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Meaning-centered dream work with hospice patients: A pilot study

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ABSTRACT

Objective: Hospice patients often struggle with loss of meaning, while many experience meaningful dreams. The purpose of this study was to conduct a preliminary exploration into the process and therapeutic outcomes of meaning-centered dream work with hospice patients.

Method: A meaning-centered variation of the cognitive–experiential model of dream work (Hill, 1996; 2004) was tested with participants. This variation was influenced by the tenets of meaning-centered psychotherapy (Breitbart et al., 2012). A total of 12 dream-work sessions were conducted with 7 hospice patients (5 women), and session transcripts were analyzed using the consensual qualitative research (CQR) method (Hill, 2012). Participants also completed measures of gains from dream interpretation in terms of existential well-being and quality of life.

Results: Participants' dreams generally featured familiar settings and living family and friends. Reported images from dreams were usually connected to feelings, relationships, and the concerns of waking life. Participants typically interpreted their dreams as meaning that they needed to change their way of thinking, address legacy concerns, or complete unfinished business. Generally, participants developed and implemented action plans based on these interpretations, despite their physical limitations. Participants described dream-work sessions as meaningful, comforting, and helpful. High scores on a measure of gains from dream interpretation were reported, consistent with qualitative findings. No adverse effects were reported or indicated by assessments.

Significance of Results: Our results provided initial support for the feasibility and helpfulness of dream work in this population. Implications for counseling with the dying and directions for future research were also explored.

KEYWORDS: Dream work, Meaning, End of life, Hospice, Palliative care, Existential well-being

INTRODUCTION

Palliative care, generally provided to individuals with advanced and serious physical illness, is a holistic interdisciplinary approach that focuses on symptom relief and enhancing quality of life (Blinderman & Cherny, 2005). Despite its holistic philosophy, palliative care has largely focused on physical states of suffering, despite the recognition that nonphysical states of distress are common at the end of life (Breitbart et al., 2004; Chochinov et al., 2004; 2009). This incongruity suggests that psychosocial and existential/spiritual concerns warrant greater attention proportionate to their clinical relevance (Heintz, 2007; Kon & Ablin, 2010) and consistent with the central tenets of palliative care that emphasize treating the patient in totality (Saunders, 1988). The present study reflected an attempt to contribute to the growing movement in palliative care

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research to develop new interventions to meet patients' psychological needs. Specifically, we piloted a new intervention meant to harness the healing power of dreams and the importance of personal meaning for those facing the end of life.

One's sense of meaning is a primary component of existential well-being, as reflected poignantly in the work of Austrian psychiatrist Viktor Frankl, whose time in Nazi concentration camps inspired his approach to psychotherapy. This psychotherapeutic approach recognized the human capacity for choosing one's attitude toward suffering, and to survive otherwise intolerable conditions when one retains a sense of meaning in life. This theory is particularly relevant for the dying, who face one of the most difficult transitions of life and often struggle to find meaning in their suffering. Furthermore, facing loss and mortality can be paradoxically productive, as the process of redefining one's sense of personal meaning can transform tragedy into personal triumph (Breitbart et al., 2004). Erikson (1980) also recognized personal meaning at the end of life in the eighth stage of his developmental model, "integrity versus despair." This stage is precipitated by an increased awareness of one's mortality and is characterized by a struggle between fears about death and acceptance of the course and meaningfulness of one's life (Jacobsen et al., 2006). The existential distress experienced in the absence of meaning during dying is an acutely demoralizing condition (Schuman-Olivier et al., 2008; Vehling et al., 2012).

Researchers have proposed several therapeutic interventions to assist the dying in fostering a sense of meaning. One of these is meaning-centered psychotherapy (Breitbart, 2003), which was developed for use with advanced cancer patients and emphasizes meaning-making through a combination of didactic, experiential, and discussion activities. A randomized controlled trial found that cancer patients undergoing meaning-centered group psychotherapy demonstrated significant improvement in spiritual well-being and sense of meaning, decreased anxiety, and a lessened desire for death (Breitbart et al., 2010). A second trial found those undergoing individual meaning-centered psychotherapy experienced significant improvements in spiritual well-being, quality of life, symptom burden, and related stress (Breitbart et al., 2012). These promising initial findings suggest that further study and innovation on meaning-centered psychotherapy is warranted (Henoch & Danielson, 2009), particularly for those at the end of life.

Dreams at the End of Life

Nonscientific literature has long suggested that end-of-life dreams can have existential significance (Barrett, 1926; Gurney et al., 1886; Wills-Brandon, 2000). However, this suggestion remains largely unexplored in the clinical literature as well as in education and practice. The existential issues raised by dreams have also been underemphasized within palliative care (Brayne et al., 2006). The limited data regarding end-of-life dreams suggest that they often reflect issues of grief and loss brought on by approaching death (Prince & Hoffmann, 1991). Studies also suggest that these experiences include common themes such as seeing deceased loved ones sitting by the bedside or coming to take the dying person away, resolution of psychological "baggage," and comfort in the face of death (Brayne et al., 2006; 2008; Fenwick et al., 2010; Kerr et al., 2014; Nosek et al., 2014). These studies describe commonalities in the manifestation and impact of dreams at the end of life and suggest that vivid dreams are not only common during the dying process (Brayne et al., 2008; Fenwick et al., 2010) but may also influence existential well-being and may play a role in psychological preparation for death. Palliative care clinicians often view dreaming as an intrinsic part of the dying process, which assists people in reconciling their lives, completing "unfinished business," and coming to terms with approaching death (Brayne et al., 2006). Furthermore, 70% of clinicians in one study reported that end-of-life dreams were a source of meaning for their patients (Fenwick et al., 2010). Some research also suggests that the content and meaningfulness of dreams follow a predictable pattern at the end of life. In a longitudinal study, Kerr et al. (2014) found that as participants approached death, end-of-life dreams and visions about deceased loved ones became more frequent and were associated with greater comfort than other kinds of dreams and visions. Taken together, these findings indicate that end-of-life dreams may be relevant to meaning-centered therapy for those preparing for death.

Although Freud (1998) was the first to systematize an approach to utilizing dreams in psychotherapy, he did not believe that those at the end of life had the cognitive capacity or mental flexibility to engage in meaningful therapeutic work (Brink, 1977). In contrast, Jung (2010) worked primarily with those in the second half of life and believed that dream work could assist patients in processing the psychological transition of oncoming death. While few studies have explored dream work with this population, those that are published appear to support Jung's position. Brink (1977) presented two case studies and reported that elderly clients benefited when they were able to affectively engage with their dreams. The dreams in those cases provided a catalyst for addressing clients' presenting concerns, and Brink noted that this procedure seemed helpful despite

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age-related reduction in REM sleep and dream recall. Muff (1996) reported increased acceptance of death following dream analysis with three AIDS patients. DeCicco and colleagues (2010) reported that 73% of women with breast cancer felt their dreams were directly related to their illness, provided insight, and lessened illness-related distress.

Terminal illness is often inherently isolating, which further contributes to existential distress. Goelitz (2001) suggested that working with dreams may lessen isolation by contributing to the development of the therapeutic relationship. This approach may be effective because dream work allows the therapist to access emotions and help a client affectively engage with his or her concerns (Brink, 1977; Hill, 1996). The emotional catalyst provided by dream work may accelerate the therapeutic process and build the foundation for discussion of difficult topics, such as the grief and loss associated with dying (Goelitz, 2007). Magee (1992) postulated that dream analysis can be helpful in facilitating the life-review process for older adults because it allows for insight into memories and reflection on the present. While these case studies provide some initial support for the concept, it is clear that further research on dream work at the end of life is warranted (DeCicco et al., 2010; Goelitz, 2007).

