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The Use of Dreams in Modern Psychotherapy

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Abstract: *We review theories of dream work. We also review the empirical research about how dreams are used in psychotherapy, as well as the process and outcome of different models of dream work. Finally, we review how dream content can be used to understand client, the role of culture in dream work, client and therapist dreams about each other, and training therapists to do dream work.*

Given that clients seek help for puzzling, terrifying, creative, and recurrent dreams, therapists need to feel competent working with dreams in psychotherapy. Unfortunately, therapists often feel unprepared for this task because dreams are typically not addressed in clinical training. In this chapter, we hope to provide therapists with information about the existing knowledge regarding working with dreams in psychotherapy, so that they can feel more confident working with dreams. We first describe the various theories of dream work, and then we examine the empirical evidence about dream work in psychotherapy.

First, let us clarify important terms we will use in this chapter. Although the more commonly used term in the literature is "dream interpretation," we use the term "dream work." Dream interpretation implies that therapists are the active agents in interpreting the client's dream, whereas dream work simply implies that dreams are a focus of attention during psychotherapy sessions, with both therapist and client actively engaged in exploring the dream. Dream work can refer either to events within therapy in which the focus is on dreams, as is typical in psychodynamically oriented psychotherapy (and of course outside of therapy), or to an entire approach to therapy (e.g., Jungian therapy or imagery rehearsal therapy [IRT]). In addition, we use the term "therapist" to refer to the person providing help (although she or he might be referred to as an analyst or a counselor in the cited literature), and we use the term "client" (rather than "patient") to refer to the person presenting his or her dream in psychotherapy.

I. Theories of Dream Work

A number of models have been developed over the last 100 or more years for working with dreams in psychotherapy. We first describe models developed for individual psychotherapy (focusing on psychoanalytic/psychodynamic, cognitive, and other models), and then describe models for group treatment.

A. Individual Psychoanalytic/Psychodynamic Therapy

The early psychoanalysts recognized the power of dreams, strongly calling for therapists to work with clients' dreams in therapy to illuminate both conscious and unconscious conflicts. Perhaps most notably, in his *The Interpretation of Dreams* (1900/1966), Sigmund Freud suggested that the primary purpose of dreams is to satisfy primitive, infantile wishes. Unacceptable to our conscious minds, he proposed that such wishes are repressed during waking life. According to Freud, however, we cannot censor our thoughts during sleep, and thus these wishes emerge in our dreams, often in distorted form (e.g., rather than dreaming of a boss directly, one might dream of a dangerous tiger). According to Freud, then, dreams provide ideal therapeutic fodder, serving as the "royal road" for examining the unconscious. His most powerful approach for working with dreams was

free association, in which the dreamer says whatever comes to mind, with as much honesty as possible. Through these associations to dream images, the origins of the dreamer's intrapsychic conflicts are revealed. In his work with patients, Freud listened to the dream and then to the patient's associations to specific images, and offered an interpretation using his knowledge of the dreamer and of dreams' symbolic meanings.

Presenting an alternate view, Carl Jung (1964, 1974) believed dreams to be a normal and creative expression of one's unconscious mind. Asserting that dreams serve a compensatory function, Jung stated that dreams reflect issues that are unexpressed during waking life. He thus believed that dreams can provide a vital means of uniting the conscious and unconscious by making dreamers aware of hidden feelings. Dream interpretation remains one of the central components in Jungian therapy, although Jung did not define specific procedures for dream work. Rather, he supported therapists' working with dreams in whatever way was most useful for the dreamer. Jung himself frequently used associations, portrayal of dreams through artistic expressions, and interpretation of dreams via archetypes and myths.

A third notable early dream theorist was Alfred Adler (1936, 1938, 1958). Believing personality to be a unitary construct, Adler asserted that the conscious and unconscious minds are the same, and thus the individual's waking personality is reflected in dreams. According to Adler, dreams are an expression of the conscious mind and provide the person with reassurance, security, and protection against damage to self-worth (e.g., a dream in which the person is able to fend off an attacker leaves the person feeling a sense of agency). Of primary importance, as well, is the emotion stimulated by the dream, which Adler believed allowed the dreamer to find resolutions to problems (e.g., a dream in which the dreamer resolved a difficult situation would provide confidence that s/he could similarly resolve situations in waking life, even if s/he could not remember the dream). Thus, dreams are a way of preparing for future activities or events and fulfill a problem-solving role. Unfortunately, Adler provided no clear guidelines for working with dreams in therapy.

Several new psychoanalytic models for understanding dreams have been proposed in the last 30 years (Fosshage, 1983, 1987; Garma, 1987; Glucksman, 1988; Glucksman and Warner, 1987; Lippman, 2000; Natterson, 1980, 1993; Schwartz, 1990). Diverging from the earlier Freudian tradition and reflecting more recent research, these theorists now propose that the manifest content of dreams reflects the dreamer's waking life rather than distortions from the unconscious. Modern Jungian authors (Beebe, 1993; Bonime, 1987; Bosnak, 1988; Johnson, 1986) have maintained much of Jung's original theory, but provide more explicit guidelines for how to work with dreams in therapy. Contemporary Adlerians (Bird, 2005; Lombardi and Elcock, 1997) have likewise provided more explicit detail for applying Adler's theory, including the replacement of fixed symbolism with an individualized understanding of dream metaphors, an emphasis on providing encouragement and positive interpretations, and a redefinition of the interpreter's role as a collaborator rather than an expert. In this revised model, the therapist nurtures the dreamer's understanding of her/his dream, as well as nurturing the ensuing ability to use this new knowledge to gain insight about events in life.

