



Article

Induced After-Death Communication: A Clinical and Research Update

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Abstract: In 1995, psychologist Allan Botkin discovered and developed Induced After-Death Communication (IADC), a psychotherapy treatment for grief designed to reduce a client's core sadness and often resulting in the client's spontaneous experience of after-death communication. In this article, we summarize the research so far on IADC, including two recent intervention studies - one in the United States and the other in Australia - both resulting in statistically and clinically significant reduction in painful grief symptoms and increase in post-traumatic growth when compared to no treatment or traditional grief counseling. We conclude with recommendations for further research.

Keywords: after-death communication, Induced After-Death Communication, grief, grief counseling, bereavement counseling

Received:
16 Aug 2026

Accepted:
30 Sep 2026

Published:
12 Oct 2026

Citation:
Holden, J.M.,
Nehmy, T., St-
Germain-Sehr, N.,
Maxey, G. (2026).
Induced After-Death
Communication: A
Clinical and
Research Update.
*Journal of Exceptional
Experiences and
Health*. 1(1), 20.

DOI:
<https://10.68606/jeeh.i1.151>

1. Induced After-Death Communication: A Research Update

Following the death of a loved one, survivors normally experience grief, a process that involves both psychospiritual distress and growth (Worden, 2018). Research has shown traditional psychotherapy for grief to be of very limited benefit. For example, in a meta-analysis of research on therapy for complicated grief—in contemporary parlance, the equivalent of prolonged grief disorder (American Psychiatric Association, 2022), Wittouck and colleagues (2011) found only a barely medium effect size. And in two other meta-analyses of traditional grief counseling (Hall, 2014; Schut, 2010), both researchers concluded that grief counseling may be more effective for the minority of bereaved with complicated grief and less effective for the majority of the bereaved with uncomplicated grief.

One type of experience that can ease bereavement distress and promote psychospiritual growth is after-death communication (ADC; Guggenheim &

Guggenheim, 1995), in which the living survivor directly perceives the physically deceased loved one (Elsaesser et al., 2020a, 2020b, 2025; Penberthy et al., 2026; Streit-Horn et al., 2022; Wollacott et al., 2022). It differs from mediumship: In the latter, communication is indirect, with a medium conveying information between the deceased and the living, whereas in the former, perception is direct between living and deceased.

Broadly speaking, ADC occurs in two contexts: unfacilitated and facilitated. In unfacilitated ADC, although the experiencer may desire and even request ADC, they do not participate in any systematic activity to facilitate it. In facilitated ADC, the systematic activity could involve a practice such as automatic writing (Cardena et al., 2023), in which the experiencer sits with pen and paper, asks a question, and, in receiving a response, seeks to surrender control of hand and pen to, in this case, a disembodied loved one; psychomanteum, in which the experiencer mirror-gazes in a darkened environment (Hastings et al., 2002; Roll, 2004); and Induced After-Death Communication (IADC), described in detail below. Whereas automatic writing and psychomanteum have not been standardized for use in psychotherapy, IADC has.

We contend that in both unfacilitated and facilitated ADC, the experience remains essentially spontaneous; that is, it cannot be invariably caused, the way an injection of Novocain invariably causes numbness. Although we have not seen data about incidence of ADC in automatic writing, research on psychomanteum has yielded an incidence of about 50% (Hastings et al., 2002), and IADC approximately 70% (Botkin, 2005b). We will return to this point about the essentially spontaneous nature of all ADC in the Discussion section.

2. Summary of Research on Unfacilitated ADC

The focus of most ADC research to date has been on unfacilitated ADC; results, however, largely apply also to facilitated ADC. To summarize the research on unfacilitated ADC (Elsaesser et al., 2020a, 2020b; Streit-Horn et al., 2022), at least 1/3 of adults worldwide have reported it; among the bereaved, as many as 80% have reported it within the first year following the loved one's death. Additionally, according to independent research conducted by Pew Research Center (2023), 53% of U.S. adults reported feeling they had been visited by a deceased relative. It has involved both deceased humans and pets (Matlock et al., 2024). People of all demographics have reported it, including both sexes—but more women than men, all ages—but more frequently as people age, all cultures—though more commonly in ADC-friendly cultures such as Hispanic and Icelandic, all belief systems—including both people who do and do not believe in an afterlife, and all health conditions—from being perfectly healthy to being on one's deathbed. ADC occurs in every state of consciousness, including natural and altered by a practice such as meditation or use of drugs. It may occur most frequently while asleep; however, experiencers typically report the experience to feel different—clearer and more real—than dreams, making, in our view, *sleep ADC* a more appropriate term than *dream ADC*.

