

Case Report

Visions at Life's End: Normalising and Validating Distressing End-of-Life Experiences – A Case Report

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ABSTRACT

The end-of-life phase in individuals with chronic and life-threatening illnesses such as cancer is a clinically significant and emotionally vulnerable period. During this time, patients may report vivid dreams and visions that typically occur in the hours, days or weeks preceding death, which are deeply subjective. There is a lacuna in the literature about end-of-life dreams and visions (ELDVs), as they often go unreported due to fear of stigma. This case describes the experience of a young female with metastatic cancer who encountered disturbing and distressing ELDV. This case highlights the therapeutic value of basic counselling skills in palliative care, particularly validation and normalisation, to alleviate the psychological distress and ensure patient comfort during the final stages of life. As one of the few cases reported from India, this report contributes to existing literature and underscores the need for open dialogue about ELDVs in palliative care.

Keywords: Counselling, End-of-life dreams and visions, Existential distress, Palliative care, Psychosocial support

INTRODUCTION

End-of-life dreams and visions (ELDVs) are a phenomenon frequently encountered in palliative care. It is estimated that approximately 50–60% of conscious, dying individuals experience such dreams or visions, which may involve seeing deceased loved ones, spiritual figures or receiving messages that symbolically prepare the individual for death.^[1] These so-called 'deathbed dreams and visions' are often comforting, pleasant and peaceful, involving departed relatives, friends or religious figures who facilitate the transition to death,^[2] however in some instances, they may also be distressing. Understanding the phenomenological experiences of people at the end of life is essential to the comprehensive treatment inherent in palliative and hospice care.^[3] Despite their psychological significance, ELDVs are frequently misunderstood or dismissed. Patients often hesitate to disclose these experiences for the fear of being judged or stigmatised, especially in certain sociocultural contexts such as India, where some of these experiences are connected with spiritual or religious frameworks. In collectivist cultural settings, family interpretations and responses often have a strong influence on whether such experiences

are acknowledged, normalised or silenced.^[4,5] As a result, many cases go unreported, especially from non-Western settings. While most literature highlights ELDVs as sources of peace and solace, this case stands out by documenting an unusually distressing experience. This case report describes a distressing ELDV experience and highlights the importance of validation and normalisation through counselling interventions in palliative care.

CASE REPORT

Mrs. S was a 30-year-old woman, educated, employed from a middle socioeconomic background diagnosed with spindle cell sarcoma of the right iliac bone with metastatic spread to the kidneys and lungs. She was in the terminal stage of her illness, receiving palliative care; her palliative performance scale was 30. She was a mother of two young children, supported by her mother and husband's family.

Mrs. S illness journey, had been both physically and emotionally taxing. Having lost her father to a malignancy at a very young age, she reported traumatic memories associated with his end-of-life experience. This resurfaced when she was faced with her own mortality. Her illness and her father's early death made this a deeply personal struggle. Although

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her disease trajectory was punctuated with multiple setbacks, Mrs. S exhibited adaptive coping to evolving challenges. She openly engaged in conversations about her prognosis and care preferences.

Mrs. S's condition worsened, and she was referred to the palliative care team on 04 August 2023, after which she was in regular follow-up. Mrs. S sought 20 consultations over 1 month, including multiple hospital admissions. The timeline of care for Mrs. S is depicted in Figure 1. Her condition remained largely stable until June 17, 2024, when she began to experience distressing ELDV. She was initially very confused about whether it was a dream or her imagination. She experienced intense fear and anxiety over these visions. Psychological distress was assessed using National Cancer Comprehensive Network (NCCN) Distress Thermometer, which showed high level of distress. She hesitated to discuss this with others, perceiving them as 'something 'paranormal' that others might not understand, and found it difficult to explain convincingly and hence refrained from sharing them with anyone else.^[6]

The frequency and intensity of the visions increased in the following weeks. It was persistent even when she went back home, when she started to believe that they signified impending death. This intensified her anxiety and a sense of helplessness, and when she could no longer handle the distress, Mrs. S shared her dreams and visions with her family. They were quick to be dismissive, attributing them to her imagination, reinforcing her reluctance to express distress. This made her feel more unheard and anxious. Moreover, this lack of validation from her family significantly intensified her emotional suffering. During one of her admissions, Mrs. S shared her dread with the palliative care team. She described recurrent episodes of seeing a black, unknown, unfamiliar character that spoke to her, while she was awake, warning that her continued life would bring her more suffering. She perceived from her recurring visions as a warning that her prolonged living signified the suffering ahead. The psychologist normalised that such visions are commonly reported by patients with advanced illness, on-going treatments and repeated hospitalisations, which was very reassuring to Mrs. S. This simple intervention provided immense relief and alleviated the associated fear.

Using foundational counselling skills such as validation and normalisation had a powerful impact. Following this, Mrs. S reported a significant reduction in the intensity of fear associated with her visions and that she was able to openly talk about it. Although the visions did not reduce, they were less distressing as she did not interpret them as threatening. Psychoeducation was provided to her family to demonstrate more understanding and supportive responses to Mrs. S's fears and emotions. Medication-induced hallucinations and delirium were considered, but there was sustained insight and orientation, suggesting these visions to be a phenomenological experience rather than psychopathology. She was under home care and telephonic follow-up to provide continuity of support. The home care team visited her until 6 days before her death on 17 July 2024. A bereavement follow-up call was made to the family on 23 July 2024 by the counsellor.