B. Individual Cognitive Therapy

Emerging in the second half of the 20th century was Aaron Beck's theory of cognitive patterns in dreams (1971). Stating not only that dreams parallel an individual's waking thoughts, Beck also posited that waking cognitions influence dreams. Although Beck acknowledged that dreams have many functions and that the dreamer does not gain insight from every dream, he nevertheless believed that some dreams in particular clarify an individual's problem and may reflect dysfunctional attitudes. According to Beck, dreams bring automatic, unrealistic thoughts to the dreamer's awareness, and so can be used to help clients recognize their distorted thinking.

More recently, other cognitive therapists have developed models for using dreams in therapy. As an example, Arthur Freeman and Beverly White (2004) described a method for using dreams as a standard homework task in cognitive-behavioral therapy (CBT). In this approach, the dream represents an idiosyncratic dramatization of the dreamer's view of both self and the world. Freeman and White also

provide 15 guidelines for conducting CBT dream work. They assert, for instance, that dreams should be understood thematically rather than symbolically; thus, the ideas or images present in clients' dreams should be taken at face value and not as symbolic representations of something or someone else. In addition, they posit that clients' affective responses to their dreams parallel affective responses to waking life events. Freeman and White also state that dreams may be particularly useful when clients are "stuck" in therapy, and that clients should be encouraged to establish a system and routine for collecting and logging their dream content. Furthermore, in seeking to understand their dreams, clients should try to discern a "moral" or primary theme from the dreams.

C. Other Individual Approaches

A number of other dream approaches, representing various theoretical perspectives, have been developed. Phenomenologists hold that dreams reflect conscious experiences and can be examined just as experiences in waking life (Boss, 1958, 1963; Craig and Walsh, 1993). Gestalt therapists such as Fritz Perls (1969) and Erving and Miriam Polster (1973) attend to the here and now and ask dreamers to imagine that each part or image of the dream is a part of themselves and to have a dialogue amongst the parts, believing that these disparate parts must be integrated for the person to become whole. Eugene Gendlin (1986) and Alvin Mahrer (1990) described experiential approaches for helping dreamers re-experience the feelings in their dreams and thus begin to accept and integrate the feelings. Gayle Delaney (1991, 1993), Ann Faraday (1972, 1974), and Lillie Weiss (1986, 1999) developed models incorporating elements of Gestalt and Jungian theories and connecting dreams closely to waking life problems.

Finally, Clara Hill (1996, 2004) integrated many of the previous theories into her cognitive-experiential dream model. Her model rests on the assumptions that (1) dreams are a continuation of waking thought without immediate input from the external world; (2) dreams' meaning is personal, and thus standard symbols or dream dictionaries are likely not useful; (3) working with dreams requires therapist and client collaboration; (4) dreams are useful for helping people

understand themselves more deeply; (5) dreams consist of cognitive, emotional, and behavioral components; and (6) therapists must have sound basic helping skills before they can effectively apply the dream model. Integrating experiential, psychoanalytic, Gestalt, and behavioral approaches to dream work, Hill's model rests on three stages (exploration, insight, and action). In the exploration stage, the therapist helps the client deeply and sequentially explores a few dream images by progressing through four steps (description, re-experiencing, association, and waking life triggers). Once several images have been thoroughly explored, the therapist helps the client construct the dream's meaning in terms of the phenomenological experience of the dream, the dream's connection to waking life, or the inner dynamics (i.e., parts of self, conflicts from childhood, spiritual-existential concerns). Once the therapist and client have co-created some meaning for the dream, the therapist helps the client talk about how she or he would like to change the dream. The therapist then bridges from the changes in the dream to changes in waking life (i.e., helps the client apply possible changes in the dream to possible changes in waking life), and then helps the client determine how to go about actually making such changes.

D. Dream Groups

In addition to the theories focusing on dream work with individual clients, there has been a growing interest in groups formed for the purpose of sharing and understanding dreams (Hillman, 1990). The major model of group dream work was developed by Montague Ullman (1987), whose approach emphasizes safety and discovery in group dream work. Importantly, the dreamer must feel safe enough with the group to disclose what may be quite intimate material. To foster such safety, all members acknowledge that the dreamer has absolute control of the dream work process at every stage. Discovery arises from the group members all adopting the dream as their own, a process that consists of four stages: (1) the dreamer describes a dream and the group asks questions to obtain a clear sense of the dream; (2) group members project their own material and their own associations onto the dream and its images; (3) the dreamer then responds to the group's input; and (4) during a later meeting, the dreamer shares any further thoughts s/he had with the group.

Building on Ullman's method, Donald Wolk (1996) created an integrative technique that uses psychodrama as a means to help participants connect their dreams to present life circumstances. After the group selects a member's dream on which to focus, the dreamer retells the dream in the first person, present tense. Next, group members ask questions to clarify the content of and feelings related to the dream. Group members then share their feelings about the dream as if it were their own, thus becoming integral contributors to the process. The focus then shifts to group members working on the dream images as if they were their own, and as if they were metaphorical expressions of something about their lives. Next, the dreamer responds to the group's feelings and offered metaphors, knowing that s/he is the ultimate authority on the many possible meanings of the dream, as well as on what s/he is willing to examine further with the group. Finally, the group leader assists the dreamer in selecting a part of the dream s/he wishes to address, then helps her/him set the scene and select dream characters and objects from among the other group participants. After the enactment, the dreamer is requested to write a comprehensive account of her/his experience of the group dream process.

