentiality. To protect confidentiality further, we occasionally combine two cases that are similar. In all instances, the substance and the results are what actually occurred.

IADC
The abbreviation “IADC” is a registered trademark owned by Allan L. Botkin, Psy.D., and stands for “induced after-death communication.”

Note on EMDR
In IADC therapy, eye movement desensitization and reprocessing (EMDR) is used in a way that differs significantly from the way it is presented in standard EMDR training. The research that supports the use of EMDR, therefore, does not necessarily support the method of using EMDR described in this book.
Nothing in my formal training in psychology prepared me for the events described in this book. After years of treating the victims of psychological trauma, I began to experiment with a relatively new and very powerful treatment called eye movement desensitization and re-processing, or EMDR. What I discovered appeared to defy everything we knew about treating patients suffering from grief and trauma, and it took me into an unfamiliar realm of human experience.

I discovered a way of helping ordinary, everyday people have an after-death communication experience that resolves feelings of grief resulting from a death to a degree that was not considered possible in the field of grief therapy. A group of psychotherapists and I have induced the experience with several thousand patients and people wanting to experience a reconnection with a lost loved one. It is a consistently positive, loving experience most people are able to have while sitting in a trained psychotherapist’s office.

I am Allan L. Botkin, Psy.D., a psychologist with twenty years’ experience working with thousands of patients at a Chicago Veterans Administration hospital and in my private practice, the Center for
Grief and Traumatic Loss in Libertyville, Illinois. My coauthor is R. Craig Hogan, Ph.D., formerly a professor of business communications at three universities, professor and interpersonal development coordinator in the graduate school at Wheaton College in Wheaton, Illinois, curriculum specialist at a medical school, and author of “The Personal Styles Inventory” as well as articles and books to help people improve their interpersonal work relationships. In recent years, Dr. Hogan has devoted himself to studying and writing about consciousness, the nature of reality, and after-death communication. His interest in the latter was further piqued when I performed on him the procedure described in this book and he had two after-death communication experiences.

This book is told from my point of view because it describes what I discovered in my therapy practice. Know, however, that Dr. Hogan’s thoughts are intertwined with mine as we tell this remarkable story together, though we use “I” and “me” pronouns.

The after-death communication induction requires use of EMDR, a powerful psychotherapeutic procedure that can be applied only by a licensed psychotherapist with EMDR training. Hence, nonprofessionals cannot induce after-death communication in themselves or induce it in others. The healing, uplifting experience is, however, available to anyone who contacts a trained psychotherapist to have the procedure done. Information about therapists who perform the procedure and about training for therapists is available at our website, http://induced-adc.com. For an explanation of the procedure an EMDR-trained psychotherapist can use to induce the experience, see appendix B of this book.

The therapy method has worked for nearly everyone with whom we have had sessions. I and about two hundred other IADC-trained psychotherapists have induced thousands of the experiences with people from a wide range of professional, racial/cultural, and religious backgrounds. We now know that a patient’s beliefs have no effect on the outcome. It works equally well for the devoutly religious, the highly spiritual, agnostics, and atheists. It works for patients experiencing normal bereavement and those suffering from horrendous traumatic...
grief. It works for patients with recent losses as well as for those who have suffered a loss many decades in the past. In short, it appears to work with nearly everyone, nearly all of the time.

The person experiences a healing from within. The psychologist often sits in silence watching for long periods while the person, quietly, with eyes closed, has an experience that profoundly reduces feelings of guilt, anger, and sadness over a loved one’s death. Afterward most experiencers insist that they had an after-death communication experience that changed their feelings of guilt, anger, and sadness to contentment, happiness, and a sense the lost loved one is well.

This book presents the story of the discovery of this therapeutic method, case studies of people who have been healed by it, and the procedure used to induce the psychological state necessary for the experience to occur.

The book includes a large number of combat-veteran cases. The reason is that I was a psychotherapist on a post-traumatic stress disorder unit at a Veterans Administration hospital for twenty years. I had a large number of veterans working through traumatic memories and feelings of loss from their experiences in combat who had the after-death communication experience. I have found, however, that the approach to therapy and the resulting after-death communication experiences are identical to those of civilian cases.