The Cognitive–Experiential Model of Dream Work

The cognitive–experiential model of dream work (Hill, 1996) is the most well-researched and empirically supported model of dream work currently in use (Pesant & Zadra, 2004; Hill, 2004). This model conceptualizes dreams as the result of an autonomous process by which the sleeping mind attempts to incorporate waking events with cognitive schemata based on past experiences. This functional approach to dreaming postulates that dreams may reflect the concerns of waking life, and vivid or emotionally arousing dreams may arise from experiences that are particularly discrepant with preexisting beliefs and memories.

Dream work in psychotherapy, according to Hill's model, is a means of augmenting this autonomous process and thereby a way to address challenging topics that otherwise might not arise in counseling. Hill postulates that because dreams are primarily composed of images and metaphorical representations, they can assist clients in approaching issues in therapy at an affective, experiential level. This approach is consistent with Epstein's (1994) cognitive–experiential self theory, which suggests that both images and metaphors communicate with a person's experiential system of information processing. This allows for greater changes in cognition and behavior than when the individual is stimulated at a rational level alone. When dreams are utilized in psychotherapy, cognitive schemata may be activated through the experiential mode by means of exploring the affect associated with various dream symbols. This may allow the therapist and client to work collaboratively toward an interpretation and action plan for addressing the discrepant experiences brought to light by the dream.

The cognitive–experiential approach to dream work proceeds through three stages: "exploration," "insight," and "action." During the exploration stage, the therapist guides the client through a retelling of the dream. Each important dream image is isolated, and the client then explores his or her associations with that image, each time returning to the original image. This leads naturally to the connection of dream images to waking experiences, feelings, and memories. During the insight stage, the therapist guides the client through the process of connecting his or her associations into a cohesive theory, or interpretation, regarding the meaning of the dream. The emphasis is on a collaborative effort between therapist and client, rather than a prescriptive approach. During this phase, several levels of interpretation are possible, including the phenomenological experience of the dream itself, the connection between the dream and waking life, reflection upon past experience, and/or the symbolic manifestation of aspects of oneself in the images of the dream. During the action stage, the client is encouraged to take some action to solidify the meaning of the dream arrived at in the insight stage, and to effect a change in schemata, behavior, and/or environment to resolve the conflicts uncovered by the dream. In forming an action plan, the client applies the new understanding achieved by consciously changing some aspect of the dream, continuing to mine the dream for further insights, developing ideas for action, or changing aspects of his or her waking life.

The efficacy of the cognitive–experiential approach to dream interpretation has been supported by a number of empirical studies (for reviews, see Hill & Goates, 2004; Pesant & Zadra, 2004). Hill and colleagues' study (2000) is of particular relevance to the application of this model to the end-of-life population. In this study, clients who had experienced recent losses and were suffering from troubling dreams benefited more from dream-focused counseling than from loss-focused counseling in terms of depth, working alliance, and insight. By extension, this intervention may be an effective way of addressing the losses associated with existential distress among the dying. Davis and Hill (2005) explored the efficacy of a modification of this model

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that included a spiritual and existential focus. They found that self-identified "spiritual" clients in a spiritual dream interpretation condition experienced greater gains in spiritual insight into dreams, as well as general existential well-being, compared to control groups. This was the first study to specifically and systematically examine the relationship between the cognitive–experiential model of dream interpretation and existential well-being. A recent study (Hess et al., 2013) explored dream-work sessions with hospice workers and was the first published application of this model to the end-of-life environment. The results of that study, that dream work helped hospice workers come to terms with the deterioration and death of those they cared for, provide further impetus for studying this approach with the hospice patients themselves.

The Present Study

The present pilot study was based on Frankl's (2006) theoretical assumption that the ability to find or create meaning allows human beings to transcend challenges to freedom, dignity, or personhood, including the prospect of death. Because hospice patients often struggle with meaning, and end-of-life dreams represent a potential source of meaning, the present study introduced a meaning-centered variant of the cognitive–experiential model of dream work for use with those at the end of life. Given the lack of dream-work studies within a hospice population, this pilot study sought to provide preliminary data on the process and outcomes of this novel counseling modality. The qualitative methodology employed was designed to facilitate exploration of the major themes in content, process, and outcome of dream sessions with hospice patients. Some quantitative data on the benefits of dream interpretation, existential well-being, and quality of life were also collected to enrich the qualitative data, in the fashion described by Seymour (2012). It was hypothesized that dream work would be helpful to participants in reconnecting to sources of meaning, that dream content would be consistent with prior studies of hospice patients' dream, and that the intervention would prove feasible and safe with this sample.

METHODS

Participants

Hospice Patients

Hospice patients who reported vivid or disturbing dreams, who expressed a desire to explore dreams in more depth, or who were identified by the care team as needing additional psychosocial support were referred to the study by members of a multidisciplinary palliative care team (nurses, social workers, chaplains, and expressive therapists). Participants had been diagnosed with a terminal illness, were not pursuing curative or aggressive treatments, and had an estimated life expectancy of six or fewer months. Recruited participants were required to be at least 18 years of age. Only those with functional scores of 30 or greater on the Palliative Performance Scale (PPS) (Anderson et al., 1996) were considered eligible, as such patients are typically able to engage comfortably in normal conversation.

Those who met the criteria for cognitive disorder, delirium, or dementia according to the DSM–IV–TR (American Psychiatric Association, 2000) were excluded from the study. Referred patients who met the inclusion criteria were approached and given the opportunity to provide informed consent if they wished to participate.

The inherent difficulties in research with hospice patients posed recruitment challenges: of 19 patients approached, 10 agreed to participate, and attrition and participant death led to a final sample size of 7. While smaller than the ideal sample size of 12–15 recommended for consensual qualitative research (CQR) by Hill and Williams (2012), this number falls within one standard deviation (11.5) of the mean sample size (15.7) they reported for published CQR studies.

Participant Demographics

Most participants ($n = 5$) were female, and the average age was 69.9 years ($SD = 14.7$). Primary diagnoses included lung cancer ($n = 2$), colon cancer ($n = 1$), ovarian cancer ($n = 1$), cerebellar ataxia ($n = 1$), adult failure to thrive ($n = 1$), and COPD ($n = 1$). All participants were of white European descent, and all reported a Christian religious affiliation. Most ($n = 4$) were referred to the study for reporting vivid dreams, one was referred for disturbing dreams ($n = 1$), and others expressed both an interest in dream work and a need for additional psychosocial support, but did not report having dreams at the time of recruitment ($n = 2$).

Procedure

Meaning-Centered Dream-Work Process

Participants underwent up to two dream-work sessions with the research therapist (first author). Sessions followed the dream interpretation procedure developed by Hill (1996; 2004), proceeding through the exploration, insight, and action stages. The insight stage was modified to include a focus on personal meaning, following the precedent set by

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Davis and Hill's (2005) spirituality-focused variant. This meaning-focused variant emphasized the relationship between participants' dreams and their sense of meaning in life. The work of Breitbart et al. (2010; 2012), Frankl (2006), and other existential psychotherapists provided the framework and theoretical foundation for this process. Specifically, the research therapist asked participants to reflect on and describe sources of meaning in their lives, attitudes toward meaning, obstacles to finding meaning, hopes for the future, and limitations related to illness, prior to commencing the insight phase of dream work.

Measurements

All sessions were digitally audio-recorded for the purposes of qualitative analysis. At the beginning of the first session and close of the second, participants also completed the Existential Well-Being Scale (Ellison, 1983) and the Spitzer Quality of Life Uniscale (Spitzer et al., 1981). At the close of each session, the research therapist administered the Exploration–Insight Gains subscale of the Gains from Dream Interpretation Scale (Heaton et al., 1998) and completed a session report form detailing the content of dreams and participants' subjective descriptions of the meaning of their dreams. The research therapist also completed the Therapist-Rated Adherence Measure (Hill, 2004) to assess adherence to the cognitive–experiential model. Each of these instruments is described in more detail below.