People experience ADC in one or more forms. Perhaps most common is a distinct sense of the presence of the physically deceased person without any sensory content. Sensory ADC includes the sight, sound, touch, or smell of the deceased in either the mind's imagery or in the physical environment. In symbolic ADC, unusual or

synchronistic environmental events signal the presence of or communication from the deceased; these can involve natural phenomena, such as flowers, insects, or birds, or electronic phenomena, such as telephone or computer (Elsaesser et al., 2020a, 2020b; Streit-Horn et al., 2022).

A living person might have one or multiple ADCs with the same deceased person and might have an ADC with only one or with multiple deceased persons. Most ADCs are solitary experiences, but two or more people sometimes share what appears to be the same experience. Although the nature of communication may be quite personal, a predominant theme, especially among ADCs occurring relatively sooner after the death, are the deceased person conveying, “I am still alive, well, aware of and connected to you, and caring about you.” ADC typically occurs less often over time, but people have reported it many years after the death of the loved one, often in the context of protective information for the experiencer.

ADC is sometimes veridical: The experiencer receives information from the deceased that could not have been known through normal means but is later verified as accurate (Penberthy et al., 2025). There is no relationship between mental disorder and ADC (Elsaesser et al., 2020a, 2020b; Streit-Horn et al., 2022). ADC is rarely emotionally distressing and is almost always pleasurable and psychospiritually beneficial (Holden et al., 2019).

3. Induced After-Death Communication

Until recently in psychotherapy, because of the uncontrollable and unpredictable occurrence of unfacilitated ADC and the absence of standardized and empirically supported procedures for practices such as automatic writing and psychomanteum use, the “mining” of the benefits of ADC has been limited to elaborating and perhaps enhancing beneficial effects by processing an unfacilitated ADC memory during a counseling session. That limitation changed when, in 1995, Allan Botkin, PsyD, discovered, quite by accident, the ability to facilitate ADC—along with its therapeutic benefits—among many of his psychotherapy clients. At the time, he was a U.S. Veterans Administration psychologist using Eye Movement Desensitization and Reprocessing (EMDR) to treat post-traumatic stress disorder among combat veterans. His approach was focused on reducing the core sadness associated with a traumatic loss. As he reported,

Then something really strange happened that I wasn’t expecting. When I was using core-focused EMDR, about 15% of my patients reported that they had made contact with the deceased person that they were grieving, during the session. And the first time that happened, I thought my patient just hallucinated. I didn’t know what he was talking about. I didn’t learn this stuff in graduate school. Hopefully, at some point, they will make this part of the regular curriculum. And like I said, about 15% of my patients were reporting these experiences. The other 85%, after going through the core-focused EMDR procedure, were leaving my office feeling considerable relief, but not the same upliftedness that the people having this experience were experiencing.

So, I went back and looked at my notes. I wondered if I was doing something different in these 15% of the cases . . . and I saw that, indeed, I did. There was an extra component that I had added to this 15% group. And what it was, I just, I gave each of these people an extra set of eye movements without providing any specific instruction. At the time, I was thinking, “Well, you know, this is working so well, that let’s give it another one. Give ‘em some dessert” . . . but there was always that extra set of eye movements after the sadness had completely processed. So, then I thought, I wonder if that’s it. (Botkin, 2005a; Holden et al., 2025).

