Psychologist and client understandings of the use of dream material in psychotherapeutic settings

by

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Thesis

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Abstract

Consistent with the marginalisation of dreams in contemporary clinical practice, the few studies conducted on the use of dreams in therapy report that therapists do not feel confident or competent in responding to their clients' introduction of dream material in therapy. This raises a number of potential consequences, such as a negative impact on the therapeutic alliance, the possible misinterpretation of a therapist's rejection of a dream narrative as a disinterest in the client's inner life, and possible questioning of psychologists' expertise arising from mismatched expectations between the psychologist and client. The relative and significant gap in the literature around the direct lived experience of psychologists and clients working with dreams in therapy points to a need for further research of real life experiences and perceptions of dreams in psychological practice.

The aims of this research were to identify and understand the experiences and understandings of psychologists and clients around dreams in contemporary Australian psychological practice. The specification of the sample population arose from the adoption of an Interpretative Phenomenological Analysis (IPA) approach, which emphasises the role of context in the examination of how people perceive or subjectively experience the world. The findings of the research are also contextualised through the lenses of existing research literature, theoretical frameworks, and the researcher's perspectives.

The first study analyses the transcripts from semi-structured interviews with sixteen psychologists. The findings of this first study demonstrate the diversity in psychologist experiences of dreams in psychological practice. Participants vary in the frequency of dream work, the way they use or do not use dreams in their work, and their feelings and opinions about dreams. Overall, this study illuminates the taboo and associated *sense of disquiet* around dreams, and attempts to reconcile dream work with being a 'good psychologist'. This is expressed through discussions about credibility, imposter syndrome, the lack of a script for dream work, and low confidence levels around dream work.

While many of the participants value the role dreams play in their practice, overall dreams are positioned as having an uncomfortable *boundary* role in contemporary Australian psychological practice at 'whole-profession' and public levels, despite the considerable variation at an individual level. With limited training around dreams, psychologists must negotiate *multiple, sometimes conflicting, influences* on their everyday practice, including

the *therapeutic alliance*, which was identified as core to both dream work and psychological practice in general. These findings can inform the development of training and practice guidelines around responding to dream material and other examples of complexity in clinical psychology and psychology training in general. Additionally, it highlights the need for continued improvements in critical reflexivity and diversity within psychological research, training and curriculum, and the psychologist community.

The second study analyses transcripts from semi-structured interviews with five psychology clients. The first theme emerging from the analysis clusters around participants' *experiences* (with emotions ranging from feeling pressured, frustrated or vulnerable, to feeling relief or validation). The participants' experiences are diverse and they vary in emotional tone, vary from one experience of therapy to the next, and are influenced by the stage of therapy. The second theme focusses on the participants' underlying assumptions or *rules*, around what to share (or not share) with whom, and when. The participants' explanations for their experiences and opinions reflect their underlying individual and socio-cultural understandings of *both* psychotherapy and dreams, with references made to dream beliefs, the stage of therapy, and psychologist cues. The participants all express the opinion that dreams have at least some relevance to therapy, although dreams are not always the sole or even a major focus of therapy. They describe multiple ways in which they and their psychologists have used dreams in psychological practice, and emphasise that dream sharing often reflects trust and the desire to engage deeply with psychologists, as sharing a dream can be a very risky and vulnerable experience. The findings of this second study highlight the value of approaching therapy (and dream sharing in therapy) from a social/cultural practice framework. This framework understands interactions or exchanges between psychologists and clients as being influenced by a range of cultural assumptions, which both parties bring into the therapy room with them.

This research makes three significant contributions to knowledge. Firstly, it adds to the growing body of literature focusing on the application of socio-cultural theories to understanding the practice of professionals (and particularly practicing psychologists). Secondly, it increases knowledge around psychologists' and clients' understandings of their experiences of dream work in therapy and of the role of dreams in contemporary Australian psychological practice. Thirdly, this research can inform the development of training and practice guidelines around responding to dream material and other examples of complexity in clinical psychology and psychology training in general.

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I would like to acknowledge the Kaurna people, the traditional custodians of the lands to which I moved to study and research at CQUniversity, Adelaide campus. I pay my respects to Elders, past, present, and future, of the Aboriginal peoples who have endured injustices and dispossession of their traditional lands and waters. I recognise and respect their relationship with the land, cultural heritage, languages, beliefs, particularly their long and rich histories of dream beliefs and practices, that are of continuing importance to the Aboriginal peoples living today.

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Dedication

I would like to dedicate this thesis to my beautiful mother Jenny Kohlhagen, who sadly died of cancer before I completed my PhD. You were always a strong advocate for women's access to education and the pursuit of career dreams. You provided a wonderful role model for your four daughters, as a wonderful mum who had a successful and impactful career. Thank you for your support of my education, career and PhD. You are loved and you are greatly missed.

* * *

I finish here with a final observation from one of my participants, which also beautifully captures a key aspect of my PhD experience:

> *everything in life is fascinating, […] dreams in particular (fourth client interview)*

RHD Thesis Declaration

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PREVIOUS SUBMISSION STATEMENT

This paper HAS NOT been submitted for an award by another research degree candidate (Co-Author), either at CQUniversity or elsewhere.

DECLARATION OF CO-AUTHORSHIP AND CO-CONTRIBUTION

Appendix I contains copyright approvals for including these published papers in the thesis.