Instruments

Exploration–Insight Gains Scale (EI). The Exploration–Insight Gains (EI) subscale of the Gains from Dream Interpretation Scale (GDI) (Heaton et al., 1998) was employed to record participants' perceptions of benefits from participating in the dream-work process. The EI subscale consists of six 9-point Likert-type items (1 = strongly disagree, 9 = strongly agree) that ask participants to rate agreement with statements of the benefits gained from dream work (e.g., "I learned more about issues in my waking life from working on this dream"). Hill (2004) reported typical correlations of 0.60–0.70 between the GDI, its subscales, and other measures of benefits from dream work.

Session Report Form. This form was used for taking notes after each session. Information included the length of each session, a brief description of the dreams reported, a description of the session as a whole, and a notation of which stages of the dream-work model were completed.

Therapist-Rated Adherence Measure (TRAM). The TRAM (Hill, 2004) was utilized to assess the research therapist's self-perception of adherence to the cognitive–experiential model of dream work. This scale includes 13 nine-point Likert-type items (1 = strongly disagree, 9 = strongly agree) that ask therapists to rate how well they completed each stage of the dream-work process (e.g., "How completely and well did you do the step of experiencing for several images?"). Hill recommended dropping sessions from analysis in which therapists rate themselves lower than five on more than one of the three stages in the model.

Existential Well-Being Scale (EWBS). The Existential Well-Being subscale of the Spiritual Well-Being Scale (SWBS) (Ellison, 1983) was employed previously in a study using the Hill dream model (Davis & Hill, 2005). The SWBS assesses one's subjective sense of spiritual well-being using Likert-type responses ("strongly agree" to "strongly disagree") to 20 items. It measures two constructs—religious well-being and existential well-being—which are assessed with two 10-item subscales. For the purposes of our study, only the EWBS subscale was employed (10 items with 6-point Likert-type scales). Both subscales have demonstrated high reliability, with test–retest reliability coefficients ranging from 0.73 to 0.89. The internal consistency of the EWBS ranges has coefficient alpha values of 0.82–0.94. The scale has good face validity, as well as good convergent and discriminant validity (Spiritual Well-Being Scale, 1995).

Spitzer Uniscale Quality of Life Measure (SUQoL). The SUQoL (Spitzer et al., 1981) was utilized to assess quality of life. This single-item instrument asks participants to rate their quality of life on a visual analog scale ranging from 0 (lowest possible quality of life) to 100 (highest possible QoL). The SUQoL is a well-established measure with high reliability and validity (Mashele et al., 2007) that compares favorably to longer multiple-item questionnaires (de Boer et al., 2004), with a reliability coefficient of 0.87, and high correlations with multiple-item measures of quality of life. For the purposes of our study, the single-item SUQoL was used to help reduce the risk of participant fatigue.

Qualitative Analysis

All 12 sessions were transcribed verbatim for use in qualitative analysis. The data were analyzed using the consensual qualitative research (CQR) method (Hill, 2012). CQR is characterized by a team-oriented approach that relies on the group process to offset individual biases. A primary team (the first three

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authors) followed a structured iterative process of coding domains, identifying core ideas within domains, and then categorizing core ideas across cases to represent the richness of data. Throughout this process, members of the primary team discussed their categorizations of data until a unanimous, or consensual, conceptual framework was created. Additionally, external auditors (the fourth and fifth authors) guided and checked the progress of the primary team, helping to offset possible biases. This method has been employed primarily for the study of therapeutic factors and techniques in counseling and psychotherapy. However, several studies have used CQR to analyze dream-work sessions using the cognitive–experiential model of dream work (Hess et al., 2013; Tien et al., 2009; Wonjin et al., 2010), as was the case in our study.

Ethical Considerations

This study was approved by the institutional review board at the State University of New York at Buffalo. Data were deidentified and stored in a secure location. Audio data were destroyed after transcription, and transcripts will be destroyed in accordance with professional ethics standards within three years of the end of data collection. Participants were informed about and monitored for possible side effects—including fatigue, discomfort, worsening mood, increased existential distress/anxiety, and increased distressing dream activity. If a participant felt unable or unwilling to continue, the session was discontinued or postponed, a supervisor was notified, and a follow-up was scheduled. Negative changes in existential well-being and quality of life were monitored, and the clinical team was notified and consulted when changes occurred. The research therapist was supervised by an experienced medical social worker and a palliative care physician.

RESULTS AND DISCUSSION[1]

Session Characteristics

Most ($n = 5$) participants underwent two sessions separated by an average of 8.8 days ($SD = 5.8$). Sessions averaged 66.4 minutes ($SD = 11.2$) in length for session 1 and 69.0 minutes ($SD = 19.8$) for session 2. Two participants did not complete a second analyzable session due to a lack of dreams in one case and rapid decline in physical condition in the other. All participants proceeded through the exploration and insight stages of the cognitive–experiential model of dream work during both sessions 1 and 2. For session 1, two participants did not proceed through the action stage. For session 2, all participants proceeded through the action stage.

Qualitative Results and Discussion

The six major domains (excluding the "other" domain) emerging from the transcripts were: (1) "exploration of dreams," (2) "insight from dreams," (3) "actions taken based on dreams," (4) "end-of-life concerns," (5) "sources of meaning in life," and (6) "perceptions of dream-work process."

After the team constructed core ideas for all domains within each case, team members independently reviewed all core ideas to identify common themes. Each team member shared an initial category list with the team, which was discussed and "argued" until consensus was reached. Once a final category list was completed, the representativeness of each theme was calculated in the manner described by Hill (2012). Categories represented in all or all but one case (6 or 7 cases) were labeled "general"; those occurring in more than half of cases (4 or 5 cases) were labeled "typical"; and categories occurring in fewer than half of cases (2 or 3 cases) were labeled "variant." Those categories that were only represented in one case were considered unrepresentative and are not reported here. Table 1 presents the final consensual category list along with frequency ratings.

Exploration of Dreams

Participants' dreams generally took place in familiar settings and typically featured living friends and relatives or unknown individuals. Participants often relived meaningful past experiences and reported dreams that centered on objects of special significance. Reported dreams typically evoked a strong affective tone, which was equally likely to be pleasant or unpleasant. When making associations between specific dream images and waking life, participants usually made connections to their waking feelings, relationships, end-of-life concerns, sense of meaning, and important past experiences. Dream images representing the dreamer's impending death were also common. See Table 2 for representative examples of general and typical categories.

These findings are consistent with previous research findings that dreams typically reflect the experiences and concerns of waking life (Hill, 1996). They also reinforce the findings of Prince and Hoffmann (1991), who concluded that those at the end of life often dream of issues of grief and loss brought on by age and approaching death. In contrast to prior research on end-of-life dreams, the current study

[1]Like some other reports of studies using the CQR method, the results and discussion sections have been combined in order to present a more integrated picture of the data (Hill, 2012).