In his similar approach, Jeremy Taylor (1992, 1998) asserted that anonymity must be maintained whenever dreams are discussed beyond the group. Furthermore, he posited that only the individual dreamer may definitively determine the meaning of her/his dream, that dreams may have more than one meaning, and that group members should always begin with the phrase, "If it were my dream ..." when referring to another person's dream.

A cognitive approach to group dream work is Barry Krakow's IRT (Krakow, 2004; Krakow and Zadra, 2006) for distressing dreams and posttraumatic nightmares. The three or four, approximately 2-hour group sessions that comprise this approach consist of two primary components. The first involves education and cognitive restructuring to help clients reconceptualize their disturbing dreams as a learned sleep disorder. Once they begin to see that these nightmares may have initially had an important function but have become habitual, clients begin to see that they can alter the behavior. In the second

component, clients are taught imagery rehearsal. They choose a nightmare, determine how they would change it into a new dream, and then rehearse this new dream during the therapy session and as homework. Krakow asserted that this technique accelerates the client's once-dormant imagery system which in itself is healing, such that not only the targeted, but also other disturbing, dreams are also positively affected. Importantly, this model is an educational approach and does not encourage a re-experiencing of the disturbing dream. In fact, clients are specifically advised to avoid rehearsing old nightmares, given that exposure is contraindicated. In addition, clients for whom the trauma is too recent or who insist on working with extremely negative nightmares tend not to do well in this approach.

Finally, another option for group dream work arises from an adaptation of Hill's cognitive-experiential model (Wonnell, 2004). This approach maintains the three-stage structure, and group members offer input in all the stages, using the Ullman phrase, "If it were my dream ..." to reinforce the dreamer's control over her/his dream. Sharing some features of the Ullman, Wolk, and Taylor methods, the Hill model provides more detailed guidelines for the dreamwork process, especially in the exploration stage, which may prove helpful for newly formed groups or new members of established groups.

E. Summary

Clearly, then, dream theories have arisen from many theoretical perspectives, and for both individual and group therapy, thereby attesting to the value of working with dreams in therapy. The diversity of these models demonstrates that theoreticians agree on no single, "correct" way to work with dreams. Although the plethora of approaches is a sign that the field is expanding and is vital, empirical validation of these theories is crucial. We thus turn now to the empirical research on dream work in psychotherapy.

II. Empirical Research on the Demographics of Dream Work in Psychotherapy

In this section, we review research about what might be considered the demographics of dream work. Specifically, we cover

what we know about the extent of dream work in psychotherapy, client factors in dream work, therapist activities used in dream work, and who volunteers for dream work.

A. How Much Dream Work Occurs in Psychotherapy?

According to several surveys (Crook and Hill, 2003; Fox, 2002; Huermann *et al*., 2009; Keller *et al*., 1995; Schredl *et al*., 2000), most therapists reported that they attend to dreams at least occasionally, although dreams were rarely a major focus of therapy. For example, cognitively oriented therapists in the Crook and Hill (2003) study reported that about 15% of clients had talked about dreams in the past year and that they had spent about 5% of therapy time working on these dreams. A comparison of the mostly cognitive-behavioral therapists in Crook and Hill (2003) with a psychoanalytic sample (Hill *et al*., 2008) revealed that the latter group worked with dreams considerably more than did the former group: The psychoanalytic sample talked about dreams with about half of their clients and such work occupied about half of the time in therapy, suggesting that therapists whose theoretical orientation values dream work are more likely to use it.

B. Client Factors in Dream Work

Therapists were most likely to focus on dreams with clients who had troubling recurrent dreams or nightmares, were psychologically minded, were interested in learning about their dreams, had posttraumatic stress syndrome (PTSD), or were seeking growth (Crook and Hill, 2003). Relatedly, clients who indicated having discussed dreams in therapy had higher dream recall, more positive attitudes toward dreams, and more encouragement from therapists to talk about their dreams than clients who did not discuss dreams in therapy (Crook-Lyon and Hill, 2004). Clients who reported that they had not talked about dreams in their therapy sessions either indicated that other issues were more pressing or that bringing dreams into therapy had never occurred to them (Crook Lyon and Hill, 2004).

C. How Do Therapists Work with Dreams?

In terms of how they actually work with dreams, cognitively oriented therapists reported that they most often listened if clients brought in dreams, explored connections between dream images and waking life, asked for a description of the images, and collaborated with clients to construct interpretations of dreams (Crook and Hill, 2003). Likewise, psychoanalytically oriented therapists also frequently engaged in these four activities, but in addition often encouraged clients to associate to dream images, worked with conflicts represented in dreams, interpreted dreams in terms of waking life and past experiences, invited clients to tell dreams, encouraged clients to re-experience feelings in dreams, used dream images as metaphors later in therapy, and mentioned to clients that they were willing to work with dreams (Hill *et al*., 2008). Similarly, clients who discussed dreams indicated that therapists most often helped them interpret their dreams, relate their dreams to waking life, and associate to dream images (Crook Lyon and Hill, 2004). Hence, although both cognitively and psychoanalytically oriented therapists used many activities to work with dreams, they most often focused on exploring and understanding the dreams; they rarely addressed how clients might change their dreams or make changes in waking life based on their understanding of dreams.

One interesting finding in the previous paragraph is that psychoanalytically oriented therapists invited clients to tell dreams and also mentioned that they liked to work with dreams. Two other studies also provided preliminary evidence that clients are more likely to talk about dreams if therapists explicitly encourage them to bring dreams into therapy (Crook-Lyon and Halliday, 1992; Hill, 2004).