Title of Paper: The marginalisation of dreams in clinical psychological practice

Full bibliographic reference for Journal/Book in which the Paper appears:

Leonard, L., & Dawson, D. (2018). The marginalisation of dreams in clinical psychological practice. *Sleep Medicine Reviews*, 42, 10-18. DOI: 10.1016/j.smrv.2018.04.002

Status: Published

Nature of candidate's contribution, including percentage of total: As lead author, I contributed substantially to the conceptual work, wrote the manuscript, and was responsible for submission, revision, and re-submission, throughout the peer review process. My contribution was equivalent to 60%.

Nature of co-authors' contributions, including percentage of total: My co-author, Drew Dawson, contributed to the conceptualisation of the manuscript and some editing. His contribution was 40%.

This paper is presented in Chapter 3, part C of the thesis, and it has been: Reprinted from *Sleep Medicine Reviews*, Vol 42, Leonard, L., & Dawson, D., The marginalisation of dreams in clinical psychological practice, 10-18, Copyright (2018), with permission from Elsevier. https://doi.org/10.1016/j.smrv.2018.04.002

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This paper is presented in Appendix K and an expanded version of the findings are presented in Chapter 5 of the thesis, and the paper is:

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List of Abbreviations

AASM	American academy of sleep medicine
ACT	acceptance commitment therapy
ADHD	attention deficit hyperactivity disorder
AHPRA	Australian health practitioner regulation agency
APA	American psychological association
APAC	Australian psychology accreditation council
APS	Australian psychological society
CBT	cognitive behaviour therapy (-E for eating disorders, -I for insomnia)
CHAT	cultural-historical activity theory
DBT	dialectical behaviour therapy
EBP	evidence-based practice
EMDR	eye movement desensitization and reprocessing
GPs	general practitioners (family doctors in Australia)
IASD	international association for the study of dreams
IPA	interpretative phenomenological analysis
OCD	obsessive compulsive disorder
PRISMA	preferred reporting items for systematic reviews and meta-analyses
PTSD	post-traumatic stress disorder
RODBT	radically open dialectical behaviour therapy

Note to Readers

For transparency, published papers have been included as PDFs to retain their formatting and style. For ease of reading, references for each paper or chapter are located at the end of that paper or chapter, rather than in a single list at the end of the thesis. Introductions that locate chapters within the broader thesis and explicit discussions about the major theoretical, personal and professional influences on the researcher at the time of writing, have been included to increase transparency and assist readers in your interpretation of my interpretative and other research processes. This final point is discussed in more detail in Chapter 2.

Chapter 1. Introduction

1.1 Introduction and rationale

Professionals are increasingly faced with complex problems involving many stakeholders and interrelated variables and for which they have inadequate data and insufficient pre-existing solutions (Cherry, 2005). Psychologists are one such group of professionals and simple manuals and scripts don't always meet their needs given the complexity that they inevitably face. This is particularly so with topics on the boundary or edge of a profession that are not a core part of training or everyday practice, but which may come up occasionally and require psychologists to respond professionally and ethically to them.

Sociological approaches that treat professions as a single entity argue that the boundaries of any profession change over time and place, with claims that particular areas of knowledge loosely associated with a particular profession fall within the boundary of that profession at certain times and not at others (Hotho, 2008). Hotho (2008) also suggests that individuals within a profession are not always aligned with the collective profession's identity. For example, despite some individual psychologists continuing to work with and value dreams, they have become marginalised in contemporary psychological practice (Leonard & Dawson, 2018). This marginalisation is due to a number of historico-cultural reasons, including psychology's alignment with an identity associated with a particular era of naturalistic science, narrowing epistemological diversity, and the pursuit of success in a wider neoliberal socio-political context (Leonard & Dawson, 2018). As an area of knowledge that falls on the boundary of psychological practice, dreams serve as an example of a complex problem that requires a response from psychologists.

The dream expert has played an important role in many cultures (Delaney, 1998; Neil, 2016) and despite the marginalisation of dreams in clinical practice, psychologists are seen by some in society to be dream experts (Dombeck, 1991). While many therapists do work with their clients' dreams at least occasionally, dream work appears to occur irregularly in therapy and it is often initiated by clients rather than by the therapist (Crook & Hill, 2003; Fox, 2001; Hill et al., 2008; Keller et al., 1995; Lempen & Midgley, 2006; Schredl et al., 2000). Additionally, in the few studies that have been conducted, many therapists report having inadequate training around how to work with dreams in therapy and describe not feeling competent or confident to adequately respond to dream material their clients bring to therapy (Crook & Hill, 2003; Fox, 2001; Freeman & White, 2002; Keller et al., 1995; Pesant & Zadra, 2004; Schredl et al., 2000). Given the intimacy associated with sharing dreams (Olsen et al., 2013), and the diversity of dream beliefs and practices in human society, this has significant implications for psychologists and clients.

Several potential consequences of significance arise from the paradoxical state of the role of dreams in psychology wherein psychologists are seen by their clients and society as dream experts, yet they may not see themselves that way. Firstly, people can feel vulnerable sharing dreams given that dreams can be deeply personal and intimate, subjective experiences (Boyd, 2005; Dombeck, 1991; Schredl et al., 2015). The failure to acknowledge the trust required to share dreams may have a negative impact on the therapeutic alliance (Carcione et al., 2021), particularly given dream sharing is seen by some as an indication of a good therapeutic alliance, as discussed by Lempen and Midgley (2006), and a tool for facilitating the therapeutic process (Carcione et al., 2021). The crucial role that the therapeutic alliance plays in therapy (Fluckiger et al., 2020; Noble & Rizq, 2020; Wampold, 2015) demonstrates the importance of researching aspects of therapeutic practice that can affect it.