That was, indeed, “it.” Botkin went on to refine his procedure and reported it, along with his clinical observations of its unique ability to relieve grief, first in a journal article (Botkin, 2000) and then in his book (Botkin, 2005b). By 2013, he was able to report that 71 clients he had seen between 2003 and 2010 showed significant improvement in nine aspects of grief assessed with a questionnaire he had devised (Hannah et al., 2013) and that 15 therapists he had trained in IADC, responding to two questions he had devised, reported virtually identical results (Botkin & Hannah, 2013). Until recently, however, the evidence of IADC’s effectiveness did not include controlled studies.

Typically, the entire IADC process comprises two 90-minute counseling sessions. First, therapist and client explore the client’s relationship with the deceased. Then, the therapist guides the client to identify the worst aspect of their grief, stating it in one concise phrase or sentence, and scaling its emotional intensity from 0 (nonexistent) to 10 (most intense imaginable)—which clients typically scale initially at 8, 9, or 10. Next, beginning with the phrase or sentence provided by the client, the therapist guides bilateral stimulation (BLS), which involves the rhythmic, back-and-forth stimulation of the right and left sides of the client’s nervous system. The original form of BLS involved eye movement—the client watching the therapist’s fingers as they waved them back and forth in front of the client’s eyes—and some therapists have adapted this technique for telehealth whereby the client watches a small ball move back and forth on the computer screen. BLS has also evolved to be auditory, such as sequential right-left clicks or tones delivered through headphones, or tactile. In in-person sessions, tactile BLS can involve the therapist using their fingers to tap the backs of the client’s hands; in telehealth sessions, the client can deliver their own BLS through the “butterfly technique,” whereby they cross their arms in front of their chest, alternately tapping their left shoulder with their right hand and their right shoulder with their left hand.

Processing the core sadness involves repeating a sequence: the client holding the current phrase or sentence in mind and, thus, feeling the full intensity of their sadness at whatever level it is occurring at the moment; receiving a “set” of BLS, usually consisting of 10-15 right-left stimulations; closing their eyes; noticing anything that happens within them visually, auditorily, kinesthetically, emotionally, and/or cognitively; opening their eyes and reporting to their therapist what they experienced, noting particularly anything that may have shifted internally for them; again scaling their grief at this point; and consolidating their current experience into a phrase or sentence. During this process, the core sadness typically either gradually or suddenly reduces. When the client reports that their grief has reduced to a scaling between 0 and 3, the therapist provides, to harken back to Botkin, another set of BLS without any additional instruction. Clinical data indicate

that approximately 50% of clients experience ADC at this point. If the client does not, the therapist asks, “If you could say just one thing to [name of client’s deceased loved one], what is the single most important thing you would want to say to them?” When the client formulates the phrase or sentence, the therapist invites the client to hold it in mind while they provide another set of BLS without further instruction. Clinical data indicate that an additional 20% of clients experience ADC.

Usually, when clients do not experience ADC, clinical observation indicates an emotional block other than the core sadness, which the therapist and/or client may or may not choose to address. As will be described below, even in the absence of ADC, IADC has been beneficial. However, ADC may contribute uniquely to those benefits, which are illustrated in the following two case examples.

4. Two Case Examples of IADC

Case 1: Samantha was a 48-year-old woman whose husband had died of cancer and who sought IADC from co-author Nehmy via telehealth (Holden et al., 2025; Nehmy, 2025, pp. 49–60). Samantha began by reporting that despite a spontaneous ADC at the time of her husband’s death, several unresolved issues remained in the relationship. Nehmy condensed these issues into five aspects of her sadness: “He was meant to be here. I’m sad for our daughter. When he got sick, I became invisible. The way he treated me was wrong. I have to deal with all this on my own.”

Following reduction in her core sadness, the session proceeded:

Samantha: (crying and gesturing with her right hand over her left shoulder) So, I can actually, like, feel him here.

Tom: Yep.

S: His energy. (crying and wiping her tears) He’s just really sorry.

T: (quiet and attentive)

S: (gesturing again over her left shoulder) He’s all here. It’s, like, very hot. That’s how I feel. I don’t know how else to describe it. I know I sound nuts, but that’s how it feels. And I can feel, I get very overwhelmed when he’s here, like that. And all I can feel is how sorry he is. It’s very overwhelming to me. (cries and wipes her tears)

T: Yeah, yeah. (sighs) And what, how do you feel in response to that, that he’s sorry?