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Table 1. *Categories and subcategories with frequency ratings*

Domains and Categories	Frequency
1. Exploration of dreams	
1.1. Dream content	General
1.1.1. Familiar setting	General
1.1.2. Living family and friends	Typical
1.1.3. Unknown people	Typical
1.1.4. Reliving the past	Typical
1.1.5. Important objects	Typical
1.1.6. Deceased family and friends	Variant
1.1.7. Unfamiliar setting	Variant
1.2. Affective tone	General
1.2.1. Pleasant tone	Typical
1.2.2. Unpleasant tone	Typical
1.3. Connections to waking life	General
1.3.1. Images reflecting feelings while awake	General
1.3.2. Images reflecting relationships	General
1.3.3. Images symbolic of end of life concerns	General
1.3.4. Images symbolic of source of meaning in life	General
1.3.5. Images symbolic of past experiences	General
1.3.6. Images symbolic of death	Typical
2. Insight from dreams	
2.1. Message of the dream	General
2.1.1. Need to change way of thinking	Typical
2.1.2. Need to address legacy	Typical
2.1.3. Need to complete unfinished business	Typical
2.1.4. Need to reconnect with source of meaning	Variant
2.2. Level of interpretation	General
2.2.1. Waking life	General
2.2.2. Inner personality dynamics	Variant
2.3. Insight into end-of-life concerns	General
2.3.1. Relational concerns	General
2.3.2. Impending death	General
2.3.3. Personal autonomy	Typical
2.4. Insight into meaning of life	General
2.4.1. Relationships	General
2.4.2. Personal history	Typical
2.4.3. Legacy and tradition	Variant
2.4.4. Enjoyable activities	Variant
2.4.5. Spirituality	Variant
3. Actions taken based on dreams	
3.1. Addressing unfinished business	General
3.1.1. Addressing aftermath concerns	Typical
3.1.2. Leaving a legacy	Variant
3.1.3. Completing day-to-day tasks	Variant
3.2. Changing thoughts and feelings	Typical
3.3. Reconnecting to sources of meaning	Typical
3.4. Spontaneous action	Variant
4. End-of-life concerns	
4.1. Relational concerns	General
4.1.1. Legacy concerns	Typical
4.1.2. Being a burden	Variant
4.1.3. Lack of support/empathy	Variant
4.1.4. Aftermath concerns	Variant
4.2. Physical concerns	Typical
4.2.1. Loss of abilities due to illness	Typical
4.2.2. Physical symptoms	Variant
4.3. Personal autonomy	Typical
4.3.1. Unable to pursue sources of meaning	Typical
4.3.2. Loss of independence/control	Typical
4.3.3. Loss of future	Variant
4.4. Impending death	General
4.4.1. Fear of death	Variant
4.4.2. Wanting to die	Variant
4.4.3. Choosing to enter hospice care	Variant
5. Sources of meaning in life	
5.1. Relationships	General
5.2. Spirituality	Variant
5.3. Legacy and tradition	Variant
5.4. Enjoyable activities	Variant
5.5. Personal history	Variant
6. Perception of dream-work process	
6.1. Overall feelings about session	General
6.1.1. Session was meaningful	Typical
6.1.2. Session was comforting	Typical
6.1.3. Session was helpful	Typical
6.1.4. Session was interesting	Variant
6.2. Specific impact of session	General
6.2.1. Increased understanding of dream or life	Typical
6.2.3. Actions taken were helpful	Variant
6.2.4. Changed feelings about dream work	Variant

General = 6 or 7 cases; Typical = 4 or 5 cases; Variant = 2 or 3 cases.

found that participants rarely dreamed of deceased relatives, and these dreams were often unpleasant and characterized by a sense of tension. This may reflect Kerr et al. (2014) recent findings that hospice patients less proximate to death tend to dream more of living friends and relatives and are more likely to experience distressing dreams, compared to those who are imminently dying. It is noteworthy that the participants in our study were recruited from a home-based hospice program as opposed to an acute inpatient facility (as was the case in the Kerr study), and therefore it is possible that the content of their dreams reflected their relative distance from death or the severity of their physical decline.

Insight from Dreams

Participants in the current study generally interpreted their dreams as an indication that change was needed in their waking lives. In most cases, their dreams suggested a need to change their way of

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Table 2. *Examples of categories in the "exploration of dreams" domain*

Categories	Example
1.1. Dream content	
1.1.1. Familiar setting	"I was leaving [my mother-in-law's] house after Christmas. 'Cause we'd always go there."
1.1.2. Living family and friends	"I dreamed that my grandson was on the floor, spinning around, wrestling with his father. And I got upset because he was saying he didn't remember his grandma."
1.1.3. Unknown people	"A gentleman on the street comments about my boots and scarf. I ignore him and walk on. A few minutes later another gentleman walks next to me and reaches over and touches the strap on my shoulder bag. I am upset and tell him to go away."
1.1.4. Reliving the past	"It was just like I was there. It was amazing. Just like it was the first time [when my daughter was born]. And she came out and I cut the cord and I was holding her."
1.1.5. Important objects	"I can see my mother-in-law like it was yesterday standing there in her white apron. She always wore one when she cooked during the holidays."
1.1.6. Deceased family and friends	"I was raking leaves in the back of the house and my [deceased] husband came through the side yard. I asked him, 'where have you been so long?' and he just said 'I am sorry I have to leave you for a while.'"
1.1.7. Unfamiliar setting	"I was sitting in a garden where everybody was peaceful and serene and just going about their business."
1.2. Affective tone	
1.2.1. Pleasant tone	"The children were running and the mother was in the kitchen. I was very happy."
1.2.2. Unpleasant tone	"I woke up at 4:30 this morning, and I was having a nightmare about the urgency to fill out this packet I have to fill out for the funeral parlor for my last Mass at church with the family."
1.3. Connections to waking life	
1.3.1. Images reflecting feelings while awake	"I felt guilty when I woke up jealous. I don't like jealousy. So that's why it's a nightmare. I can't be jealous that I can't be there [with my daughter]."
1.3.2. Images reflecting relationships	"What do I associate exotic food with? Probably the pleasant relationships I have had with people. Just friends and let's say a girl I dated."
1.3.3. Images symbolic of end-of-life concerns	"The apron makes me think of keeping clean, no mess—My mother-in-law's death was clean—The thing is, if you're sick, you're going die, go fast, don't linger on. The suffering is terrible. I kind of wish I would die real fast, I wish I would die. I don't enjoy life being like this."
1.3.4. Images symbolic of source of meaning in life	"Everyone feels that the kitchen is the lifeblood of the house— The kitchen was the center of my role as a mother."
1.3.5. Images symbolic of past experiences	"So what comes to mind when you think of those boots?" "The wonderful trip that I had made around the country and going through Texas, and I have used them in teaching square dancing."
1.3.6. Images symbolic of death	"Are there any roads to the unknown, any dirt roads in your life that you see coming up?" "Death. Death doesn't go any clear way. I would like it to be clear and simple. But it isn't."

thinking, to address legacy concerns, or to complete unfinished business. These dreams appeared to represent the second type of end-of-life dreams identified by Fenwick and colleagues (2010)—"final meaning" dreams—which are based on the dreamer's waking concerns and relate to themes of reconciling with family members and resolving unfinished business in preparation for death.

Working with dreams generally led participants to new insights regarding end-of-life concerns, which most often revolved around relational issues, the specter of impending death, or the desire for personal autonomy. In almost all cases, participants gained new insights into sources of personal meaning in life. Generally, this involved new ways of thinking or feeling about their relationships. In many cases, dream work also provided new perspectives on personal history. Occasionally, participants also gained new insight regarding their legacy and family traditions, enjoyable activities, and sense of spirituality. See Table 3 for representative examples of insight categories.

Actions Taken Based on Dreams

Based on dream interpretation, participants generally felt the need to take action by addressing unfinished business. Common examples included addressing concerns regarding the aftermath of their death, finding a way to leave a legacy, or completing day-to-day tasks. Action plans also typically involved making changes in thoughts or feelings and reconnecting to sources of meaning. Participants occasionally reported having been so moved by their dreams that they took spontaneous action immediately after awakening. See Table 4 for representative examples of the actions taken.