Secondly, any rejection of or indifference towards a shared dream narrative could be interpreted as disinterest in the client's inner life (Leonard & Dawson, 2018), leaving the

client feeling rejected or invalidated (Carcione et al., 2021). Alder (2016) uses a transcript analysis to demonstrate that for a client who values and shares dreams, negative therapist responses to dreams can have a negative impact on that client's opinion of the therapist.

Thirdly, as discussed by Lempen and Midgley (2006), clients may offer dreams as gifts for which they expect the reciprocal gift of interpretation from their therapist. There is a possibility that differences in client and psychologist expectations around appropriate responses to dreams may lead clients to question psychologists' competence in other areas of practice in which they expect them to be experts (Leonard & Dawson, 2019).

The universal importance of dreams to human society can be seen in the plethora of artwork, writing, beliefs and practices associated with dreams across time and culture (Delaney, 1998; Palagini & Rosenlicht, 2011; Pesant & Zadra, 2004; Van de Castle, 1994). This has resulted in an extensive literature around dream theories and models of dream work, across many academic disciplines. Despite this rich theoretical development, a range of historico-cutural factors have contributed to dreams being pushed to the periphery of psychological practice, when it comes to what is included in psychologist training, or what happens in the therapy room (Leonard & Dawson, 2018). For example, the economic and political context in which psychology evolved as a profession separate from psychiatry, influenced psychology's choice to embrace behaviourism and align itself with the natural sciences (Pilgrim, 2010), which contributed to a changing perception of dreams in therapy. Other factors, like a narrowing interpretation of evidence-based practice, and perceptions that dream work requires long-term therapy, long-term training, or is of little value to clinical practice, have also had an impact on the marginalisation of dreams in contemporary psychological practice.

The aforementioned factors, that have influenced the theoretical development and clinical practice patterns around dream work, have also led to particular patterns in the dream research literature. For example, there are a number of surveys focussing on therapist

estimates of dream sharing prevalence and dream-related activities in therapy, but there is a significant gap in the literature around the direct lived experience of professional therapists working with dreams in their everyday practice (Hackett, 2020, 2021; Leonard & Dawson, 2018). An IPA study of Irish therapists by Hackett (2021) and the ethnographic work on dreams and professional personhood in America by Dombeck (1991) are rare exceptions. The serious potential consequences for therapy and the profession if psychologists reject or respond inappropriately to shared dreams (Carcione et al., 2021; Leonard & Dawson, 2019), point to a need for further in-depth examination of actual experiences and sense-making, in a way that captures detailed, real life examples.

Furthermore, there are very few studies that focus on the client's perspective on dream sharing in therapy (Crook-Lyon & Hill, 2004). Examining both clients' and therapists' epistemological points-of-view is critical because dream sharing may be seen as a social interaction or an exchange in which dreams may be offered as gifts. Given the client experience of a therapist is also an important factor in therapy (Amos et al., 2019), it is essential to include the client voice in this area of research. The presence of the client voice in psychological practice research is consistent with primary health policy initiatives that seek to include the user in all aspects of their care (Boyd, 2005), and of benefit to psychological research and effective therapy (Elliott, 2008). Such research could also inform practice guidelines that benefit both clients and therapists.

This research project focussed on identifying psychologists' and psychology clients' understandings of the role of dream material in therapy and their experiences of the introduction of dream material in psychotherapeutic settings. The findings of this research project inform the further development of culturally sensitive and diverse psychology curricula, training, psychologist communities, and clinical guidelines for psychologists working with dream material and other examples of complexity that they will inevitably face in their practice. Such developments can play a valuable role in increasing psychologists' feelings of competence and confidence in relation to dream work, potentially benefitting

both psychologists and clients. The project also supports increasing diversity in psychological research through the inclusion of diverse methodologies, topics, theories, and the client voice.

1.2 Definition and scope

This research focuses on psychologists' and clients' understanding of the role of dream material in therapy within the context of contemporary Australian psychological practice; and their experiences of dream material being introduced into therapy. The unit of analysis is the activity of understanding the experience of sharing dreams in therapy and their role in contemporary Australian psychological practice. This project applies social science theories to interpret and contextualise the participants' accounts, to draw implications for professional practice, and education and training. It investigates and contextualises an aspect of professional practice rather than evaluating an intervention for a disorder.

1.3 Defining dreams and dream work

There is no universally accepted definition for dreaming or a dream, and many journal papers about dreams do not provide any definitions at all (Pagel et al., 2001). Definitions that have been provided in the literature vary considerably due to the diversity of fields or disciplines interested in dreaming and the variety of research questions across these disciplines. The consensus findings of an interdisciplinary group from the Association for the Study of Dreams (now the IASD – International Association for the Study of Dreams) and the AASM (American Academy of Sleep Medicine) was that any definition of the term *dream* should refer to the sleep/wake continuum, recall continuum, and content (Pagel et al., 2001). These guidelines led to the development of an initial definition of dreaming for this research project as a self-reported (during wakefulness) experience of mental activity during sleep. This is similar to the definition provided by Schredl (2010) that a dream or dream report is the recollection of mental activity which has occurred during sleep.

Any definition of dreaming is hampered by the current inability to directly measure or witness another's dream experience, which results in validity issues around whether a report of an experience is synonymous with the experience itself (Schredl, 2015). This in turn raises the issue of memory or dream recall and other factors that may impact choices around how an individual presents or represents a dream in a dream report. These factors include, but are by no means limited to, the dream reporter's decision-making around whether to edit details the dreamer or the listener may find embarrassing, frightening or irrelevant. The requirement for a dream report in much research has obvious implications for studying dreams in people or animals who are unable to communicate a dream experience. Such a requirement calls into question how dreaming is defined and measured. Moreover, cultural diversity in perceptions of consciousness, theories of mind and continuums of reality influence individual interpretations of what constitutes a dream as well as how and why any dreams should or should not be shared. All these factors influence the data collected in dream research.