S: I feel . . . good. I know I don’t *look* good (laughs).

T: (smiles and laughs with S.) That’s alright.

S: It feels good that he’s sorry. I can feel that he feels sorry.

T: Yeah. And is there anything that you want to say in response to this apology from him?

S: Yeah, that I just, I accept that he’s sorry, and I’m sorry. Can we just leave it in the past so I can move forward now? I don’t want to carry this anymore.

T: (nods) Mm-hmm. (pauses) So, let's do another set around that. Follow the blue ball and think about feeling his presence and just go with whatever happens, OK? (pause) What did you notice then?

S: Yeah. So, it's like, what he's saying is, it feels, this is how it feels, that he's saying to me that he loves me more than anything, that he wants to take that away. So, it feels like it's going (she waves her hand repeatedly). And it just felt very light, like everything was very light and almost going here (gestures, waving her hand repeatedly to her upper right), you know, almost like it was just going.

T: Yeah, yeah. Was it like he wants to take the bad stuff away? Is that what you mean?

S: Yeah, yeah. He'll take it with him. I don't need it. He doesn't want me to have it, so he's taking it.

T: He's taking that baggage away, lifting it off you.

S: Yeah. So, I feel (waving both hands repeatedly from shoulders up into the air) lighter and more, started to feel more peaceful about it. (blinks and looks calmly into camera, smiling slightly)

T: Yeah, great. That sounds good.

S: (smiling wryly) I sound like a lunatic. (laughing with amusement)

T: Not at all. You sound like someone who's having an after-death communication. It's pretty normal to me. (joins S in amused laughter).

In response to Tom's follow-up inquiry a few days later, Samantha emailed:

I am absolutely incredible. The treatment has worked. My sadness has gone completely. So weird and I don't miss it at all. I feel really happy and like myself again. It is the first time in so many years there is no internal battle. I also never realized how sad I was until it was gone. It was more of a burden for me than I realized, in terms of constantly draining my energy. I feel very optimistic about my future and the next chapter.

Case 2: While conducting an IADC training session, co-author Maxey demonstrated a session with one of the trainees as the client and, with her permission, recorded it for possible use in future training. The client was a 60-year-old woman whose husband had died a few years before and who had turned to her daughter as her primary source of emotional support. Three years after his death, her 24-year-old daughter attended a party, overdosed on fentanyl, and died.

The following description of the session is organized by lapsed time. After spending the first half-hour exploring the client's relationship with her daughter, for approximately the next half hour, the client indicated very little change:

30 minutes:44 seconds – Graham's comment: We confirmed that the most painful part, the *core sadness*, was the memory of "*When I touched her hair (in her coffin at the funeral), that was the worst moment. This was her vehicle, and she is no longer in it.*"

48:30 – [after 1st BLS set] – "*I feel a total collapse in my heart and chest.*" She rates the intensity of the pain at "10" on 1-10 scale.

50:51 – [after 2nd set] – "*I feel like I can breathe a little deeper.*"

54:21 – [after 4th set] – *“I think [the intensity of distress] is about an 8.”*

55:36 – [after 5th set] – *“I am noticing other things around me in the funeral home.”*

58:42 – [after 6th set] – *“I think I am about at a 7 [in intensity of distress]”*

58:56 – [G’s direction before 7th set: “Lean back into that original scene”] – *“It was about a 10, again.”*

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Then, a sudden shift occurred:

61:24 [after 8th set] – (chuckling) *“It’s bizarre. It just suddenly felt like it wasn’t important. How could I go from a 10 to it not being important? It’s really like a 1. What? This is blowing my mind.”*

64:33 [G’s direction before 9th set: “Just do another set and see what it’s like to be at a 1.” (gentle laughter) *“When I was back there now, I’m kind of fixing her hair (makes smoothing motions) and I see her [daughter] standing there laughing at me. (smiling and more laughter). She was teasing me.”*

65:43 [G’s question: What is your impression of all that?] *“It was a gentle reminder that she is still here, she still sees me, she can still joke with me. That wasn’t the end of her.”*