The action stage was the only stage of the cognitive–experiential dream-work process that was not completed for all sessions. In two cases, the session time expired and the action stage was postponed until the second session. While sessions were initially planned to take 50 minutes, it soon became clear that participants needed more time to explore their dreams. Originally, the session time had been limited in order to reduce the likelihood of fatigue among this vulnerable population. These findings suggest that Hill's (1996) observation that it can take up to 90 minutes to conduct a dream session also applies to those at the end of their lives.

The action stage was further complicated by the issue of personal autonomy, which is often compromised in those with an advanced, terminal illness. Dream work during the action phase therefore necessitated a focus on hope and the use of meaning to transcend despair and loss of autonomy. While some participants took concrete actions (e.g., one woman wrote a book of messages to be delivered to loved ones after her death), others took less overt actions (e.g., one man decided to spend his solitary time reflecting on the joy he felt about his new grandson, rather than ruminating on despair). It was helpful to ask clients to reflect upon the sources of meaning in their lives and encourage them to creatively reimagine ways of engaging with life. This is contention that, when all other freedoms are taken away, human beings retain the ability to choose their attitude towards life circumstances.

End-of-Life Concerns

All participants voiced concerns regarding their death, most commonly pertaining to their relationships. This typically included concerns about personal legacy, as well as occasional feelings of being a burden, a lack of empathy or support, or concerns about the social aftermath of their death. Participants typically also shared their physical concerns, including loss of abilities due to illness as well as unpleasant physical symptoms. Loss of personal autonomy was another major concern, which included an inability to pursue sources of meaning, loss of independence, and loss of future. While participants generally expressed concern about their impending death, specific concerns varied between fear of death, a desire to die, and mixed feelings about entering hospice care. See Table 5 for representative examples of end-of-life concerns.

Psychosocial concerns were more prevalent than physical concerns, lending further support to Chochinov et al.'s (2004) observations. This may reflect the relative strength of palliative care in addressing physical symptoms compared to psychological, social, and spiritual sources of suffering (Chochinov, 2006; Heintz, 2007). This finding also reinforces the need for further attention to these aspects of hospice patients' lived experiences. End-of-life concerns expressed by participants reaffirm the importance of existential issues such as the need for dignity, loss of autonomy/control, and leaving a legacy. Some participants struggled with demoralization and loss of the will to live. Most participants described difficulties surrounding meaning, specifically the loss of connection to prior sources of worth or purpose. Collectively, these concerns are congruent with Schuman-Olivier et al.'s (2008) definition of existential distress, which includes identity disruption, loss of control, loss of dignity, hopelessness, meaninglessness, isolation, death anxiety, fear, and panic.

Sources of Meaning in Life

In the current study, most participants indicated that relationships provided their greatest source of meaning. Less frequently, participants reported finding

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Table 3. *Examples of categories in the "insight from dreams" domain*

Categories	Example
2.1. Message of the dream	
2.1.1. Need to change way of thinking	C: "Well, it burned down, the house I lived in as a child." T: "Why do you suppose you were having this dream in the last few months?" C: "Because I think about my past life and the years raising the kids all the time. [The dream] is telling me to stop worrying about them. They're fine. They have their own lives now."
2.1.2. Need to address legacy	"It's about my son and then his son. And I feel like I'm not careful, it could be my fault that that [negative family pattern] keeps getting passed on. If I don't somehow try to break that chain or if I failed at breaking that chain—So yeah, it's on my mind because I'm still trying to reach my son."
2.1.3. Need to complete unfinished business	T: "So that is interesting that this search in your dream is related to that quest to close things up." C: "Yes, yes, and I can't seem to find it yet. It still must be within me to keep forging forward so to speak. But I don't know where I am going."
2.1.4. Need to reconnect with source of meaning	T: "So why do you think you had the dream?" C: "I was in a state of depression. I was wondering when God was gonna take me because my grandson was born and I was wondering how long I could live in this vein, you know, alone. Now I gotta wait and see. I think he gave me that dream to remind me, 'you've got a grandson that you want to see grow.' I think that's why he sent that dream to me."
2.2. Level of interpretation	
2.2.1. Waking life	"I believe [I had the dream] because I've had [the paperwork] for a month and I was supposed to be going over it, and I kept putting it off. And lately a lot of my symptoms have been changing in my disease. And all of a sudden I felt a great urgency to get this done."
2.2.2. Inner personality dynamics	C: "I felt guilty and angry, but I'm always telling people not to have [those feelings." T: "So I sense that there may be a little bit of a conflict between who you want to be and who you actually are." C: "Right. That's what I think. And you can't just pretend it's not there either. Cause that don't work. Maybe that's what [the dream] is all about."
2.3. Insight into end of life concerns	
2.3.1. Relational concerns	C said C is having a hard time dealing with being sick. C does not like the kids feeling like they have to take care of C, but they do. C does not want to take this away from them because C knows it is part of their healing process. T suggested it might be meaningful for C's kids to care for C. C agreed and feels this dream gave C insight into C's situation.
2.3.2. Impending death	C described challenges of deciding to accept hospice care because it is like giving up. C felt C was falling through the cracks before. C can identify with the dummy on the gurney [in the dream] because of medical problems and being headless.
2.3.3. Personal autonomy	C is an independent person who does not want to be controlled. C has had to face many things alone, and this is where C gets strength from because C is using C's own thoughts, and while they are not perfect they are C's own. The man in the dream is connected to the caution C takes in life and desire not to be controlled.
2.4. Insight into meaning of life	
2.4.1. Relationships	C. said C wouldn't leave her children behind [in the dream], because they are important and C didn't go down either road because they are in the house and they need C. C described the structured childhood C gave C's children, and how they had a good life— C agreed with T's observation that the house was solid and structured like the environment C had created for C's children.

Continued

Table 3. *Continued*

Categories	Example
2.4.2. Personal history	C noted that everything in C's whole life is reflected in C's childhood. C lived in a cluttered house and longed for a nice house with a bunch of children. C said the cluttered house in the dream reminded C of C's childhood home.
2.4.3. Legacy and tradition	C has been thinking about the grandchildren who will come after C dies. Images in the dream make C think about how C has been trying to pass on tradition, and is concerned that they won't get transmitted to the next generation.
2.4.4. Enjoyable activities	C is an adventurer, but a careful one. C has charted C's own course. This has allowed C to find joy. Traveling was like medicine for C because you are in a different world and everything is exciting.
2.4.5. Spirituality	C feels C is not supposed to feel anger and fear, because fear is the opposite of faith. C knows you can't just pretend these feelings are not there, because that doesn't work. C thinks this might be why C is having the dream.

C = Client; T = Therapist.

purpose in spirituality, passing on traditions, leaving a legacy, engaging in enjoyable activities, and reflecting on their personal history. Table 6 displays examples of sources of meaning.

These findings are closely related to the sources of meaning identified by Viktor Frankl, as summarized by Breitbart and Applebaum (2011) (see Table 7). They identified "creativity," "experience," "attitude," and "history" as the four major sources of meaning. In general, creativity, experience, and history accounted for the content of participants' own accounts of personal meaning, whereas attitude reflected the therapeutic process of dream work employed in our study (i.e., finding new ways to reconnect to sources of meaning in the face of limitations). As described in the sections on insights gained and actions taken, the interpretation of participants' dreams often involved reframing attitudes toward life and death and finding new ways to reconnect with sources of meaning. This reflects the spirit of Frankl's logotherapy, which suggests that the freedom to choose our attitude toward a situation is our final refuge against suffering. The findings of our study are also consistent with research on end-of-life dreams, supporting the observation that many dreams provide the dying with a renewed sense of meaning and help them in preparing for death (Brayne et al., 2008; Kerr et al., 2014).