Initially, a working definition of a dream as a self-reported (during wakefulness) experience of mental activity during sleep was accepted as helpful in understanding dream sharing in psychotherapeutic setting. However, the aforementioned definitional issues resulted in a final decision for the term *dream* to not be pre-defined for participants in this study. This decision allowed participants to include the broadest possible range of experiences and relevant opinions and to minimise missing potentially relevant data due to use of too narrow a definition of the term. Definitions of dreams varied among participants as did conceptualisations of dreaming around whether dreams are a single phenomenon or whether dreams should be divided into various subtypes or categories such as dreams and nightmares, or meaningless dreams and meaningful dreams and so on.

The definition of *dream work* also varies among the studies cited in this paper. For example, Keller et al. (1995) operationalised dream work in their survey by asking respondents about their use of dream reports and dream interpretation in therapy. Crook

and Hill (2003) suggest that the lack of specificity in dream work definitions in studies like Keller et al.'s, means that different studies may be sampling different dream work methods, contributing to variance in therapeutic outcomes across studies. Crook and Hill (2003) therefore decided that in relation to defining dream work in their study, that they would provide participants with a list of potential activities therapists may engage in when working with dreams. This enables the collection of more useful data for quantitative or mixed-methods analyses.

Due to the focus of this study on collecting rich data about individuals' understandings of their experiences and attitudes towards the role of dreams in psychological practice, an interpretive phenomenological approach was taken and the semi-structured interviews allowed for a broad definition of *dream work* while enabling participants to describe in detail what they do with dreams in therapy. For the analysis in this study, the term *dream work* is used to refer to any use of dream material in a therapeutic setting including, but not limited to, using a theoretical model to explore meanings in dream narratives, using dream material as a source of clinical information or as a part of an assessment, or responding to the sharing of dream narratives to build or measure rapport and the therapeutic relationship. This definition is designed to be inclusive as possible to avoid missing idiosyncratic ideas of what dream work looks like or particular experiences and opinions about dreams and therapy that may not have been included in a pre-determined list.

Dream work can therefore not just include various theoretical models of how to work with dreams, but also include treating dreams the same as any other material the client introduces during therapy. Of relevance here is Hartmann's meteorite versus gemstone conceptualisation of dreams (Hartmann, 2010), which due to space constraints, could not be explored in greater depth in the *Dreams as gifts* paper presented in Chapter 3b. Hartmann (2010) developed a continuum (gemstone) view of dreams. The gemstone approach views dreams as creative, like works of art, which are located at one end of a

continuum of mental activity that is beyond, but comparable to, daydreaming. This view enables psychologists to conceptualise shared dreams just as they would any other form of material introduced to therapy, such as the retelling of an incident at work or a discussion about a worry they had experienced. Hartmann argues that this view enables psychologists to engage with clients and their dreams without feeling they require specialised training in a separate discipline. Thus there is no need for an examination of randomised controlled trials showing a dream 'intervention' *works,* as the therapy is whatever the psychologist is using with the client for any material, including dreams, that they introduce, rather than the dream being something that needs to be *fixed* or *solved*.

1.4 Aims

The aims of this research were to identify psychologists' and clients' understanding of the role of dreams in contemporary Australian psychological practice and of their lived experiences of the introduction and use of dream material in therapy.

1.5 Objectives

Interpretative phenomenological analysis (IPA) is a qualitative approach to research interested in examining how people perceive or subjectively experience the world (Willig, 2013). The objectives of this research project were to undertake an interpretative phenomenological analysis of transcriptions from semi-structured interviews with Australian psychologists and adult clients (current and former) of Australian psychologists about psychologists' and clients' perceptions of their experiences around the introduction of dream material in therapy and the role of dreams in contemporary clinical practice. The specification of the participants engaging in psychological therapy in Australia at this point in history is necessary to understand the phenomenon being examined due to the influence of culture on dream beliefs and practices, and psychological practice. This is consistent with interpretative phenomenological assumptions around context, which are discussed in greater detail in the methodology section of this thesis in Chapter 2.

1.6 Research questions

The central questions for this project were:

1. How do psychologists understand their experiences of dream work in psychotherapeutic settings?
2. How do psychologists make sense of the role of dreams in Australian psychological practice?
3. How do clients understand their lived experience of dream sharing in psychotherapeutic settings?
4. How do clients make sense of the role of dreams in Australian psychology?

1.7 Significance

This research makes three significant contributions to knowledge. Firstly, in terms of theoretical significance, it adds to the growing body of literature focusing on the application of socio-cultural theories to understanding the practice of professionals (and particularly practicing psychologists). Secondly, this research increases knowledge around psychologists' and clients' understandings of their experiences of dream work in therapy and of the role of dreams in contemporary psychological practice in Australia. Thirdly, in terms of its significance for clinical practice, this research informs the development of training and practice guidelines around responding to the introduction of dream material and other examples of complexity in clinical psychology and psychology training in general. Additionally, it also highlights the need for continued improvements in critical reflexivity and diversity within psychological research, training, and the psychologist community.