Although these reports of how dreams are used in therapy are informative, most of the studies involved surveys of therapists and clients retrospectively recalling events. Thus, the data might represent attitudes more than the actual occurrence of dream work. To more directly answer the question of how dream work actually occurs in therapy, then, we are currently conducting a study within ongoing psychotherapy where therapists indicate after every therapy session whether a dream was mentioned and what activities were used to

work with the dream. This study should provide preliminary information about how often dreams are presented in therapy and what methods therapists use to work with these dreams.

D. Who Volunteers for Dream Work?

Two studies provide evidence that not everyone wants to do dream work. In Hill *et al*. (1997), 336 undergraduates obtained extra credit for participating in a study in which they completed a wide range of self-report psychological measures and kept dream journals for 2 weeks. After completing the study, students were asked whether they would like to volunteer for no credit to work on a dream with a therapist in training. Of the 336 participants in the larger study, 109 (32%) indicated a willingness to participate and then 65 (19%) actually did participate. The students who were most likely to volunteer to participate were women, had high estimated dream recall, positive attitudes toward dreams, and high levels of absorption (i.e., capacity to restructure one's phenomenal field), and were open to new experiences. In a similar type of study in Taiwan, Tien *et al*. (2006) obtained a slightly higher participant rate of 177 of 574 (31%) students agreeing to participate in a dream session. Those students who volunteered had more positive attitudes toward dreams than those who did not volunteer. These findings are consistent with those reported above that clients were more likely to bring dreams into therapy if they had positive attitudes toward dreams, and thus emphasize the importance of attitudes toward dreams in deciding whether or not to ask a client to work with dreams in therapy.

III. Empirical Research on Models of Dream Work

Many case studies, both anecdotal and empirical, indicate the appropriateness and effectiveness of working with dreams with a wide range of clients (e.g., clients with trauma, homelessness, sexual problems, depression, masochism, obsession) in both individual and group therapy (see review in Hill and Spangler, 2007). Eudell-Simmons and Hilsenroth (2005) also reviewed a number of case studies indicating that dreams themselves change as a function of successful psychotherapy. For example, Caroppo *et al*. (1997) reported that the last 18 dreams of one client were more adaptive and

integrated than were the client's first 18 dreams in therapy. In Dimaggio *et al*. (1997), pleasant emotions in dreams increased as the client improved. Thus, at least according to case studies (which have inherent bias in terms of selection factors), dream work appears to produce salutary results.

Fortunately, we also now have a solid body of research on larger, randomly selected samples indicating the effectiveness of dream work. This empirical work has primarily been conducted on two models—Hill's cognitive-experiential approach and Krakow's IRT—and so we turn now to a review of this research.

A. Research on Hill's Cognitive-Experiential Dream Model

One caveat we acknowledge is that studies on the Hill model have mostly involved single sessions of dream work or brief therapy involving dream work, all with recruited clients presenting dreams, rather than dream work within naturalistic ongoing psychotherapy with non-recruited clients. Studying recruited clients in single sessions or brief therapy allowed Hill and colleagues to control extraneous variables and isolate variables of interest, and thus provide evidence about the effectiveness of dream work. Generalizing to ongoing psychotherapy, however, is premature.

1. Outcomes of Dream Work

The outcomes of dream work using Hill's model have been assessed in several ways, including (1) session quality, (2) the goals of dream work (e.g., insight, action ideas, target problems, and attitudes toward dreams), and (3) broader outcomes for general psychotherapy (e.g., symptom change, changes in interpersonal functioning, decreases in depression, well-being, communication).

i. Session Quality

The quality of sessions involving dream work has been assessed by client and therapist ratings of depth, working alliance, and satisfaction, typically using measures completed immediately after

sessions. In 12 studies, clients consistently rated the quality of dream sessions (using the Hill model of dream work) significantly higher than regular therapy sessions (see review by Hill and Goates, 2004). It would seem that clients felt better about the quality of the sessions when they focused on dreams than when they focused on other topics.

ii. Goals of Dream Work

With regard to the specific goals of dream work, gains in insight have been assessed through several methods (open-ended questions of clients, standard measures of insight and understanding, and ratings of insight reflected in interpretations given by clients of their dreams). From studies using these various approaches to investigating the Hill model comes convincing evidence (see review in Hill and Goates, 2004) that clients gained insight into their dreams. Interestingly, in Hill *et al*. (2006), clients had a moderate level of insight into their dreams prior to sessions and gained insight after both the exploration and insight stages of dream work, and also reported gaining additional insight at a 2-week follow-up. These findings reflect that clients might be stuck prior to sessions in terms of understanding their dreams, but rapidly become unstuck in their ability to keep thinking about their dreams

Hill and colleagues have also assessed changes in the quality of clients' action ideas following dream sessions (again see review in Hill and Goates, 2004). They found that clients became more clear and focused about what they could do differently in their waking lives based on what they learned about themselves in the dream sessions. Interestingly, the quality of action ideas was lower than insight both before and after sessions, suggesting that action does lag behind insight.

Another dream-related variable relates to changes in the target problem reflected in the dream. Clients are asked after sessions (because they often do not know before sessions) to describe the target problem reflected in the dream and then rate their functioning on the target problem both for the current time and also retrospectively with regard to their functioning on this problem before the session. In Hill *et al*. (2006), clients reported increases in

functioning on their target problems after a dream session, suggesting that clients felt that working with their dreams directly helped them resolve problems in waking life.