While some readers will embrace the discovery in this book easily because it is consistent with what they already believe to be true, and others will read it with a healthy degree of skepticism. I was trained as a behavioral psychologist with a research background, so I will never lose my scientist’s skepticism. I would not be presenting this if I did not feel, wholeheartedly, that the therapy method has worth and should be explored by the psychotherapeutic community. I ask that you resist allowing your skepticism about these phenomena to close down your openness to hearing about this therapy that works so dramatically. It doesn't matter what I believe or the patient believes or you believe. IADC therapy appears to heal grief regardless of beliefs.

What I discovered is consistent with the direction that the field of grief therapy started to turn in before the IADC discovery. It asserts
that, rather than disengage from the deceased, those in grief should continue a changing, dynamic relationship with the loved one. This new direction is already starting to take hold. I hope that IADC therapy contributes to the growth of that movement.

This discovery has deepened my understanding of life, of people, and of my profession. I hope it does the same for you.
Chapter 1

AN UNEXPECTED AFTER-DEATH COMMUNICATION

The beginning of knowledge is the discovery of something we do not understand.

—Frank Herbert

Becky excitedly described to me what she experienced. “I saw my mother,” she said, a broad smile across her tear-stained face. “I told her, ‘I love you,’ and she said, ‘I love you too.’ Then she hugged me. I could actually feel her arms around me.”

At the time of this experience, Becky’s mother had been dead for five years.

Becky wasn’t describing a dream. She was sitting in my office when she had the experience. She said she felt the touch of her mother’s arms and was joyful to see her mother’s smiling face, but only she and I were there and her eyes were closed. Her mother’s warm, familiar embrace seemed vibrant and alive, but her mother was dead.

Her sense that she felt the touch of her deceased mother’s arms was unusual enough, but the life change that resulted was remarkable. “I’ve been an atheist my whole life,” she said, “but I’m sure now there
really is a life after death. I used to worry about dying, and I felt so much pain when my mother died. I know now, though, that my fear and grief were based on something I didn’t understand. I know that everything is OK and that I need to remember this when I feel life is getting me down.” Her grief reduced dramatically and remained resolved in the months that followed.

When Becky came to my office that day for help to alleviate the deep sadness she was feeling over her mother’s death, I was able to use a new form of therapy I had discovered to help reduce her grief. I had learned to use the method through a long journey that began with an accidental occurrence in a session. In time I was able to identify how I could help a patient experience it at will.

The story of that discovery follows.

My Skeptical Behavioral Scientist Training

The radical behaviorist movement was at its peak in the 1960s. Nowhere was it stronger than among a group of professors at the University of Kansas in Lawrence, where I was an undergraduate psychology major. Radical behaviorism asserted that only observable behaviors are worthy of scientific consideration. The practice of inferring private, mental events in people may be appropriate for mind readers and other nonscientific thinkers, but it had no place in a science of psychology. We were confident that inferences about inner states are unnecessary because understanding the relationship between observable behaviors and environmental variables is all that is needed to understand people’s problems and provide treatment.

I carried that behaviorist, scientific underpinning into my master’s degree studies at Illinois State University and through my work in community mental health for three years. I became adept at counting behaviors while manipulating the environment to evaluate how the counts changed. Finally, I ended my studies at Baylor University in Waco, Texas, in the comfortable familiarity of a cognitive-behavioral paradigm, the most widely accepted scientific psychological model of the early 1980s that continues to dominate psychology today.
No matter how my perspectives broaden, the instincts and skepticism of the scientist will never leave me. Anything I believe must be verifiable.

After completing my Doctor of Psychology (Psy.D.) at Baylor, I accepted a position at a Chicago-area Veterans Administration hospital working with post-traumatic stress disorder veterans, a focus that was to become my career. The first seven or eight years of using the cognitive-behavioral model with these traumatized vets were grueling for me and for my patients. The half-dozen professional staff on the unit all felt the same. The prevailing cognitive-behavioral model for treating victims of psychological trauma was “exposure therapy.” We repeatedly exposed patients to reminders of their traumatic experiences in a safe, supportive environment so that, over time, their intense emotional responses might become less intense.

While the approach made sense from a theoretical point of view, and we did get some modest results, the therapeutic changes were minimal and didn’t appear to hold up over time.