1.8 Rationale for thesis structure

This thesis is structured with the methodology chapter in Chapter 2 followed by literature reviews in Chapter 3. Many of the thesis chapters also include an introduction that discusses various influences on the research and researcher. The decision to structure the thesis this way was influenced by several factors related to interpretative phenomenological analysis. These included hermeneutics and reflexivity, and the subsequent need for transparency, contextualisation, and trustworthiness strategies like triangulation.

An explicit examination of how the researcher influences the research process through both personal and epistemological reflexivity is generally encouraged in qualitative research approaches (Willig, 2013). The structure of this thesis was intended to increase transparency, making it easier for readers to identify influences on the researcher and the research processes (the double hermeneutic). It provides readers with a lens through which they can read the literature reviews, having gained a clear understanding of the research project already in the second chapter, and an explanation for how concepts associated with IPA, like reflexivity, triangulation strategies, and hermeneutics, are used to position the literature reviews in the third chapter as a data source and early iteration within the analytic process.

The way this thesis is structured is heavily influenced by the IPA concept of a double hermeneutic. A double hermeneutic refers to the idea that a researcher is assumed to have interpreted the participants' accounts of experiences in the context of other accounts, the researcher's personal and professional experiences and values, and existing research and theory (Smith et al., 2009). It is also assumed that any readers of this thesis will interpret it within the context of their own experiences, values, and knowledge, forming something akin to a triple hermeneutic

Sensitivity to context in relation to the socio-cultural milieu in which a study is conducted, the existing literature, methodological decisions, sampling, the interpersonal nature of data collection, and how participants understand their experiences, are critical for producing quality knowledge in IPA approaches to research (Smith et al., 2009). The multiple theories applied throughout the thesis are an intentional use of concepts and theories as tool kits that can be used for problem solving, as advocated by Bourdieu (Bourdieu & Wacquant, 1992).

This exploration of different theoretical orientations as a part of the hermeneutic practice of IPA, sought to open up interpretative possibilities. As a part of the hermeneutic practice and reflexive development of the researcher, the literature reviews in this thesis reflect an early iteration within the analytic process, forming the basis for the subsequent interpretation of the interview transcripts. The use of multiple theoretical frameworks also acts as a triangulation strategy. Triangulation strategies making use of multiple types of research methods, multiple sources of data, multiple theoretical lenses, or comparison to existing research findings for data interpretation, can be used to improve quality in qualitative research (Leavy, 2017).

1.9 Thesis outline

This first chapter of the thesis provides a brief introduction to the project, along with an outline of the research problem, the rationale for and significance of the research, the aims and objectives of the research and the research questions.

Chapter 2 provides a rationale for the choice of methodology, a description of the interpretative phenomenological approach selected, its underlying assumptions, associated issues, and the specific methods used to collect and analyse data in this research project. The second chapter makes sense of the decision to structure this thesis with the methodology chapter being presented before the literature reviews, by explaining

concepts around iterative analytic processes, hermeneutics, and reflexivity, in greater depth.

Ijams and Miller (2000) advocate a multi-disciplinary approach to dream research that encompasses the unique perspectives that each discipline can contribute to our understanding of dreams. The relevance of dreams to multiple disciplines can be seen in the International Association for the Study of Dreams (IASD) community. The IASD is connected with the APA journal *Dreaming*, it provides funding for dream research, and runs an annual dream conference. It is an incredibly multi-disciplinary organisation that includes lay voices in addition to academic and professional ones. The IASD includes disciplines as varied as anthropology, archaeology, religious studies, neuroscience, psychology, education, visual arts, literature, and music. This diversity is apparent in the contextualisation of the research questions through the literature reviews.

Chapter 3 contains an examination of particular theories and areas of knowledge that contextualise the research project and provide the reader with information about the influences on the interview transcript analysis. The chapter is divided into two sections: A and B. After an introduction, Part A provides a historical context for the current research. It focusses on the creation and maintenance of a role for experts in sleep and dream medicine in ancient Greece. The origins of modern Western medicine can be traced back to ancient Greece and the two examples of dream medicine experts these papers focus on are the well-known Hippocratic physicians and the cult of Asklepios. Details about the specific beliefs and practices of sleep and dream medicine in the cult of Asklepios and classical Greek dream beliefs have been included.

Bourdieu's work is used to undertake a social field analysis of Hippocratic sleep and dream medicine. It examines the origins and the implications of the role of the dream and the dream expert in ancient Greek sleep medicine for psychotherapists working with dreams in contemporary, Western medical settings. The influence and relevance of science

studies research and changing cultural perceptions of expertise (Collins & Pinch, 1993; Collins, 2007; Collins & Evans, 2002) are also evident in this part of Chapter 3, positioning discord around dreams in psychological practice as a historically- and culturally-influenced epistemological issue, rather than an issue related to evidence-based practice.

Part B contains two further papers. Firstly, a narrative literature review that provides further context for the understanding the justification for this research, reflecting anthropological influences in much dream research. The paper was published in *Dreaming* (Leonard & Dawson, 2019). It takes a Maussian perspective of the social practice of sharing dreams, discussing the implications of this framework for dream sharing in psychotherapeutic settings.

The second paper is a final narrative literature review, which has been published in *Sleep Medicine Reviews* (Leonard & Dawson, 2018). This review focuses on the marginalisation of dreams within clinical psychological practice, examining the historical and sociocultural factors contributing to the marginalisation or privileging of particular epistemologies, methodologies, and topics, within psychology, and the consequences of this for clinical practice and research. The literature reviews in Chapter 3 provide a context and justification for the current research. Throughout the chapter and again at the end, there are also explicit discussions around reflexivity.