Perception of Dream-Work Process

All participants expressed their thoughts and feelings regarding the dream-work intervention. Their comments fell into overall as well as specific categories. Participants typically reported perceptions that the sessions were meaningful, comforting, helpful, and occasionally interesting. More specific perceptions focused on increased understanding of the dream or waking life, the helpful nature of actions taken based on dreams, and occasionally changed feelings about dream interpretation itself. Table 8 provides examples of these perceptions.

Case Example: Mary's Dream of "A Fork in the Road"

In her first session, 92-year-old Mary,[2] a hospice patient residing in a nursing home, described a recurring dream in which she was standing at a fork in the road where a *dirt road* branched off of the *paved road* she had been walking down. At the fork was a windowless *house* with a red roof (major images italicized). Figure 1 illustrates the following discussion of how the meaning-centered dream-work process unfolded with Mary.

[2]Names changed.

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Table 4. *Examples of categories in "actions taken based on dreams" domain*

Categories	Example
3.1. Addressing unfinished business	
3.1.1. Addressing aftermath concerns	T suggested C could look for more help in accomplishing the things C needs to do before dying. C does not want to keep piling things on C's oldest niece. T suggested hospice volunteers or others may be able to help and suggested that C ask social worker about this. C agreed to speak to social worker.
3.1.2. Leaving a legacy	T suggested that T could help C create a document to leave for loved ones telling them things C wants them to know. C said that this might be very good and C would think about this during C's vacation.
3.1.3. Completing day-to-day tasks	C decided to start destroying documents that need to be taken care of.
3.2. Changing thoughts and feelings	C thinks just recognizing and getting over anger and jealousy is how C wants to deal with it. Like how C is doing with the fear. C is getting over all of it by being aware of everything that happens every day. C is acknowledging feelings because C has no choice, so it becomes real.
3.3. Reconnecting to sources of meaning	Session 1: C said C wishes C could play the piano more, but feels unsure about eyesight. Session 2: C ended up playing the piano because the music in the auditorium in previous dream made C think about that.
3.4. Spontaneous action	When C woke up, C immediately found self working on the funeral paperwork. C felt proud and called godmother in the morning, who was happy and had been worrying about C.

C = Client; T = Therapist.

Exploration Stage

The research therapist encouraged Mary to reexperience this dream in vivid detail as though it were happening there in the session. She described not only the setting of the dream but how it made her feel. She felt that in the dream she was being presented with a decision about which path to take, and when she awoke she often wondered why she always stopped at the fork. She was also very curious about the significance of the wooden house, which always stood out to her in this recurring dream. The research therapist then asked Mary to describe the associations that came to her mind when she envisioned each of the major images in the dream.

Mary stated that "the paved road is certainty." She also associated it with "civilization, people, houses, and businesses." This contrasted with her sense of uncertainty connected with the dirt road image, insofar as "you walk on it, but don't know where it is going." She also described the dirt road as "challenging and rough" but described a sense that she was destined to walk down it eventually: "I wonder if I should take the paved road, but the dirt road is there, and I feel certain that I am going to take it." Mary was struck by the red paint on the roof of the house. When asked what the color red reminded her of, she said, "It is a strong color. If you are painting something red, it is because you want it to be sure and certain." She also associated the house with stability and structure, as well as her role as a mother having raised several children with little support from her husband.

Mary and the research therapist worked together to find connections between these associations and Mary's waking life. When asked where in her life she experienced something like a paved road (i.e., something certain and associated with people), she connected this to the path of her life up until her illness, which she would "not be walking down much longer." When asked where she experienced something like the dirt road in her life (i.e., something challenging and uncertain that she was destined to do), she said, "My death. Death doesn't go any clear way. I would like it to be clear and simple. But it isn't." When asked about what the house in the dream (i.e., something associated with stability, strength, and raising her children) might represent, Mary reflected on her childhood, during which she felt "uncared for." "I tried to give my children a more structured and stable childhood than I had," she said. She speculated that the red roof on the house symbolized the strength and stability she had provided for her children, but that the lack of windows and doors on the building might have reflected her having gone too far in ensuring her children's safety, to the point of limiting their freedom.

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Table 5. *Examples of categories in the "end-of-life concerns" domain*

Categories	Example
4.1. Relational concerns	
4.1.1. Legacy concerns	"[The dream] makes me think about how I've been trying to tell them [how to act]. In a way it's silly, because it gets carried on through tradition, right? That's how people and families get remembered, through tradition, right? I'm hoping that I taught them enough that they do that. And hoping for the best cause I also know we have no control over nothing."
4.1.2. Being a burden	"I feel like there's no freedom. I'm this big burden to everybody. That's how I feel."
4.1.3. Lack of support/empathy	"There's not enough people with [my disease]. My one doctor says 'you need to get into a support group.' Well, there are no support groups for [my disease] cause so few people have it."
4.1.4. Aftermath concerns	"My oldest niece is my executor, and I worry about her and I pray every night that she is protected in taking care of things. She is going to have a lot of responsibility in handling my estate. I have gone through taking care of two estates and I know what a headache that can be."
4.2. Physical concerns	
4.2.1. Loss of abilities due to illness	"I am anxious about not being able to think clearly. I don't want to take drugs that will impair my reasoning. I don't really take much medicine at all. I am only on high blood pressure pills. I know they are always trying to give me more pills of some kind, but I hold it off until I really need it."
4.2.2. Physical symptoms	"I find I am getting a lot more tightness in the neck. Because of the pain I think I try to prevent it from happening, so therefore I am overdoing things. Hopefully, I don't have to go into morphine. That one I am dreading."
4.3. Personal autonomy	
4.3.1. Unable to pursue sources of meaning	[My grandkids and I] used to go shopping, that was fun. Those are the things I miss. I still have a little bit of that. I wish I had the whole thing."
4.3.2. Loss of independence/ control	"So [my son] has been wanting to come and spend every night here as it is. And I've been stalling. Hanging onto my last couple weeks or whatever of independence."
4.3.3. Loss of future	"And I was thinking about the grandchildren that are gonna come afterwards. You know what I mean? That I won't be here for."
4.4. Impending death	
4.4.1. Fear of death	"I think of [death] every day but I try to put it out of my mind."
4.4.2. Wanting to die	"The suffering is terrible. I kind of wish I would die real fast, I wish I would die."
4.4.3. Choosing to enter hospice care	"I have been living since December knowing that I am terminal. That is a shocker to begin with. That is a whole new challenge in my life. To be told with that news and to have a choice at that time of Hospice or continuing on with medication."

Insight Stage

The research therapist assisted Mary in processing feelings associated with her life as a mother and her approaching death and worked with her to weave her waking life associations into a coherent interpretation of what the dream might mean for her. As part of this process, the research therapist asked Mary to reflect on what gave her life meaning. Mary again described how her "uncared-for" childhood had inspired her to make sure her children had a better upbringing. This reflected Frankl's observation that adverse and challenging circumstances can give rise to one's sense of meaning in life. "My father wasn't around much, and my mother didn't care for us very well. Being a good mother for my children was my job. All I wanted was to have a pretty house and lots of children, though that seemed like a foolish wish so I never voiced it."