DISCUSSION

This case highlights ELDV in palliative care, underscoring the impact of basic counselling skills to ensure comfort during the final days of life. Acknowledging Mrs. S's experiences as not abnormal and reassuring her that they do not imply loss of control was pivotal in her journey. Utmost care was taken to ensure that this normalisation did not come across as dismissive or undermine her sense of dread. Expressing her anxieties in a non-judgmental space made her feel emotionally protected. Rabitti *et al.* (2024) reported that an individual's self-worth can be positively affected through active listening, validating experiences and normalising end-of-life visions.^[4] Similar studies by Grant *et al.* (2023)^[7] have corroborated these findings, emphasising the need to provide a free and tolerant environment that encourages discussion of ELDVs. When Mrs S's family was made aware that her experience was genuinely a clinical case and not something to be ignored or ridiculed, it made her feel very emotionally stable and comforted. Research from family-centric cultures emphasises that end-of-life experiences are interpreted through collective beliefs, which makes family validation as critical as clinical normalisation (Boston *et al.*, 2011; Venkatesh *et al.*, 2015; Rabitti *et al.*, 2024).^[4,5,8] The interpretations amongst the patient, her family and clinicians

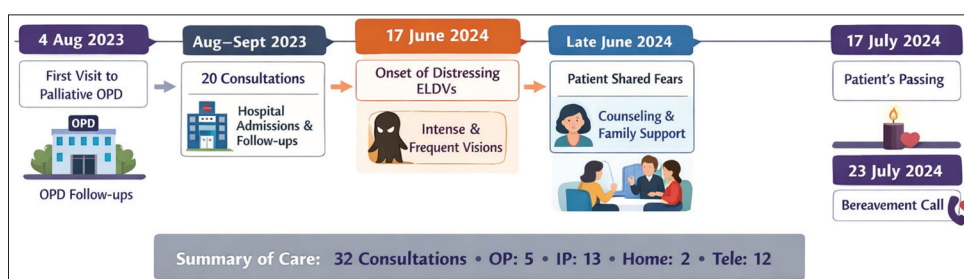


Figure 1: Timeline of care for Mrs. S. ELDV: End-of-life dreams and visions, OPD: Outpatient department.

Table 1: Key differences in perception and response to ELDVs amongst patients, families and clinicians.

Aspect	Patient's perspective	Family's perspective	Doctors' perspective
Emotional domain			
Emotional response	Distressing, frightening, fear of being judged	Patient is confused, ignore her distress	Drug-induced confusion, terminal delirium, recognised the need for communication
Impact	Increased anxiety and distress	Fear of patient's death and lack of emotional support for the patient	Importance of psychological interventions
Cognitive domain			
Interpretation	Signified impending doom, losing control, approach of death	Considered side effects of drugs, lack of sleep, losing cognition	Medical phenomenon, delirium-related
Reason for perception	Fear of judgment and lack of understanding about ELDVs	Lack of awareness and cultural beliefs	Palliative training emphasised holistic approach
Behavioral/communication domain			
Communication	Hesitant to share due to stigma and sought validation	Dismissed her experiences as imagination	Recognised the need for validation and reassurance, especially in medical interactions
Intervention and outcome			
Intervention	Psychological support provided relief	Psychoeducation helped them understand and acknowledge	Validation and reframing reduced distress
Consequences after intervention	Felt heard and validated, leading to reduced distress and increased peace.	Became more emotionally available and supportive, strengthening patient-family bonds.	Developed a more holistic approach, incorporating existential and emotional aspects into care.
ELDVs: End-of-life dreams and visions			

are summarised in Table 1. Six vital points were highlighted as utmost critical to ensure honest exchanges on ELDVs, based on research conducted amongst 13 multidisciplinary hospice providers. The essential themes identified were: Normalisation, rapport building, active listening, individual meaning-making, barriers and education.^[7]

The findings of Boston *et al.*, in 2011, stressed that patients and their family members often failed to freely exchange their anxieties and feelings with one another, even during an existential distressing situation^[8] in synchronisation with the highlights reported in our study. As advocated by the study, clinicians can play a vital role by delving deep into patients' individual experiences to understand the correct situation rather than automatically concluding on the pathology with a preconceived bias. This is similar to our strategy, which reiterates the significance of an unbiased, neutral, empathetic approach to issues contributing to both patients' and their families' mental solace and acceptance of the situation. These studies demonstrate the value of training on ELDVs for clinicians as part of their palliative care education. Existing literature on ELDVs typically describes seeing deceased family, friends or religious figures and lessens the fear of dying, making the transition from life to death easier for those experiencing them.^[9] However, the present case differs significantly from this. Unlike the predominantly pleasant and meaningful ELDVs reported in earlier studies,

Mrs. S experienced recurring visions that were frightening, unpleasant and distressing. The traumatic loss of her father to malignancy might have shaped the unresolved grief and developed her sensitivity to death. Rather than offering solace, these experiences heightened her emotional discomfort and fear. This underscores the importance of recognising the variability in ELDV content, and the need for sensitive psychological support when such visions are experienced as disturbing. Encouraging Mrs. S to view these visions as part of how her mind processes her journey, rather than as something external, allowed her to regain peace. Engaging with her regularly provided her reassurance and also ensured that she felt heard and supported throughout her final days.

CONCLUSION

Psychosocial support in palliative care is very important. This case highlights the necessity of basic counselling principles in alleviating distress. Enabling patients to express their feelings, fears or desires gives them a profound sense of control. Validating the meaning patients attribute to their experiences, within their cultural and family context, especially in end-of-life care, fosters dignity and peace. Systematic documentation of such cases is very crucial, as it contributes to a deeper understanding of end-of-life care, and every experience is unique. This case emphasises the need for ELDV awareness training within palliative teams; furthermore, it encourages

clinicians to explore patients' subjective experiences without prematurely pathologising them.

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