Chapter 4 focuses on the findings from the first study, for which psychologists were interviewed about their perceptions of the role of dreams in contemporary clinical practice and their experiences of the use of dream material in therapy. This chapter reveals the uncomfortable and liminal experience of working with dreams for the psychologist participants. As an example of a topic on the boundary of psychological practice, Chapter 4 highlights issues related to the complexity of psychological practice in general and the benefits of focussing on the development of epistemic fluency and actionable knowledge during psychologist education and training. The influences of Complexity theory, higher

education and professional training research, organisational leadership research, professional identity, history studies of psychology, Van Gennep's *Rites de Passage,* and Cultural-historical activity theory (CHAT) are particularly evident in this chapter.

Chapter 5 focusses on the findings from the second study, for which clients were interviewed about their understanding of the role of dreams in contemporary Australian psychological practice and their experiences of the use of dream material in therapy. This chapter returns to focus on the socio-cultural influences on dream beliefs, practices, and research, and ideas from the Gift theory work of Mauss. A paper accepted for publication in *Dreaming*, which focusses on the second study in this project can be found in Appendix K.

The final chapter of the thesis, Chapter 6, includes a summary of both studies, and a discussion about the research project as a whole.

1.10 Conclusion

Psychologists, like professionals in other fields, are increasingly faced with complex problems for which they do not have a pre-existing response. Dreams are an example of this. In the few studies conducted on the use of dreams in therapy, therapists report that they do not feel confident or competent to adequately respond to their clients' introduction of dream material in therapy. This raises a number of possible consequences, such as a negative impact on the therapeutic alliance, the possible misinterpretation of the therapist's rejection of a dream narrative as a disinterest in the client's inner life, and potential questioning of psychologists' expertise. The relative and significant gap in the literature around the direct lived experience of professional therapists and clients working with dreams in therapy points to a need for further research of real life experiences and perceptions of dreams in psychological practice.

The literature reviews in the third chapter of this thesis provide contextualisation for the project. They demonstrate the development of the role of the medical dream expert, the cultural perception of psychologists as dream experts, the implications of the cultural understandings of reciprocity in relation to sharing dreams with others. They show the development of psychological dream theories and models of practice. They explain how some aspects of psychology have been privileged, while others, like dreams, have been marginalised within contemporary, clinical psychological practice. They also form part of the reflexivity process, providing readers with a more transparent account of the iterative influences on the interpretation of the interview transcripts.

Across two studies, this IPA research project examines semi-structured interview transcripts of firstly psychologists' and then psychology clients' understandings of the role of dreams in contemporary Australian psychological practice and their experiences of the introduction of dream material into therapy. The findings are contextualised through the lenses of existing research literature, theoretical frameworks, and the researcher's perspectives. The terms dream and dream work were left to the participants to define to minimise the risk of missing potentially relevant and rich data due to the adoption of too narrow a definition of these terms.

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Chapter 2. Methodology

This second chapter of the thesis contains a detailed background to the selected methodology. The chapter goes back to the basics so that readers can follow the chain of logic of the thesis through methodological choices, assumptions, and their relevance to the overall project. This is particularly for the benefit of readers who may be unfamiliar with Interpretative Phenomenological Analysis (IPA).

2.1 Methodology

Interpretative Phenomenological Analysis (IPA) was selected as the best fit-for-purpose for this project. IPA is a qualitative approach to research that is committed to examining how people perceive or subjectively experience the world rather than assuming an objective truth about a phenomenon can be discovered (Willig, 2013). This is closely aligned with the aims of this project to identify psychologists' and clients' understanding of the role of dreams in contemporary Australian psychological practice and of their lived experiences of the introduction and use of dream material in therapy. The interpretive nature of the data analysis process in IPA studies reflects an understanding that the transcripts are surface level manifestations of underlying structures (Willig, 2013). The influences of phenomenology, idiography, and hermeneutics are evident in IPA and researchers seek to develop a rich, transparent, and contextualised analysis of a small, homogenous group of participants' accounts that has theoretical transferability rather than generalisability (Smith et al., 2009).

This chapter is divided into two sections, with the first focussing more on underlying methodological issues and the second focussing more on methods of data collection and analysis. The chapter opens with the process of explaining which method for collecting

and analysing data best addresses the identified research questions. This process involves an examination of relevant values, beliefs, experiences, and assumptions that held by the researcher, as well as the ontological, epistemological, and theoretical assumptions underlying a range of potentially relevant methodologies. Despite the interactive dance between these assumptions and influences on the decision-making and research processes, I have presented them separately. Matters relating to epistemological reflexivity are presented in the following four sections at the start of this chapter, while matters relating to personal reflexivity are covered in more detail in the *Reflexivity, locating the researcher, and self-as-data* section of the chapter.

2.1.1 Qualitative methodology

This research extended the small body of previous research on the use of dreams in therapy undertaken through survey methods. Leavy (2017) points towards the use of qualitative approaches when a study has research aims and research questions of an exploratory nature as this one does. Quantitative methodologies tend to focus on statistical approaches that involve measuring, controlling variables, and seeking random samples to produce generalisable results. The analytic processes applied within most quantitative research compromise the capacity to retain an individual's experience and sense-making that some qualitative approaches enable. In contrast, qualitative research allows for smaller sample sizes and focuses on examining meanings within rich, detailed data, which is generally in the form of everyday language and accounts of experiences (Levitt et al., 2018). In summary, a qualitative methodology that allowed for purposeful sampling and had the capacity to capture individual experiences and sense-making was required to address the study's aims to develop insights into two specific groups' (psychologists and clients) understandings around dream work in psychological practice.