A New Technique for Reducing Trauma and Grief

Then, in the late 1980s, psychologist Francine Shapiro, Ph.D., discovered a radical new therapy technique she named eye movement desensitization and reprocessing, or EMDR. In EMDR therapy, the psychotherapist, usually sitting before and slightly to the side of the patient, moves his or her hand, with the index and next finger extended, left and right in front of the patient on the same level as the patient’s eyes. While focusing on the psychotherapist’s hand and keeping the head stationary, so only the eyes move left and right rhythmically, the patient attends to a disturbing thought, feeling, sensation, or image.

During a set of eye movements, the patient experiences a spontaneous, natural reprocessing of the thought, feeling, sensation, or image. After several sets of eye movements, patients typically report psychological breakthroughs that normally would take months to achieve. The procedure is now being used for a wide variety of...
disorders, from multiple personality disorder to the post-traumatic stress disorders I worked with.

Experience has taught me that EMDR does two things better than any other approach. First, it rapidly and completely uncovers past traumatic events that are repressed or partially remembered. It is very common for a patient to say something like, “I can see the whole thing very clearly now” or “I felt like I was back there again.” This experience by itself doesn’t help the patient resolve the traumatic experience; in fact, patients generally feel very distressed when they fully uncover a traumatic memory.

Once the traumatic memory is fully accessed in this way, however, the second strength of EMDR is that it allows the patient to process the memory so that the reliving component of the memory is eliminated, and the patient can then remember the traumatic event in a more abstract way. It is clear that this processing can only occur if the traumatic event is first uncovered and fully accessed.

No one is quite sure how it works, although it’s clear that it speeds up mental processing and is similar to the rapid eye movements (REMs) people experience in dream sleep. It is well known that during dream sleep, our brains process and integrate information more efficiently than when we are awake. It has been assumed that this increased processing during sleep causes the rapid, back-and-forth eye movement. Having a fully awake person purposefully shift the eyes in the same way, as in EMDR, seems to cause the brain to process information rapidly and efficiently. Thus EMDR draws upon the person’s own natural ability to heal.

A number of studies have looked at the effects of EMDR on brain functioning. Levin, Lazrove, and van der Kolk (1999), for example, used neuroimaging to study the effects of EMDR. They found that when subjects accessed a traumatic memory before EMDR, deep structures in the brain that represent the sensory and emotional components of the traumatic event were activated in isolation. After EMDR treatment, however, areas of the brain that hold the memory in a more abstract or symbolic manner were also activated. More recent studies have supported this conclusion. These findings support
the consistent clinical observation that prior to EMDR, when people access a traumatic memory, they feel they are reexperiencing the event; after EMDR, they are able to remember the event in a more abstract and emotionally detached manner. I know of no other psychotherapeutic technique that can demonstrate such a clear change in brain function and an accompanying dramatic shift in the patient’s perspective. In my opinion, EMDR is more rooted in neuroscience than any other available psychotherapy.

**EMDR Is Not Hypnosis**

I am frequently asked if EMDR is similar to hypnosis. Professionals trained in both EMDR and hypnosis, including me, believe that the techniques involve two very different types of mental processing. The best way to explain the differences is to use this analogy. Consciousness is like an internal movie projector that ceaselessly projects mental images onto the mind’s screen. Hypnosis gets a person into a relaxed, focused state so the projector slows down. Because the projector is slowed, hypnosis can be used to go back to places on the film where forgotten or repressed memories are thought to exist. While hypnosis can assist in retrieving memories, the problem is that a person in a hypnotic state is also very suggestible and may unknowingly put an event on the screen that in reality never occurred. False memories, as they are now called, can seem very real to the person after the hypnosis.

EMDR, on the other hand, accelerates information processing in the brain so it speeds up the consciousness projector. When people repeatedly experience a traumatic memory, their projectors are, in essence, stuck in time and keep replaying the moments when the event occurred. EMDR speeds up the projector, unsticking it to allow it to run smoothly. The traumatic event then ceases to intrude in an unwanted way into consciousness.

At the same time, EMDR does not increase the suggestibility of the subject, so false memories are not a problem. In fact, I have used EMDR to undo false memories. Tim, for example, had an alcoholic mother who was prone to fits of rage. For years, he was very troubled
by a vague memory of feeling smothered and having difficulty breathing in his mother’s presence. While under hypnosis with another therapist, he developed an image in which his mother was holding a pillow over his face, trying to kill him.