The research therapist asked Mary to identify where her role as a mother would be located, if it were to appear in the scene depicted in her dream. She responded, "In the wooden house. That is where my motherhood would be, because it is built on solid ground. Built to last." The meaning of the dream became somewhat clearer to Mary as she reflected on why she had always stopped walking in the dream when she reached the house, in spite of her feeling that the dirt road was her destiny: "I worry about the children. They're all alone. There's some animosity and unhappiness," she said. "I don't want to keep walking down the dirt road while my children are still in that house." Mary and the research therapist discussed her feelings that she was not ready to die yet because she was still concerned for her children, who were the most important thing in her life. As she said, "That must be why I am standing there. I don't go down either road because they are in the house, and they need me." Mary concluded that she could not move on and start preparing for death as

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Table 6. *Examples of categories in "sources of meaning of life" domain*

Categories	Example
5.1. Relationships	T: "What would you say is the most important thing in your life?" C: "My children definitely. Always has been and always will be to the end."
5.2. Spirituality	T: "Are you a religious person?" C: "I would say yes. I don't go on preaching it or anything but I have been brought up with religion in my life and I certainly feel that powers to be have helped me in many cases."
5.3. Legacy and tradition	C: "I'm hoping that because of that, I was able to help build that bridge, that everlasting bridge with all of them." T: "Does that connect to that tradition idea you're talking about?" C: "Yep. All of it."
5.4. Enjoyable activities	T: "What does that mean to you, having [your cabin]?" C: "It's my little security den. I've never had a little place of my own that I could call my property. I feel excellent when I'm there."
5.5. Personal history	"It has been a while since I have been [to New York City]. I can't do the traveling anymore, and that is, again, a sadness in my life because I am housebound so to speak. But I've got scrapbooks if I can find them."

C = Client; T = Therapist.

Table 7. *Sources of meaning described by Breitbart and Applebaum (2011)*

Sources of Meaning	Description
Creativity	Engaging in life through work, deeds, causes, artistic endeavors, hobbies, and so on. Examples include our careers/job, volunteer work, involvement with church/synagogue, political and social causes.
Experience	Connecting with life through love, relationships, nature, art, and humor. Examples include our family, children, loved ones, the sunset, gardening, beaches, museums, playing with pets, and so on.
Attitude	Encountering life's limitations by turning personal tragedy into triumph, things we have achieved despite adversity, rising above or transcending difficult experiences. Examples include achieving an education despite personal/financial challenges, overcoming grief/loss, persevering through cancer treatment, and so on.
History	Legacy given (past), lived (present) and left (future).Examples include our story, our family history, the history of our name, our accomplishments, and whatever we hope to leave behind.

Table adapted with permission from Breitbart and Applebaum (2011).

long as she was worried about her children, but acknowledged that her children were probably capable of caring for themselves by this point in their lives. When asked what the dream meant, Mary said, "It's telling me to stop worrying about them. They're fine. They have their own lives now." Mary also expressed her wish to stay connected to her children after her death: "In the afterlife, I feel I will still have a connection to this life— I want to look back down the dirt road and see them— I feel that at some point, the house will have a door and windows again."

Action Stage

Mary felt that she learned something from working on her dream but was unsure of what to do with this insight due to her isolation and physical immobility. The research therapist asked Mary what she was hoping for, and she said, "maybe I'll have a dream where I walk up the dirt road with the children." The research therapist suggested that Mary could have that dream during the session, and she agreed to participate in a guided-imagery exercise to change the ending of the dream. The research therapist guided Mary through reexperiencing the dream once again. At the point where she reached the fork in the road, the research therapist asked Mary what would happen next. She said,

> I'm going over to the door on the other side of the house. I never knew it had a door before now. I see five windows and one door. It is stained brown. I am going up and opening the door. I don't go in. The children are all standing there. Mark is in the forefront; Melissa is in the back. The others are there, too. They all come out. And they follow

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Table 8. *Examples of categories in "perceptions of dream-work process" domains*

Categories	Example
6.1. Overall feelings about session	
6.1.1. Session was meaningful	"It's very meaningful because I am here at the end of my life. Talking about the dream helped me explore and put thought into it. I feel good. I liked discussing the dream. Talking about it gave it more meaning."
6.1.2. Session was comforting	"It was a very nice experience, and I found it very comforting. My past affects me very much, and talking about this dream made me more comfortable."
6.1.3. Session was helpful	"I think it is helping me see another direction that I can go in to settle some of these things that are unsettling in my mind."
6.1.4. Session was interesting	"It was good. It was interesting. I do see how a lot of people in hospice have nightmares. Cause I actually only had one good dream since this whole thing started."
6.2. Specific impact of session	
6.2.1. Increased understanding of dream or life	"I can see a little bit more understanding of what these things are. I am not as afraid; let's say of the headless dummy. That bothered me as far as a danger to a family member. Now I am more relaxed with it."
6.2.3. Actions taken were helpful	"I never ever thought of [changing the end of my dream]. That was wonderful."
6.2.4. Changed feelings about dream work	"It started out as a little dream. [When we interpreted the dream] these things all came out, and boom, they went in how many directions."

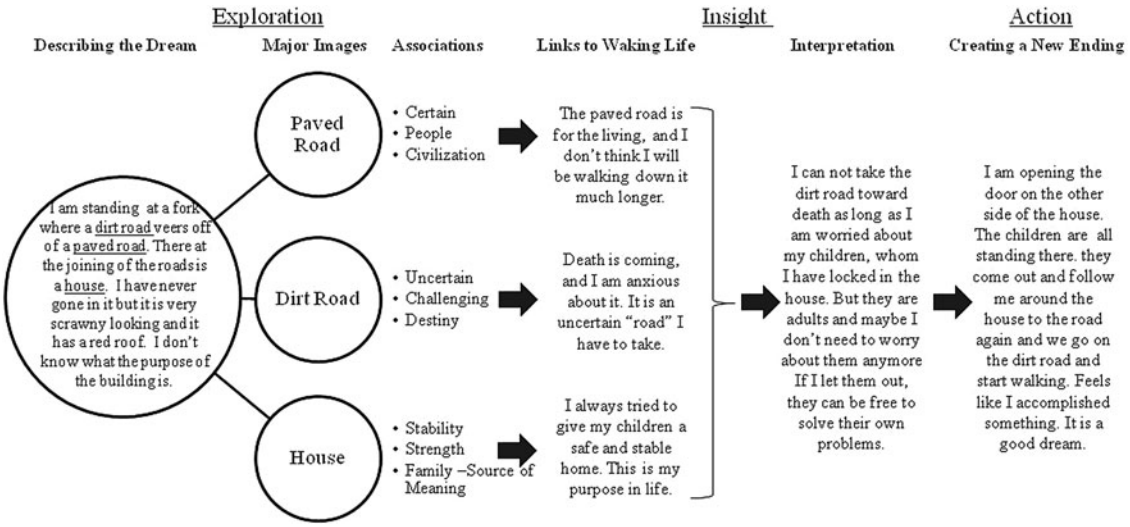


Fig. 1. Sample dream interpretation with a hospice patient using meaning-centered variant of the cognitive–experiential model of dream work.

me around the house to the dirt road again, and we start walking.

At this point, Mary's eyes welled up in tears of joy:

> I hear them talking as they follow me up the dirt road. It is an easy, calm walk. I see all the colors in the ground and sky and the red roof on the house. It feels like I accomplished something. It is a good dream."

Mary appeared touched by the guided-imagery exercise, which served as an action to make the insights gained during meaning-centered dream work more concrete. When asked about her perceptions of the overall process, she said,

> I liked talking about the dream and thinking about its benefits. It takes a load off me. My thoughts about the dream are much more peaceful. It was very illuminating and very good. It was a very nice experience, and I found it very comforting. My past affects me very much, and talking about this dream made me more comfortable.