Researchers have also used a more standardized measure (impact of specific events) to assess changes in specific target complaints. Here, clients reported improvements in relation to divorce in Falk and Hill (1995) and loss in Hill *et al.* (2000).
Yet another dream-related outcome is change in attitudes toward dreams. Tien *et al.* (2006) applied the Hill model in Taiwan and found that volunteer clients presenting dreams reported better attitudes toward dreams after two to three dream sessions than did controls who did not receive a dream session.

iii. Broader Outcomes

In terms of broader outcomes for therapy as a whole, some research has found decreases in general symptoms (Diemer *et al.*, 1996; Hill *et al.*, 2000; Wonnell and Hill, 2005) and in depression (Falk and Hill, 1995), as well as increases in existential well-being when spiritual insight was the focus of the dream work (Davis and Hill, 2005). Mixed results have been reported for changes in interpersonal functioning (Diemer *et al.*, 1996; Hill *et al.*, 2000). In their investigation of group dream work with separated and divorced women, Falk and Hill (1995) found that those in dream groups scored higher in self-esteem and insight than did those in the wait-list control at the final assessment. Kolchakian and Hill (2002) found increases in other dyadic perspective taking but no changes in dyadic adjustment, primary communications, and self-dyadic perspective with couples' dream work.

In sum, consistent and positive changes have been reported in session quality and on outcomes that are specifically focused on dream work (e.g., insight, action ideas, target problems, and attitudes toward dreams). Less clear evidence has been reported on outcomes not specifically targeted in dream work (e.g., depression, anxiety, and self-esteem). Given that dreams may not necessarily reflect these broader outcomes, it is not surprising that fewer changes have been found in broader outcomes than in outcomes specific to dream work.

2. The Process of Dream Work

Now that we have established positive outcomes for Hill's model for dreamwork, we present evidence regarding the process of dream work. Specifically, we focus first on components of the model, and then review more general process components (client involvement, therapist input, other therapist characteristics, and the development of insight).

i. Components of the Model

A number of experimental studies have been conducted examining components of the exploration, insight, and action stages. In a study involving description of dream images only, association to dream images only, or description and association in the exploration stage, Hill *et al*. (1998) found slightly more benefit in terms of outcome for the association-only condition, but in general found that both description and association were helpful. In terms of the insight stage, no differences were found in outcomes for waking life versus parts-of-self interpretations (Hill *et al*., 2001), nor were differences found in nonspiritual outcomes for waking life versus spiritual interpretations, although spiritual interpretations led to more spiritual insight (Davis and Hill, 2005). In terms of the action stage, Wonnell and Hill (2000) found that clients who completed all three stages (exploration, insight, action) had better action ideas and rated sessions higher on problem solving than did clients who only completed the exploration and insight stages. Furthermore, Wonnell and Hill (2005) found that intention to carry out action plans was predicted by the client's perception of how much the therapist used action skills, the level of client involvement, and the level of difficulty of the action plan. Implementation of action was predicted by the level of difficulty of the action plan and the intent to act.

Another way of examining components of the model has been through qualitative investigations that involved asking open-ended questions of participants who experienced dream work. In four studies (Hill *et al*., 1997, 2000, 2003; Tien *et al*., 2006), clients mentioned that gaining insight, making links to waking life, hearing a new or "objective" perspective, experiencing feelings/catharsis, and hearing

ideas for changes were helpful components of working with dreams. Interestingly, few clients mentioned hindering aspects; when they did, there was no consistency in what they did not like, suggesting that variables unique to the session, client, or therapist rather than the model itself were problematic.

ii. Client Involvement

Four studies (Diemer *et al.*, 1996; Hill *et al.*, 2006; Wonnell and Hill, 2000, 2005) found evidence that client involvement (i.e., active engagement in the session, actively exploring, coming up with insights, and generating action ideas) is related to the outcome of individual dream work, although one study (Falk and Hill, 1995) did not find that client involvement was related to outcome of group dream work.

iii. Therapist Input

Therapist's input was mentioned in three aforementioned qualitative studies (Hill *et al.*, 1997, 2000, 2003) as a helpful component of the dreamwork process. In addition, two studies (Heaton *et al.*, 1998; Hill *et al.*, 2003) found that volunteer clients gained more from working with a therapist than they did from using the same approach in a self-help format. We note, however, that a small subgroup of clients in the latter study preferred working by themselves. Liking the therapist was mentioned in two qualitative studies (Hill *et al.*, 2000, 2003) as a helpful component of the process. One study (Hill *et al.*, 2006) found evidence that therapist adherence to the model and competence using the model were related to session outcome. In contrast, Hill *et al.* (2003) did not find evidence for the effects of therapist input (interpretations in the insight stage and action ideas in the action stage) when they compared empathy alone and empathy plus input. Furthermore, Hill *et al.* (2007) found no differences between an empathy condition and an empathy and input condition for clients of East Asian descent, although clients who were more anxiously attached and lower on Asian values had better outcomes in the empathy-only condition, whereas clients who were less anxiously attached and higher on Asian values had better outcomes in the empathy and input condition. It is likely that clients in

the earlier sets of studies enjoyed working with a therapist, but the empathy might have been the crucial factor. Hence, although it appears that the therapists' empathic presence is beneficial for most clients, the exact helpful components of therapist interventions are less clear.

iv. The Development of Insight

Additional evidence for the effects of specific process components was presented in a series of three case studies (two of whom gained a lot of insight, and one gained very little insight) examining how insight develops in dream sessions (Hill *et al*., 2007; Knox *et al*., 2008). The two insight-gained clients were very motivated and involved in the sessions, nonresistant, trusting of others, and affectively present but not overwhelmed by affect. In addition, their therapists were able to skillfully use probes for insight and manage countertransference reactions toward the clients. In contrast, the client who did not gain insight was resistant, untrusting, and emotionally overwhelmed in the session, and the therapist was not skillful in conducting the session and was not able to manage her negative countertransference. In another examination, Baumann and Hill (2008) found that therapists' interpretations, self-disclosures, and probes for insight were associated with high levels of client insight in the next speaking turn in the insight stage of dream sessions, suggesting that these are helpful interventions for facilitating insight. Across studies, therapist probes for insight appear to be particularly helpful.

v. Summary of Process Evidence

All components of the Hill model (exploration, insight, and action) appear to be helpful. Furthermore, it is helpful for clients to gain insight, make links to waking life, hear a new or "objective" perspective, experience feelings/catharsis, and hear ideas for changes. It also appears that client involvement and motivation are key components of dream work using the Hill model. Finally, if clients are to gain insight, they need to not be overwhelmed by affect in the session and be open to and trusting of the therapist. Furthermore,

therapist presence and perhaps empathy are important, along with the
ability to use probes for insight.