When I used EMDR with Tim, he immediately went back to the time he felt smothered and clearly remembered that his mother was preparing to take him outside on a very cold day and was bundling him up in his snowsuit as he lay in his stroller. His mother had tied a scarf tightly around his face, which caused him to have some difficulty breathing. Without any suggestion from me, Tim discovered what really happened and, from that moment on, was no longer distressed by the memory. Had he discovered that his mother was trying to kill him, more EMDR would have been required to get his “stuck projector” running smoothly again.

**EMDR Is Becoming Mainstream**

EMDR is making its way into mainstream mental health. Over fifty thousand professionals have been trained in EMDR therapy worldwide, and the number is growing. EMDR training is only available to people who are already recognized by their state as independent providers of mental health services.

There have been a very large number of scientifically controlled studies of the efficacy of EMDR. Overall, these studies support the value of EMDR. In addition to reducing post-traumatic stress disorder problems, it is also effective in the treatment of grief, phobic and panic disorders, sexual dysfunction, dissociative disorders, performance difficulties, and chronic pain. EMDR is still in its infancy and other applications will certainly be found.


The most important testimony supporting EMDR, however, is that we have seen it work repeatedly and reliably with thousands of patients.

My Personal Experience with EMDR

A colleague and I on the post-traumatic stress disorder unit were preparing to complete the formal certification training at Dr. Francine Shapiro’s EMDR Institute in Watsonville, California, when a very distressing event forced me to experience the power of EMDR before my training. My two-year-old son nearly asphyxiated when a piece of food lodged in his throat. He first began choking and we weren’t sure what was happening; then he stopped breathing and started turning blue. A successful Heimlich maneuver dislodged the food and he survived the ordeal, but the image of my son, blue, frantic, and dying before my eyes disturbed me often for two weeks after the incident.

When I explained my distress to the colleague who was planning to go through EMDR training with me, he suggested he use the technique as we understood it then to help my mind reprocess the troubling memory. We did several sets of eye movements while I focused on the incident. In ten minutes, the image had lost its distressing nature for me, and my anxiety over it had decreased dramatically. It seemed too good to be true. The effect appeared to be the result of my own inner processing of the memory, a source of healing I had learned was inconsequential in my behaviorist training. But that was only the first rock to dislodge from the foundation of certainty about behaviorism I had stood on since my earliest days at the University of Kansas.

The Remarkable Results

My colleague and I completed the EMDR training and began using it in our post-traumatic stress disorder unit at the Veterans Administration (VA) hospital to see the effects it had on our patients.
The results were dramatic. Often we achieved in a single session changes in patients that we had not been able to approximate after years of conventional psychotherapy. It was a heady time for us. Regularly, one of us could be seen scurrying down the hall into a colleague’s office to excitedly describe a successful session with a patient, doing a high five in triumph.

In 1992, Dr. H. Lipke and I published “Case Studies of Eye Movement Desensitization and Reprocessing (EMDR) with Chronic Post-Traumatic Stress Disorder” in *Psychotherapy*. We were elated for our patients and for ourselves as professionals earnestly seeking ways to make a difference in our patients’ lives.

EMDR proved especially powerful in healing grief. People who experience grief, especially traumatic grief, generally feel many intense emotions. Initially, survivors often experience shock and numbing. Then, more chronic feelings of anger, guilt, and sadness surface; they may be crying one moment and full of anger the next. A primary task for the psychotherapist is to create a supportive psychological environment in which patients can openly express these feelings and work through them.

By working through these feelings, patients are usually able to achieve some level of acceptance of their loss and get on with their lives. Generally, the loss is never fully resolved; reminders of the loss can trigger periods of sadness, guilt, or anger throughout the patient’s life.

If, for example, parents have a child who is hit and killed by a car while playing in the street, the parents will likely experience all three of these emotions (sadness, guilt, anger) very intensely at different moments. At times, they will be enraged at the driver who killed their child; at other times, they will feel intense guilt for not watching their child more closely. In their most despairing moments, they will feel the cold clutch of intense sadness at their loss and the painful feeling of disconnection from their child.

I believe that at the core of grief is profound sadness. The core sadness is so painful that the patient unconsciously shrouds it in guilt and regret and gets stuck on “What if?” questions. What if I could
have prevented her death? What if I had been a more loving friend? Both the guilt and sadness are often avoided by anger or rage—at God, the doctors, the commanding officer, or anyone else available as a target. The doctors should have been more attentive. Our lieutenant had no business putting us in that dangerous position. However powerful they seem when acted out, the layers of guilt and anger are only defenses the patient’s mind uses to keep from feeling the painful sadness at the core.

