

Experiencer-Aware Care

A clinician's quick reference | The Experiencer Team | experiencerteam.com/professionals

First, the stance

- Listen first. Let the person set the pace. Stay neutral on what literally happened.
- Most experiencers are well. Distress usually comes from the experience itself and from being disbelieved, not from an underlying disorder.

Screen as you would with anyone

Risk (C-SSRS), trauma (PCL-5), psychosis, dissociation (DES-II), sleep, substances, and medical or neurological causes. Let the findings, not the content of the story, guide you.

Reassuring signs (a well person)

- Experience bounded in time rather than ongoing and escalating.
- Reality-testing intact; distress proportionate and easing as the person feels heard.
- Functioning preserved; the person can hold uncertainty about what happened.

Refer or escalate when present

- Worsening functional decline, self-neglect, or withdrawal.
- Disorganized thinking, or beliefs that are fixed, systematized, and expanding.
- Command content or direction toward harm; suicidal or homicidal ideation, intent, or plan.
- First onset of marked change in mid or later life; heavy substance use or a fitting medical picture.
- If risk is present, act on it.

Common conditions to rule in or out

- Sleep paralysis with hypnopompic or hypnagogic imagery (the nighttime 'presence in the room').
- Psychotic or prodromal presentation; dissociation (altered or 'missing' time).
- Substances and medications; neurological causes (temporal-lobe activity, migraine aura).
- Bereavement and after-death communication, which are normative in grief.

Documentation

When a spiritual or anomalous experience is the focus and no disorder is present, use the DSM-5 code Religious or Spiritual Problem (V62.89, ICD-10-CM Z65.8). It is a Z-code, not a diagnosis.

A useful opening

"Tell me about the experience in your own words, and what it has been like to live with."