67:50 – [G’s direction before 10th set: Sit with that and see what you notice]. *“She came over behind me and stroked my hair.”*

69:03 – [G’s direction before 11th set: See if you can go back to that original scene and see if you can experience that at a 10.] *“It was (now) a very peaceful moment with her. (I experienced) love, gratitude.”*

When Graham contacted her for permission to use her case in future professional presentations and publications, she said:

The transformation in that session of the grief in that moment of my deepest sadness was indeed stunning. And the transformation continues to this day. The IADC session took that excruciating moment and, rather than erase it or ease it, IADC expanded the moment to include a much greater understanding of ‘more,’ more love, more peace, more gratitude. And even more importantly, spontaneously and organically in the session, [my daughter] and I made a new joyful memory of being together, one of uplifting joy, humor, love exchange, and gratitude. I still feel our little laugh together, and each time I remember that, a huge smile comes to my face. And I’m sure to hers as well. What a gift.

Although clinical reports of the effectiveness of IADC were encouraging, the data did not rise to the evidential level of controlled studies involving psychometrically established assessment instruments. That deficit has recently been corrected by two controlled studies of the effect of IADC on grief.

5. Two Recent Clinical Studies of IADC

5.1 Study at the University of North Texas, Denton, Texas, United States

In this study (Holden et al., 2019), researchers compared the effects of IADC to those of traditional grief counseling (TGC), the latter based on the tasks of grief described by William Worden (2018). Participants were 41 adult Texans who were grieving the loss of a loved one deceased at least six months before the study and who were predominantly female, over 50 years old, and White/non-Hispanic. They were prescreened for an absence of pathological dissociation, psychotic disorder, and suicidality and then randomly assigned to one of the treatment groups: 26 IADC and 15 TGC clients completed the study, reflecting the much higher attrition rate in the TGC group following the first counseling session—despite their option to receive two no-cost IADC sessions after completing TGC.

Each participant completed a pre-assessment package consisting of the Prolonged Grief Disorder scale (Prigerson et al., 2009), the Hogan Grief Reaction Checklist (Hogan et al., 2001), and the Continuing Presence subscale of the Ongoing Attachment Inventory (Hogan et al., 2014), followed by a 90-minute in-person session in their designated treatment modality, then returned one week later to complete a second 90-minute session with the same counselor and modality and complete the assessment package again along with narrative responses to questions about their subjective reactions to their counseling experience.

Results showed an overall significant treatment effect ($p = .02$) with a very large effect size ($\eta^2 = .40$; Datastatpro, 2025); IADC was significantly more beneficial than TGC. Further analysis revealed that, compared to TGC participants, IADC participants showed greater improvement on all variables.

For the six Hogan factors, with a Bonferroni adjusted ANCOVA significance criterion of $p < .008$, IADC participants showed a significantly greater reduction in Blame and anger ($p = .007$, medium effect); a near-significant greater reduction in Despair ($p = .009$, medium effect); and a non-significant greater increase on the Hogan factor Personal Growth ($p = .06$, small effect) and greater reduction in Disorganization ($p = .10$, small effect), Panic Behavior ($p = .14$, small effect), and Detachment ($p = .56$, no effect).

For the Ongoing Attachment Inventory factor, with a significance criterion of $p < .05$, IADC participants showed a near-significant greater increase in Continuing Presence ($p = .06$, small effect). Participants' narrative responses corresponded to these quantitative results. Regarding prolonged grief disorder, the same two TGC clients who met criteria at pre-test also met it at post-test, whereas only two of the four IADC clients who met criteria at pre-test also met it at post-test.

At least three points are worth emphasizing regarding the results. One point is the rarity of a two-session treatment to show a large treatment effect. In this study, IADC was, indeed, shown to be a uniquely powerful intervention to reduce distressing and increase beneficial grief symptoms. Another point is that, to our knowledge, this study was the first to confirm with data that mentally healthy people experience ADC—as all of our participants had been screened for good mental health, and most of the IADC participants reported ADC.