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QUANTITATIVE RESULTS AND DISCUSSION[3]

Exploration–Insight Gains

Mean scores on the Exploration–Insight Gains Scale, which measures a client's perceptions of what was helpful about participating in a dream session, were high for both sessions 1 ($M = 7.57$, $SD = 0.55$) and 2 ($M = 7.43$, $SD = 1.03$). Scores for each item were also high across the 12 sessions. Overall, these high ratings suggest that dream-interpretation sessions were helpful to them in terms of exploring and making new connections based on their dreams, supporting the hypothesis that meaning-centered dream work is therapeutically beneficial for those at the end of life. This is also consistent with the generally positive assessments reported in the qualitative results.

Therapist Adherence

Therapist self-reports of adherence averaged 5.76 ($SD = 0.46$) for session 1 and 6.36 ($SD = 0.48$) for session 2, out of a maximum score of 9. Scores fell within the acceptable cutoff limits of adherence suggested by Hill (2004). Because no more than one stage per session of the cognitive–experiential dream-work process was rated below a 5, no sessions were excluded from analysis due to lack of adherence. While therapist-adherence scores were adequate, some relatively low scores were noted. On item 9, "How completely and how well were you able to work on the level of inner dynamics?" the therapist rated himself low because this level of interpretation was rarely of interest to participants. The high salience of dying-related concerns may account for the relative preference of waking-life interpretations. For session 1, the item on the action stage was low because there was often not enough time to complete the action stage during the first session. In all such cases, action ideas for the first reported dream were addressed during session 2. Item 11—"How completely and how well did you do the step about changing the dream?"—received low ratings because that step was not conducted with all participants. In most cases, other forms of action seemed more appropriate to specific participants.

Existential Well-Being and Quality of Life

Overall existential well-being scores averaged 45.9 ($SD = 12.3$) before session 1 and 38.0 ($SD = 15$) after session 2, out of a maximum possible score of 60. These averages fall into the range (21–49) categorized as reflecting moderate life satisfaction and sense of purpose by Bufford et al. (1991). Scores before session 1 ranged between 23.0 (low life satisfaction and sense of purpose) and 60.0 (high life satisfaction and sense of purpose). Scores after session 2 ranged between 14.0 (low) and 52.0 (high).

Quality-of-life scores on the Spitzer Quality of Life Uniscale (Spitzer et al., 1981) averaged 67.0 ($SD = 24.7$) before session 1 and 51.8 ($SD = 31.1$) after session 2 (maximum score 100), suggesting overall moderate levels of quality of life. Scores before session 1 ranged between 12.0 (low) and 83.0 (high), and scores after session 2 ranged between 10.0 (low) and 76.0 (high).

With the exception of one participant, there were no large increases or decreases in quality of life or existential well-being. In cases where scores decreased, the authors perceived these changes being due to two factors. First, participants typically physically declined between sessions, which may have affected their perceptions of overall quality of life and existential well-being. Second, some participants who were initially reluctant to endorse negative feelings on the questionnaires became more forthcoming as the therapeutic relationship developed. It is also possible that pre-intervention clinical issues (e.g., preexisting clinical depression) could have affected obtained scores. However, it should be noted that even those who reported declines in existential well-being and quality of life reported benefits from working with their dreams.

Implications for Counseling at the End of Life

The findings described provide tentative support for the hypothesis that dream work offers an effective method of assisting those at the end of life with the psychological transitions inherent in the dying process. The subjective reports from participants add to the findings of previous studies suggesting the therapeutic benefits of dream work with the dying, including addressing presenting concerns (Brink, 1977), coming to terms with death (Goelitz, 2001; Muff, 1996), gaining insight and decreasing distress (DeCicco et al., 2010), breaking through isolation to form a therapeutic bond (Goelitz, 2001), facilitating life review (Magee, 1992), and accelerating the therapeutic process (Goelitz, 2001). In many cases, dream work appeared to provide a means to help participants address highly intimate concerns. Interpreting dreams with a focus on meaning in life seemed to allow indirect and relatively "safe" access to

[3]The quantitative data were collected to augment qualitative findings regarding this sample and should not be generalized due to the small sample size.

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participants' core concerns, consistent with Goelitz's (2007) assertion.

The benefits of the meaning-centered dream-work intervention reflect the strategies for dealing with existential distress noted by other researchers (Boston & Mount, 2006; Mok et al., 2010) as well as the various interventions developed by clinicians. Specifically, research suggests that those who accept and positively reframe stressors related to illness experience greater existential well-being (Mazzotti et al., 2011). This is the essence of meaning-centered therapy (Breitbart, 2003), which rests on the premise that finding meaning in despair can make the most difficult circumstances bearable. Meaning-centered dream work may offer another avenue through which people can accomplish this difficult task.

These pilot findings suggest that meaning-centered dream work may be safe for use with the vulnerable end-of-life population. No adverse reactions were reported as a part of this study, and though participants declined physically over time, no large changes in existential well-being or quality of life were evident. Even those individuals who experienced very low scores on these scales reported positive perceptions of the dream-work process. In cases where participants experienced strong emotions as a result of dream work, they expressed appreciation for the research therapist's assistance in helping them address those emotions constructively and safely.

CONCLUSIONS

The content themes that emerged during dream-work sessions reflected the most common end-of-life concerns. The dreams reported were also typical of those reported in other studies of dreams and visions at the end of life with respect to content and meaningfulness. Participants' dreams overwhelmingly reflected their reconciliation with the process of death and confrontations with crises of meaning. This is consistent with the well-supported theory that dreams arise from the concerns and events of waking life. During the process of dream work, participants were able to gain insights and take concrete actions based on what they learned from their dreams. In most cases, this involved resolving unfinished business pertaining to personal relationships.

The results of this pilot study support previous findings regarding the usefulness of dream work as a tool for counseling with the dying and contribute a new perspective to the body of literature on dreams experienced at the end of life. Our study provides initial support for the feasibility, safety, and efficacy of the meaning-centered dream work (MCDW) intervention. Based on Hill's (1996) three-stage model, this approach presents a simple and replicable technique that can be easily taught to mental health professionals working with those at the end of life. This novel combination of the cognitive–experiential dream-work model with meaning-centered therapy provides a promising new method of assisting the dying with the unique psychological and existential issues they face.

LIMITATIONS

Our study had a number of limitations. First, the sample was composed of mostly older women and consisted entirely of white European-American Christians. This homogeneity means that the content and process of dream work reported here may not reflect the way dream work would function within other cultural and religious groups. Second, one person conducted all the dream-work sessions, opening up the possibility that some of the results obtained are due to that person's therapeutic style, personality, and biases. Third, the overwhelmingly positive endorsements of the intervention by participants should be considered in the light of possible effects of social desirability, as the research therapist who conducted the intervention was the same person who surveyed participants. Fourth, the inherent logistical difficulty of conducting research with terminally ill hospice patients limited the research therapist's ability to collect complete data or to follow study protocols fully in some cases (e.g., one session was abbreviated due to a nurse visit).

FUTURE RESEARCH

Future research could address these limitations by recruiting a larger and more diverse sample, employing multiple therapists, and relying more on standardized quantitative research methods. Future research could also compare the MCDW intervention to other forms of therapy for the dying, such as dignity therapy, meaning-centered therapy, expressive therapies, and standard psychosocial care. It would also be interesting to know whether the meaning-centered element of MCDW has any advantages over the standard cognitive–experiential dream-work model for work with this population. Another direction would be to explore the use of this approach with family caregivers of hospice patients, both during patients' time in hospice and during bereavement. Future research could also include assessment of the therapeutic relationship, which as the largest factor in most psychotherapeutic success is likely responsible for at least some of the benefits of dream work. As hospice patients often struggle with loneliness and isolation, an evaluation of this factor might

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also help illuminate the intrinsic benefits of therapeutic presence, listening, and relationship in dream work with this population. Overall measures of participant affect and distress could also be included to help contextualize and evaluate quality-of-life and existential well-being measures.

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