Creswell et al. (2007) examine the relative merits and characteristics of a number of qualitative approaches to research, including case studies, grounded theory,

phenomenology, and participatory action research. The type of research aims and questions vary among these influencing their appropriateness for the current project. For example, a case study could provide insights into a single experience of and the role of dream work evaluated within the context of therapy for a particular client. The research questions for this project however, required an approach that was broader and could look across multiple examples to better understand the experience and role of dreams in psychological practice. As another example, Creswell et al. (2007) described participatory action research as best suited to the type of problem in which a community issue needs addressing for change to occur. This research approach was also rejected as the current project sought to address the lack of data on this topic, meaning there was insufficient data to identify an issue in need of change or an appropriate solution. Another example, a grounded theory approach, was also rejected as the research questions were more focussed on understanding shared and divergent experiences and perceptions of psychologists and clients around dreams in psychological practice, rather than seeking to develop an explanatory theory.

2.1.2 Phenomenological approaches

Phenomenology is interested in the study of human experience, so stood out as a useful qualitative approach for researching how psychologists and clients understand their experiences around dreams in therapy and the role of dreams in psychological practice. There are a number of schools of phenomenology, stemming from the work of Husserl, a philosopher in the late nineteenth - early twentieth century (Creswell et al., 2007). Husserl developed the idea of intentionality and the phenomenological method of bracketing, or separating off one's assumptions and perceptions about the world. He assumed that the essence of the experience being studied could be accessed through a series of reductions, each with its own lens or perceptions about the phenomenon studied (Smith et al., 2009). This type of descriptive phenomenology showed the value of experience, perception, and reflection.

In contrast to Husserl's approach, hermeneutic phenomenology, influenced by Heidegger, argued that un-interpreted phenomena do not exist and that the use of language to capture a lived experience is inherently interpretive (van Manen, 1990). Thus while description and reflection remain essential to all phenomenological approaches, their nature and role vary from more 'pure' approaches such as transcendental phenomenology through to hermeneutic phenomenological approaches like that by van Manen (1990) and interpretative phenomenological analysis. Heidegger's work identified the value of people's meaning-making for phenomenology, with the idea that people exist in a world of objects, relationships and language and that being-in-the-world is unavoidably temporal, only able to be understood in relation to something, and unavoidably viewed through perspective (Smith et al., 2009).

The more interpretative approaches to phenomenology aim to provide rich descriptions of people's experiential meanings in order to better understand the phenomenon being studied (Bourgeault et al., 2010; Creswell et al., 2007). They assume people use awareness or consciousness to make sense of social reality and focus on how people think about their experiences (Leavy, 2017). This suggests an interpretivist/constructivist paradigm, which is one that is interested in the way in which people create and develop meanings or understandings through their experiences (Brocki & Wearden, 2006).

Hermeneutics, or the theory of interpretation, is interested in the purposes and methods of interpretation and it was introduced into phenomenology through Heidegger's work (Smith et al., 2009). In particular, the concept of the hermeneutic circle, examining the relationship between the part and the whole at different levels, has been incorporated into interpretative phenomenology. While criticised for its logical failings, it provides a useful description of the iterative, analytic process of interpretation and the dynamic, non-linear way of thinking required (Smith et al., 2009).

2.1.3 Interpretative phenomenological analysis (IPA)

The decision to use an interpretative phenomenological analysis (IPA) approach was based on it being described as a qualitative approach to research that is committed to examining how people perceive or subjectively experience the world (Willig, 2013). This description of IPA was closely aligned with the aims of this project, to examine how psychologists and clients understand their experiences around dreams in therapy and the role of dreams in contemporary Australian psychological practice.

IPA has quickly become one of the well-known and commonly used qualitative methodologies in psychology over the past few decades (Smith, 2011). The IPA approach has been influenced by phenomenology, hermeneutics, and idiography throughout its development. A brief background of phenomenology and hermeneutics has been provided in the previous section. Extending this, the IPA approach to research recognises that participants' accounts are an interpretation of their experiences rather than a pure, complete and unadulterated description of an objective truth. IPA also recognises that researchers interpret their participants' accounts of experiences in the context of other accounts, the researchers' personal experiences and values, and the researcher's knowledge of existing research and theory (Smith et al., 2009). This is referred to as a double hermeneutic. For transparency, explicit discussions of relevant readings that influenced the researcher during the research process are included at the start of most chapters in this thesis and citations are also used throughout the thesis to show the reader which parts of the literature base were considered in relation to each point made. It is also assumed that readers of this research will also add their own layer of interpretation in light of their own experiences, values, and knowledge base, which could even be seen as a triple hermeneutic.

Hermeneutics can be approached from various positions. The two main positions are an insider's position of empathy in which the researcher tries to reconstruct original

experience in its own terms and an outsider's position of suspicion in which the researcher uses outsider theoretical perspectives to provide insights into the phenomenon (Smith et al., 2009). IPA advocates a questioning approach that values the insider's perspective, seeing what it is like from the participant's point of view and values the outsider's perspective, standing beside the participant to examine what they are saying from a different perspective (Clarke, 2009). Hence IPA does not attempt to replicate the participant's account. Instead, it includes an interpretation component that can be described as the researcher attempting to understand what an experience is like for the participant, making sense of it for the researcher and reader(s) of the research outputs. IPA analysis therefore moves through several levels of analysis, increasing in depth with each one.