3. Predicting Who Benefits from Dream Work

We have some knowledge regarding what types of clients
achieve the greatest benefit from dream work. First, clients with
positive attitudes seem to have positive outcomes (Hill *et al*., 2001,
2006; Zack and Hill, 1998). Taken together with the finding that the
people who volunteered for dreams sessions had more positive
attitudes toward dreams than those who did not volunteer (Hill *et al*.,
1997), valuing dreams may be an important precondition for dream
work. A second important variable is the salience of dreams, in that
clients who profited most from dream work presented dreams that
seemed potent or powerful to them (Hill *et al*., 2006). Third, self-
efficacy for working with dreams seems important (Hill *et al*., 2008), in
that clients needed to feel that working with dreams would help them
accomplish their goals.

In addition, in Hill *et al*.'s (2006, 2008) studies, clients who
profited most from dream sessions had poor initial functioning on the
problem reflected in the dream, low initial insight into the dream, and
poor initial action ideas related to the dream. Hence, clients who had
more to gain in terms of their functioning related to the specific dream
gained the most from the sessions.

The valence of the dream has garnered less consistent results.
Zack and Hill (1998) found the best session outcomes when dreams
were moderately unpleasant or extremely pleasant, and the worst
outcomes when dreams were moderately pleasant or extremely
unpleasant. Hill and colleagues (2001), in contrast, found that session
outcomes were best when dreams were pleasant. No relationship
between dream valence and session outcome emerged in Hill *et al*.
(2003). Perhaps, as Hill *et al*. (2007) suggested, dreams should be
categorized into several types (positive interpersonal, negative
interpersonal, interpersonal agency, interpersonal nightmares, non-
interpersonal dreams, all others) rather than by valence. Furthermore,
Hill *et al*. found more positive process and outcome for clients with

positive, agency, and non-interpersonal dreams than for clients with negative dreams and nightmares.

Minimal evidence exists for the importance of other client characteristics (e.g., sex/gender, race/ethnicity, psychological mindedness) and other dream-related characteristics (e.g., recency, vividness, arousal, distortion) in terms of outcome of dream sessions (see also review in Hill and Goates, 2004).

In conjunction with the findings presented in the section on the demographics of dream work in naturally occurring therapy, these results suggest that it is best to do dream work with clients who have positive attitudes toward dreams, high self-efficacy or confidence in their ability to work with their dreams, who have salient dreams that are puzzling or dreams that reflect underlying concerns, who have low insight and action ideas related to the dreams, and who are willing to discuss dreams in therapy.

B. Empirical Research on Imagery Rehearsal Therapy (IRT)

Barry Krakow and colleagues have conducted a number of studies demonstrating the effectiveness of IRT in reducing nightmare frequency/intensity and increasing sleep quality in survivors of sexual assault (Krakow *et al*., 2000, 2001), adolescent girls in a residential facility (Krakow *et al*., 2001), crime victims with PTSD (Krakow *et al*., 2001), and nightmare patients (Germain and Nielson, 2003). These studies have shown not only positive outcomes but also the maintenance of changes over ~3 months. Interestingly, these same studies also found that symptoms of anxiety, depression, and PTSD decreased after successful nightmare treatment. Furthermore, Germain *et al*. (2004) demonstrated that the new dreams created by clients contained fewer negative elements and more positive elements and mastery than did the nightmares.

In their summary of this body of literature, Krakow and Zadra (2006) noted that about 70% of clients reported clinically meaningful improvements in nightmare frequency, with the percentage increasing to 90% when clients regularly used the techniques for 2–4 weeks.

Krakow (2004) noted that the results are best for those clients who do not have major psychiatric distress or disorders. For example, in Krakow *et al*. (2001), one-third of sexual assault survivors dropped out of IRT before initiating treatment or very early in treatment, suggesting that IRT did not resonate well for them. No work, however, has yet been done to dismantle this approach and thereby determine the relative effectiveness of its various components (e.g., education about nightmares as a learned behavior, imagery rehearsal).

C. Empirical Research on Other Methods of Dream Work

In a comparison of their four-step group method and Ullman's group method, Shuttleworth-Jordan and Saayman (1989) found that therapists and clients were more involved and experienced less tension or loss of control in the former than the latter method. Furthermore, three studies have shown the effectiveness of systematic desensitization in reducing nightmare frequency and intensity (Celucci and Lawrence, 1978; Kellner *et al*., 1992; Miller and DiPlato, 1983), although one could question whether systematic desensitization is actually dream work.

IV. Empirical Research in Other Areas Related to Dreams and Psychotherapy

There are a number of other ways that dreams can be used in psychotherapy. We focus here on just a few of these applications.