A final point involves the findings of the two grief researchers (Hall, 2014; Schut, 2010) who had concluded that grief counseling is more effective for clients who meet the criterion for, or are at risk of, prolonged grief disorder: In our study, the majority of IADC participants, who did not meet this criterion, showed significant change, indicating that IADC may be uniquely beneficial to the majority of people who struggle with grief but not to the point of emotional and/or functional impairment.

5.2 Study at Adelaide University, Adelaide, Australia

For this study, researchers (Nehmy et al., 2026) compared the effects of IADC therapy on grief to participants' own grief symptoms during the month prior to therapy. Participants were 43 predominantly female adult Australians who had lost a loved one at least six months prior, who were not suicidal, and who were willing to tolerate very strong affect during the research intervention. Participants were assessed once, and then again one month later, to establish a baseline; at which point they received two 90-minute IADC sessions one day apart—18 participants in person and 25 via telehealth; then were assessed again one month later for follow-up. The assessment consisted of the International Prolonged Grief Disorder Scale (Killikelly et al., 2020), the Hogan Grief Reaction Checklist (Hogan et al., 2001), the Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995a, 1995b; Crawford & Henry, 2003), rating of subjective average daily sadness from 0 (not at all sad) to 10 (as sad as I've ever felt), the Continuing Presence subscale of the Ongoing Attachment Inventory (Hogan et al., 2014), and reported occurrence of ADC.

Results indicated that between baseline and one-month follow-up, the primary measures of global grief severity and average daily sadness decreased significantly, with a very large treatment effect ($d = -1.56$; Sullivan & Feinn, 2012), and on all six Hogan subscales and all three DASS subscales, participants improved, with large effects. In addition, of the nine participants who met criteria at baseline for prolonged grief disorder, three met criteria at follow-up, a statistically significant reduction. Treatment effects were not related to time since loss, initial symptom severity, or in-person vs. telehealth delivery method. Having an ADC did not predict better outcomes on the primary measures, but the statistical power of this analysis was low, because most participants had an ADC during the intervention, so these results are equivocal. Those who had an ADC were significantly higher on the Continuing Presence factor at follow-up, with a large effect. Reductions in sadness did not depend on having an ADC but, rather, were the result of the BLS aspect of the intervention.

Perhaps most noteworthy about these results is comparison of the very large effect size—the clinical treatment effect—of this study to the effect sizes found in meta-analyses of some of the most widely used psychotherapy interventions, ranging from medium to large; see Figure 1. And, once again, IADC in this study proved effective both for participants who met criteria for prolonged grief disorder and for those who did not.