The grief therapy we had been practicing before we began using EMDR sought to reduce the immobilizing pain of grief by helping patients peel off the shrouds of anger to reveal the guilt, then peel off the layers of guilt to reveal the sadness, then talk out their sadness to help them work through it. That process took years of frustration and seemingly endless therapy appointments. With EMDR, we could help patients rapidly process all of these layers, sometimes in a single session.

**Accessing the Core Sadness**

EMDR had proven to be such a reliable, effective procedure for uncovering and alleviating traumatic grief that I felt comfortable with encouraging patients more strongly to go to the core sadness immediately and stay with it. I was able to bypass the overlying guilt and anger that preoccupied normal therapy sessions for months or years and go directly into the sadness, all in one session. When we were able to process the core sadness fully, guilt and anger simply vanished without even being directly addressed. This was a huge breakthrough. It demonstrated that guilt and anger only protect patients from experiencing the deep sadness. I also found that patients responded better when they closed their eyes briefly after a set of eye movements, so I instructed all patients to close their eyes. I called my direct approach to the underlying sadness “core-focused EMDR.” The results were very successful and occurred even more rapidly than with standard EMDR.

Denny’s case is an example. Denny, a combat veteran, lost a good friend during an intense firefight in Vietnam. His friend had been in
Vietnam only a short time and Denny had taken it upon himself to show him the ropes. During this firefight, his friend raised his head above the barricade from which they were firing, was shot in the temple, and died instantly.

Denny finished telling me the story in a rage. “If that damned lieutenant hadn’t ordered us where we knew we shouldn’t have been, he’d still be alive.” He said he had told his friend repeatedly before this battle to keep his head down, and he felt very guilty, turning his anger on himself, because he hadn’t warned him again before the firefight. “I could have saved him. Why didn’t I tell him again?”

I asked him whether he felt any sadness about his friend’s death and he said he did feel some, but “only to a small degree.” When I started the core-focused EMDR, I ignored the guilt and anger, telling him to pay attention to the sadness. I did a set of EMDR eye movements and his sadness increased quickly. He began to sob. I stayed with the sadness, administering more sets of eye movements until the sadness was at a peak. He cried and shook his head. “Stay with that feeling,” I told him and administered more eye movements.

Finally, with additional core-focused EMDR, his sadness began to decrease. After several more sets, I asked him, “How is your sadness now?” “It’s pretty well gone,” he said, smiling weakly. “I feel much better about it.”

“What about your anger and guilt feelings?” I asked.

He thought for a moment. “Gone,” he said. “I just feel like it happened and there’s nothing I could do about it. No one could have told him enough times to keep his head down. It wasn’t my fault.”

Once the core-focused EMDR had addressed Denny’s sadness, the guilt and anger disappeared. They were no longer needed to conceal the deep sadness at the root of all the emotions.

Changing Patients’ Lives

EMDR had proven to be a wondrous gift to our patients and us, and core-focused EMDR was taking our patients to their core problem, healing it in even more dramatic fashion.
The years that followed were filled with accomplishment and victories. We honed our skills and, in partnership with our patients’ inner resources, made a difference in their lives. Our inpatient unit was one of the first in the country to use EMDR consistently and successfully. It seemed that we had a vista from which we couldsurvey the known psychological terrain with confidence and optimism.

Then one day, during an otherwise normal session with a patient, the core-focused EMDR took me and the patient into a realm I didn’t know existed.

Observing My First After-Death Communication

On the day I first discovered the induced after-death communication (IADC) phenomenon, I was in a psychotherapy session with Sam. I handed him a box of Kleenex as tears trailed down his face, dropping from his chin to his shirt. I had worked with Sam, a forty-six-year-old patient at the VA Hospital, on other traumatic memories of his Vietnam War experience, but he had avoided bringing up this one because it was too painful.

While in Vietnam, he had developed a very close relationship with Le, a ten-year-old orphaned Vietnamese girl. She had made Sam’s base camp her home after both of her parents were killed. She helped with daily chores on the base and in return was given food, shelter, and companionship. The other American soldiers watched out for her, but Sam and Le developed a special relationship. Le reminded Sam of his two younger sisters, and helped him maintain a sense of his own humanity amid the dehumanizing brutality of war.