A. Therapist Use of Dream Content to Understand Clients

Eudell-Simmons and Hilsenroth (2005) suggested that therapists examine the content of dreams to better understand their clients. Given that dreams provide information about the person, and clients are often invested in their dreams, examining the content of dreams can be a nonintrusive way of assessing personality problems. Relatedly, a substantial amount of evidence exists showing that dream content differs for different diagnostic groups (see reviews in Hill,

1996; Van de Castle, 1994), allowing therapists to assess whether their clients' dreams are similar to those of clients with depression, hysteria, schizophrenia, chronic brain syndrome, or a history of sex offenses.

Research regarding the prevalence of interpersonal themes in dreams may also prove beneficial for therapists. The typical dream, for instance, involves other people and feelings about these people (Hall and Van de Castle, 1966). Interestingly, the response of others in dream narratives was typically to reject and oppose the dreamer, whereas the responses of self were typically to feel anxious, ashamed, and helpless (Popp Diguer *et al.*, 1998; Popp *et al.*, 1998).

Dreams can also be used by therapists to understand aspects of the therapeutic process. From a psychodynamic perspective, Bradlow and Bender (1997) suggested that the first dream presented in analysis reflects crucial themes. Furthermore, Gillman (1993) described three types of undisguised transference dreams (a response to a break in the analytic barrier, a defense against an emerging transference neurosis, and reflection of a specific character defense). In addition, Sirois (1994) suggested that client dreams often signal sensitive moments in therapy, especially occurring when the client perceives the therapist's interventions as traumatic. Finally, clients sometimes present dreams about termination (Oremland, 1973). Intriguing as these observations are, empirical research is needed to increase our understanding of the role of dreams in psychotherapy (see also later section on client dreams about therapists).

B. Culture, Dreams, and Psychotherapy

1. Dream Work with Men

Men and women have different dream experiences. Men have lower dream recall than women (Cowen and Levin, 1995; Schredl, 2000), and men's dreams contain more aggression, anxiety, achievement, and work-related themes than do women's dreams (Schredl and Piel, 2005; Van de Castle, 1994).

Aaron Rochlen (2004) modified Hill's cognitive-experiential model for men. He included strategies to overcome men's resistance, such as providing more explanations about why each of the stages of dream work is necessary, encouraging men to move beyond concrete thinking in their work with dreams, providing models for men who are emotionally constricted, and recognizing when clients are too focused on action. Rochlen and Hill (2005) tested this model among men with different levels of gender role conflict: Men with high gender role conflict discussed conflicts between work and family, restrictive emotionality, and preoccupation with achievement and competition in sessions more often than did men with low gender role conflict. The outcome of sessions, however, was not different for men who had high versus low gender role conflict. These results suggest that once men agree to dream work, they find it helpful regardless of their level of gender role conflict. Of course, as reviewed earlier, it is difficult to get men to volunteer to work on their dreams.

2. Dream Work with East Asian Clients

Hill *et al*. (2007) successfully used dream work with East Asian clients. They found, however, no support for the oft-cited premise that East Asian clients should benefit more from a directive than nondirective approach. In fact, there were no overall outcome differences between a nondirective approach (i.e., therapists provided only empathic responses such as probes and reflections) compared with a directive approach (i.e., therapists provided input in addition to empathy, such that they gave probes, reflections, interpretations, and suggestions for action). Client variables, however, did moderate the results: Clients who were more anxiously attached and lower on Asian values did better in the empathy-only (nondirective) condition, whereas clients who were less anxiously attached and higher on Asian values had better outcomes in the empathy + input (directive) condition.

Sim *et al*. (2010) did an additional analysis of the data of those East Asian women in the Hill *et al*. sample who were first- and second-generation students. They found that interpersonal issues and academic/postgraduation/career issues were typical for both subgroups, but that first-generation Asian women more often disclosed

issues related to immigration/cultural/adjustment and physical/health than did second-generation women. In terms of action ideas, both subgroups typically talked about making interpersonal behavioral changes, but first-generation Asian women talked more about changing thoughts and feelings than did second-generation Asian women. Hence, not only might race/ethnicity play a role, but also immigration status may play a role in what clients talk about in dream sessions.

3. Spirituality and Dream Work

Dreams have long been regarded as reflections of spirituality (Davis, 2004; Jung, 1964; Van de Castle, 1994), but not much is known about the relationship between spiritually centered dream work and therapeutic outcome. In one study, Davis and Hill (2005) examined the Hill cognitive-experiential model with clients who were spiritually oriented. In this study, clients gained more spiritual insight and had greater increases in existential well-being when therapists provided spiritual interpretations of their dreams in the insight stage than when therapists offered waking life interpretations. These findings suggest that there may be some value in therapists addressing spiritual and existential concerns with clients who are spiritually oriented.

C. Client Dreams about Therapists

Although many therapists, particularly of a psychoanalytic orientation, have written about the clinical importance of client dreams about therapists (e.g., Eyre, 1988), only a few empirical studies have investigated this phenomenon. Harris (1962) and Rosenbaum (1965) reported that about 10% of client dreams reported in sessions were manifestly about the therapists, and Rohde *et al*. (1992) found that 33% of clients who were themselves therapists had dreams in which their own therapists appeared in undisguised form. Hence, these data indicate that some clients, particularly those in psychodynamic therapy, do have dreams about their therapists.

In terms of the content, Harris (1962) indicated that client dreams about therapists reflected transference, but Rosenbaum (1965) reported no such evidence. Harris also reported that the

manifest content ranged from wish fulfillment to a reflection of anxiety, whereas Rohde *et al*. found themes of separation-rejection, seduction-antagonism, protectiveness-responsiveness, and praise in dreams. Thus, it appeared that client dreams about therapists covered a range of topics, although many appeared to be negative, with the therapist/analyst treating the client badly. Methodological problems plagued these studies, however: Harris used his own clients and did his own data analyses from case notes; Rosenbaum surveyed a small non-representative sample of analysts and relied on his own judgment to analyze the data; Rohde *et al*. used trained judges and a larger sample size, but their sample consisted of psychotherapists and thus their findings might not generalize to clients who are not therapists. A study that we are currently conducting in a clinic setting examining client dreams about their therapists might provide some further evidence about this topic.