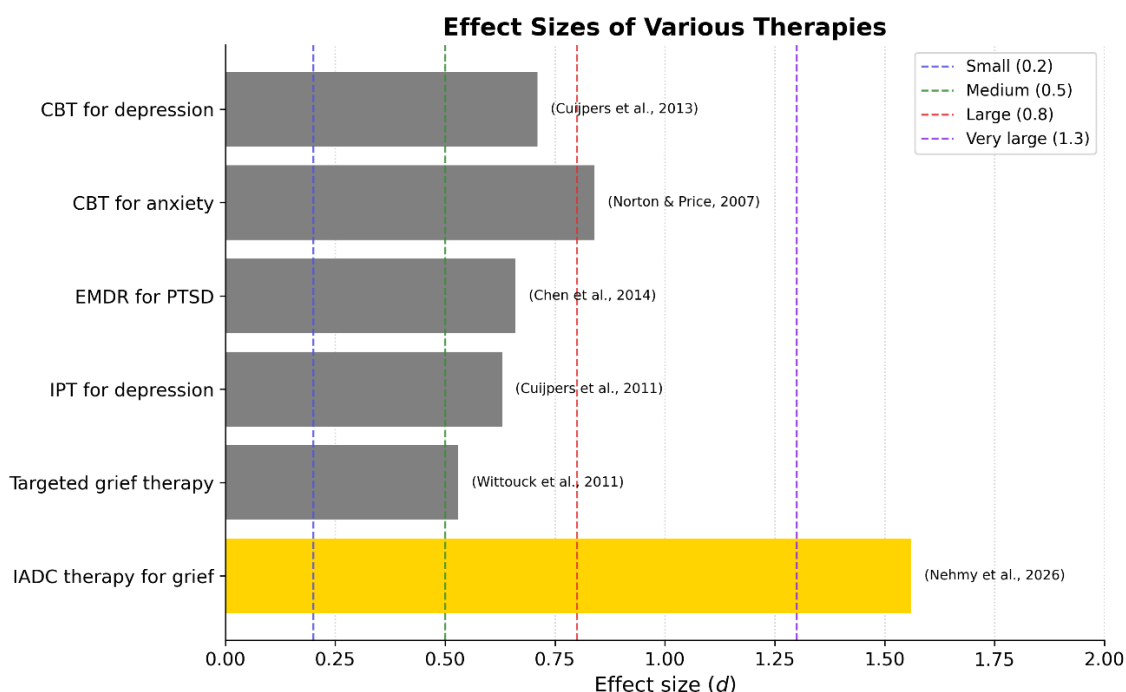


Figure 1: Comparison of Effect Sizes of Meta-Analyses of Widely Used Psychotherapy Interventions to Effect Size of This IADC Study

6. Other Studies Referencing IADC

Four other studies have been published with reference to IADC. The first of these was an intervention study. It is unclear whether the IADC protocol in this study was the same as the protocol used in the aforementioned two studies: Although the text of the article indicates that it was, personal communication between the lead author and a co-author of the above studies brings into question whether the protocol of this third study may have included suggestion and prompting of participants, which is absent in the classical IADC protocol. Although comparison of results of this third study to those of the previous two may, therefore, be “apples and oranges,” summary of this study, and three subsequent ones related to it, are certainly worth mentioning here.

In the intervention study, Fabio D’Antoni and colleagues (2025) compared the effects on grief of their IADC intervention to those of talk therapy with EMDR (T&E). They assessed their 42 IADC participants and 43 T&E participants at pre-treatment, post-treatment, and six-month follow-up with four instruments, including the psychometrically established Inventory of Complicated Grief (ICG) and IADC Grief Questionnaire (IADC-GQ). IADC participants received two 2-hour sessions one week apart, whereas T&E participants received at least four hours of therapy, though exact data in this regard could not be collected. They found that the IADC participants showed significantly greater reduction in grief intensity on the ICG at post-treatment and non-significantly greater reduction at follow-up, with effect sizes not reported; marginally significant reduction in grief symptoms on the IADC-GQ Clinical subscale at post-test, with medium effect, and significant reduction at follow-up, with medium effect; and significantly higher continuing bonds scores at both post-treatment and follow-up, with no effect sizes reported.

In one further study, D'Antoni and Lalla (2026) used a pre-post design to investigate predictors of clinical outcome in IADC therapy with 73 bereaved adults. They found significant reduction of grief symptoms, with a large effect; significant increase in continuing bonds, with a small effect; and high patient-reported satisfaction with the intervention. They also found that participants improved significantly less who scored relatively higher in alexithymia, anxious attachment style, and need for approval, and significantly more if they scored higher on the personality trait of Openness. They did not indicate which participants did or did not have an ADC during the intervention or whether any of the assessed factors were related to the occurrence or absence of ADC. They suggested that IADC practitioners assess for the three potentially clinically complicating factors they found and provided suggestions for practitioners working with clients evidencing one or more of those factors.

In two further studies, Lalla and D'Antoni ventured further into new research territory. In one of these (Lalla & D'Antoni, 2025), they administered the Italian version of the Near-Death Experience Scale (Pistoia et al., 2018) to 56 former IADC clients—who presumably had experienced ADC during their intervention, although the authors did not state this point explicitly—and found that 51 scored 7 or higher, indicating the presence of a near-death experience (NDE) and, thus, substantial phenomenological overlap between IADC experiences and NDEs. In the other study (Lalla & D'Antoni, 2026), the researchers established the Emergency Post-Loss Experiences Scale (EPLS) to assess the phenomenology of EPLEs, their new term for ADC.