Every time Sam’s unit returned from his patrols in the jungle, Le would pick him out of the group, run to him, and give him a hug. Other soldiers in Sam’s unit became accustomed to seeing them together, talking about their lives before they met. Le particularly enjoyed his stories about life in America. After a few months, Sam decided to adopt Le and bring her home.

Orders came from headquarters, however, that all orphaned Vietnamese children on the base were to be sent to a Catholic orphanage.
in a distant village. Sam was devastated. A few days later, Sam, in tears, helped load Le and the other orphaned Vietnamese children onto a flatbed truck to take them to the orphanage.

Just as they got all of the children onto the truck, shots rang out and bullets zipped past. Risking their lives, Sam and the other soldiers quickly pulled the children off the truck to the relative safety of the ground. The shooting stopped as quickly as it had started, and they began to put the children back onboard. Nearly all of the children were back on the truck when Sam realized he didn’t see Le. He walked to the rear and saw her lying face down with a spot of blood on her back. Sam rolled her over and was horrified to see that her front torso was blown open from a bullet that had entered from behind. Sam sat on the ground, holding her lifeless body, and cried. Other soldiers eventually had to pull Sam away and take Le’s body to bury her.

The incident was Sam’s psychological undoing.

For the remainder of his tour in Vietnam, he numbed the pain of his profound loss with anger and rage, volunteering for dangerous patrols to kill any enemy he could find or be killed himself. After Vietnam, he returned to the States and fathered a daughter, but then avoided her for years because she triggered anger, guilt, deep sadness over Le’s death, and gruesome images of Le’s dead body. For nearly twenty-eight years, Sam spent most of his days secluded in the basement of his home, separated physically and psychologically from his family.

To help him open up and work through the grief that was dominating his life, I decided to use core-focused EMDR. Sam sobbed quietly from the overwhelming pain of his grief. I asked him to focus on his sadness while I administered the first set of eye movements. As I expected, the sadness that had held him isolated in grief for twenty-eight years increased. I gave him more sets of eye movements and his sadness began to decrease.

While tears ran down his face, I administered a final eye movement procedure and asked him to close his eyes. Neither of us was prepared for what happened next. The tears that had been flowing from
his closed eyes suddenly stopped, and he smiled broadly. He giggled softly. When he opened his eyes, he was euphoric.

“When I closed my eyes, I saw Le as a beautiful woman with long black hair in a white gown surrounded by a radiant light. She seemed genuinely happier and more content than anyone I have ever known.”

Sam’s tear-reddened face glowed. “She thanked me for taking care of her before she died. I said, ‘I love you, Le,’ and she said ‘I love you too, Sam,’ and she put her arms around me and embraced me. Then she faded away.”

Sam was ecstatic and absolutely convinced that he had just communicated with Le. “I could actually feel her arms around me,” he proclaimed.

As Sam’s psychologist, I wasn’t sure what to make of what he was telling me. I assumed that the agony of his grief had somehow produced a hallucination based on fantasy or wishful thinking. I had never witnessed or heard of such a response during psychotherapy.

After Sam left my office on that day, the image of his smile showing through his tears and his assertive statement that he felt he had communicated with Le played over and over in my mind. I sat in the quiet of my office trying to understand what had happened.

Sam experienced a grief hallucination, I thought. I had heard of these. But that didn’t explain what I had witnessed. The creativity had been remarkable. I had not seen that spontaneous imagination in any patient and had never read about anything similar in the literature. If that was a hallucination, then his mind had miraculously created an experience that was completely healing. During my clinical rotations on wards with the chronic and severely mentally ill, no patient ever reported a hallucination that was so positive and healing.

Something in Sam flowered in an instant, without direction from me, reversed the sadness in which he was immersed, and brought him a notable feeling of release from intrusive images, anxiety, and depression that had consumed him for twenty-eight years.

I left the VA hospital building that day still feeling puzzled by what had happened. I wondered whether I would ever in my professional
career see such a remarkable scene again. Probably not, I thought. Sam’s experience was one of those events a psychotherapist would see once in a professional lifetime and I could just file it away as a one-time aberration. But I also felt concern that if Sam had hallucinated, the intense stress of his traumatic memories had somehow compromised his ability to differentiate reality from fantasy. That worried me.