D. Therapist Dreams about Clients

We found three empirical studies about therapists' dreams about clients. In a survey of members of the Canadian Psychoanalytic Society (Lester *et al*., 1989), 78% of participants reported having had countertransference dreams (i.e., dreams where the client appeared in undisguised form in the manifest content of the dream). These dreams most often occurred at difficult points in the therapy (when there was a strong erotic transference, 46%; when therapists were not understanding their clients, 46%; when clients were angry, 32%), although they also occasionally occurred when progress was being made (26%), or when therapists were introducing something new into the therapy (14%). Most therapists reported having gained insight into their dreams about clients (76%), although a few indicated guilt (22%) or embarrassment (20%). Male therapists had more sadistic/erotic, competitive, and sadistic dreams and fewer identification/closeness dreams than did female therapists.

Kron and Avny (2003) studied dreams of 22 Israeli therapists about 31 clients. The majority of the dreams (65%) were characterized by negative emotions, in that therapists felt betrayed, abandoned, and forsaken by clients who were characterized as aggressive, neglectful, abandoning, or invading of their personal

space. Kron and Avny speculated that the dreams reflected therapists' unresolved issues, a projection of clients' difficulties, or problems in the therapeutic relationship.

Spangler *et al*. (2009) qualitatively examined eight experienced therapists' dreams about their clients. Therapists' dreams reflected either particularly challenging clients or an extreme amount of stress in the therapists' life. The dreams typically involved negative interpersonal content (e.g., awkwardness, boundary violations, aggression), although there were a few positive interactions.

In sum, therapists' dreams about clients are most often negative, reflecting difficult or challenging interactions, although some involved positive interactions. A caveat across these studies, however, is that all were retrospective (collected using a survey format or interviews) from selective samples of therapists. In addition, recall bias may have played a role, in that more salient or more negative dreams may have been remembered more often. We are currently conducting a study where therapists keep dream journals, and thus may be able to obtain a clearer picture of the frequency and types of dreams therapists have about clients.

E. Training Therapists to Do Dream Work

Three studies were found that examined training in dream work, all using a retrospective survey method (i.e., asking practicing therapists about their training). In all three studies (Crook and Hill, 2003; Fox, 2002; Keller *et al*., 1995), most therapists indicated that they had at least minimal graduate training in dream work. In addition, Fox (2002) found that the more training therapists had in dream work, the more likely they were to perceive themselves as competent in working with dreams and to consider dream work to be effective. Similarly, Crook and Hill (2003) found that the more training therapists had, the more likely they were to feel competent in working with dreams, to have had clients who brought up dreams in therapy, to have spent time in therapy working on dreams, and to have used many activities for working with dreams. These findings suggest that therapists feel more competent and engage in more dream work when they have had training in dream work. These studies were

correlational, however, so we cannot rule out the possibility that those therapists who felt more competent in working with dreams sought out more dream training. To address the issue of the effects of dream training, experimental work is needed.

Ullman (1994) presented an experiential group approach for teaching therapists how to make connections between dream images and waking life experiences. In this method, he stressed the importance of dialogue between the dreamer and therapist, with the therapist listening to and questioning the dreamer to elicit relevant client information. He also stressed the importance of safety to help the client feel free to engage in the discovery process. Unfortunately, there is yet no empirical evidence regarding Ullman's training method.

Crook (2004) developed a training model for the Hill cognitive-experiential approach in which therapists read about the model, participate in discussions of the model, and then practice the model in group and dyadic settings. In a recent empirical study with s small sample and only one trainer, Crook-Lyon *et al*. (2009) found evidence that therapists felt more self-efficacy for working with dreams, had more positive attitudes toward dreams, and had higher self-reported competence for working with dreams as a result of training. In addition, there was some preliminary evidence that feedback from supervisors about their performance in sessions and practice doing sessions with clients both led to higher levels of self-efficacy, attitudes toward dreams, and ability to conduct dream sessions, but these findings await replication with larger samples.

V. Future Directions

Given the potential effectiveness of dream work, it seems appropriate for therapists to incorporate such content into psychotherapy, especially after being adequately trained in how to work with dreams. Therapists would ideally be trained by experts to use approaches that have received empirical support, but, alternatively, therapists can learn methods for working with dreams by reading texts and practicing on their own.

In terms of research, we need more empirical investigations of the efficacy and effectiveness of different dream models, including direct comparisons of various dream models. For example, Hill's cognitive-experiential model and Krakow's IRT have quite different approaches to affect in dream work: Hill recommends re-experiencing and processing the affective material, whereas Krakow recommends avoidance of exposure to the dream images. Both of these approaches appear effective, so it would be important to compare the two directly, and also to determine if each is more effective with certain types of clients.

Furthermore, work is needed to determine the effectiveness of various components of the different models. More work is needed, as well, on the best methods for including dream work in therapy and for training therapists.

We hope that this review is helpful in encouraging therapists and researchers to pay more attention to dreams in psychotherapy. In a similar review of dream work, say 20 years from now, we hope that there will be many more approaches to dream work and that these approaches will have received substantial empirical attention so that we will know more about when, with whom, and how to use dreams in psychotherapy effectively.

Notes

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