7. Discussion

Especially considering that IADC is a two-session treatment, compared to most psychotherapy interventions that are multi-session, IADC appears to provide an especially efficacious approach to grief counseling that is economical to clients in both time and expense. In addition, despite meta-analysis yielding only a barely medium effect for targeted grief therapy (Wittouck et al., 2011), IADC research has yielded two studies with significant results indicating very large treatment effects. And despite previous grief researchers concluding that traditional grief therapy may be effective primarily for clients who meet criteria for prolonged grief disorder (Hall, 2014; Schut, 2010), both of the IADC studies showed improvement for participants who did not meet those criteria but who, nevertheless, were motivated to seek relief from painful grief symptoms.

As of the writing of this article, the developer of IADC, Al Botkin, passed recently—February 26, 2026. He contributed to the world not only an apparently exceptional psychotherapy intervention for bereaved clients but also a unique insight into the essentially spontaneous nature of ADC. While he was training co-author Holden, he related the following experience.

He had been providing IADC for a few years when he was working one day with an IADC client, a young man who was grieving the death of his brother. This client, it turned out, had an exceptional ability to connect with his disembodied brother, with contacts that involved long, detailed—and, of course, very healing—conversations. Because of this success, Al had seen this client for more than the standard two sessions. As one of these later sessions came to a close, the client felt finished for the day, but about

10 minutes remained in the session. Al reportedly said something to the effect of, “I’ve never asked a client this question before, but you have such an affinity for connection with your brother, and I have a few unanswered questions about IADC that I would love to ask your brother. Would you be willing to ask him these questions on my behalf?” The client agreed, and Al provided a set of eye movements for his client to inquire whether his disembodied brother was also willing—which, the client reported, he was. After asking a couple of questions, Al got to his biggest one: In the approximately 20% of cases in which an IADC client did not have an ADC, Al almost always thought he knew why: Some other emotional block stood in the way of contact with the disembodied loved one. But in some cases, Al detected no such block—nor any reason why the client “shouldn’t” have an ADC, yet they did not. Al wondered if the disembodied brother might offer some insight. He provided a set of eye movements to his client, who then closed his eyes, and Al waited for the client to relate the brother’s response. When he did—without opening his eyes—he said to Al, “My brother says to tell you that you think you’re in charge, but we’re in charge. We decide *if* we will come, *how* we will come—and it all depends on the wellbeing of the living person. If we don’t think it’s in their best interest to come, we won’t” (A. Botkin, personal communication to Holden, 2006).

In the absence of an empirical explanation for why some clients show every indication of the ability to have an ADC during IADC but do not, this admittedly anecdotal experience of Botkin’s provides a possible transpersonal explanation. It points to what, for the living, may explain the essentially “spontaneous”—that is, unpredictable—nature of ADC: that no one can actually induce an ADC. Rather, one can only facilitate a state of consciousness in the bereaved in which an ADC is more likely to occur—and the ultimate cause of whether it does occur lies outside the control of any person, client, or therapist—indeed, outside the control of the material world at all. The experience in both facilitated and unfacilitated conditions remains essentially spontaneous.

Returning to the perspective of the material world with its empirical demands, we believe that IADC is well on its way to becoming an evidence-based practice (EBP; APA Presidential Task Force on Evidence-Based Practice, 2006). The research evidence so far is uniformly positive but still very limited, especially with regard to randomized controlled studies—only Holden et al. (2019) so far, demographic diversity of clients, and multiple studies that can be meta-analyzed. For the intervention to firmly achieve EBP status, researchers will ideally conduct additional randomized, controlled studies, ensuring use of the classical IADC procedure and, in particular, involving participants who represent diverse demographic characteristics to establish its broad applicability, leading to meta-analyses that yield strong clinical effects. The clinical picture would also be enriched if, like Elsasesser et al. (2025) who included qualitative data in their research on unfacilitated ADC, future IADC researchers included qualitative analysis of the ADCs that participants reported.

Meanwhile, licensed mental health professionals interested in becoming an IADC Certified Therapist can find empirical justification for IADC from the existing cases and experimental evidence and can obtain training information at <https://www.iadcinstitute.com/training>. Our vision is a world in which people worldwide have access to this uniquely healing approach to grief counseling.

Conflict of interest: We have no known conflict of interest to disclose.

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