Drawing on idiography, IPA research concentrates on particular instances of lived experience rather than trying to include all possible instances. Firstly the analysis focuses on an individual experience and how an individual makes sense of an experience in a particular context (Miller, Chan & Farmer, 2018), then on uncovering common meanings and themes across the whole data set. This means IPA is interested in both convergences and divergences within and across the data. To this end, emerging themes may be generalised across the participants in the one study and comparisons made that focus on the differences or tensions within and among participants' experiences and sense-making.

Rather than seeing research as empirically generalisable, IPA focuses on theoretical transferability, assuming that a rich, transparent and contextualised analysis of the participants' accounts enables the reader to make links between an analysis in an IPA study, their own experiences, and the wider literature on the topic (Smith et al., 2009). Locating the participants and their accounts within or against the existing research literature can help the reader with this process. For this reason, the findings or results sections relating to this research have included comparisons with existing research literature and the discussion sections of this thesis include the application of several

existing theories that serve as useful tools for explaining the findings. This is also consistent with the critical realism influence present in this research, which will be discussed in the next section.

2.1.4 Ontological and epistemological assumptions

Ontology is concerned with the nature of reality and whether it is real or true, while epistemology is concerned with the nature of knowledge and various methods for producing knowledge (Willig, 2013). The underlying assumptions of a particular methodology determine what kind of knowledge it aims to produce and which types of tools and aims may be appropriate. At one end of the range of ontological positions is naïve realism or objectivism, which assumes there is an objective, knowable reality. This is consistent with a positivist epistemology for example, which assumes that reality can be measured and that data collected during research provides information about how things really are as it is objective, value-free, and decontextualised. Such research would require the researcher to adopt a neutral (value-free) stance. Procedures and tools such as quantitative, experimental designs that seek to control or verify/falsify hypotheses, and produce generalisable results may suit these assumptions. At the other end of the range of ontological positions is the relativist constructivist position that assumes there is no such thing as a single, pure, objective, and true reality, but rather only subjective, socially constructed interpretations (Willig, 2013).

IPA research seeks to understand experience rather than assume that the objective truth can be discovered, as a naïve realist or objectivist ontological position would assume. IPA is generally seen to take a somewhat flexible middle ground ontological stance between realism and relativism. Critical realism can be a good ontological fit with IPA, as it can take the position that while a particular phenomenon or reality exists, it is mediated by the multiple and changing meanings attached to it (Willig, 2013). A critical realist ontological position was adopted for this project with the assumption that the research can provide

insights into a participant's perspective about an actual experience, but that they will be influenced by context and both intra- and inter-personal factors associated with the participant and researcher.

IPA is also consistent with a social constructionist epistemological stance which assumes that meaningful reality is created or constructed through the interaction between a person and the world, acknowledging the influence of factors such as culture. IPA research with this epistemological assumption aims to understand experience rather than trying to uncover an objective, universal truth. Consistent with this, the interpretive theoretical influences on IPA encourage researchers to deeply analyse accounts of an experience, interpreting what is said within a historical context to identify cultural or other factors beyond those explicitly spoken about by the participant, which may provide insights about the research questions. Thus, IPA is understood to produce knowledge about the quality and texture of a person's experience as well as its meaning within a particular cultural and social context (Willig, 2013).

The knowledge produced through IPA is co-constructed by the researcher and participant, requiring the researcher to explicitly locate themselves in the research and to engage in reflexivity in an ongoing way throughout the entire research process.

2.1.5 Reflexivity, locating the researcher, and self-as-data

Qualitative research encourages an explicit examination of how the researcher influences the research process through both personal and epistemological reflexivity (Willig, 2013). Reflexivity should begin at the start of the process of developing a research project. Consideration to the selection of the topic, the researcher's relationship to the topic, the researcher's underlying assumptions, the underlying assumptions of relevant existing theory and literature on the topic influence the development of research aims, questions, scope, methodology, design, analysis, research outputs and so on.

The previous sections in this chapter have focussed on epistemological reflexivity while this section focuses more on personal reflexivity, approaching it from the position of self-as-data. Personal reflexivity usually considers how aspects of the researcher, such as gender, age, ethnicity, personal and professional relationship or experience with the research topic, might influence the data collection and analysis through to how the research has affected the way the researcher sees the topic at the end of the project (Willig, 2013). To assist the reader in their interpretation of the current study, information about the researcher (relevant to her role as researcher), is included below. This information is presented around three of the many clusters of factors considered in the reflexivity process. Two extracts from my reflection memos are reproduced in Appendix H.

2.1.5.1 Personal and professional assumptions and methodological choices

My views that culture is dynamic rather than static, and that humans are complex and diverse beings capable of some degree of change, have influenced me throughout my previous career in psychology and are evident as influences on this project. Also consistent with how I used to practice psychology, rather than strict adherence to a single perspective, multiple approaches have been valued and synthesised for this work.

A critical realist stance sits comfortably with my growing personal scepticism of both ontological extremities. As I developed my project proposal, I settled on the position that reflexivity enables us to use each new experience, theoretical lens, framework, language or other tool to catch another glimpse or insight into the structures that shape us and our experience of the world. This potentially enables us to be less constrained by at least some of them, but never fully free from them all. There are therefore high levels of agreement between my personal world view and the assumptions underlying my chosen research methodology. During this research, I tried to follow the advice of Finlay (2014) to embrace a human science sensibility by being open, attentive and managing subjectivity, rather

than futilely trying to eliminate bias by falling for the natural sciences fallacy that pure objectivity is possible.

Quantitative approaches would not address the research questions I was interested in for this project, leading to the selection of a qualitative approach. However, the dominance of quantitative approaches in my research training was a significant influence on me throughout the research project. My reflective memos revealed that I often thought about my sample, data analysis, and the quality of my research in relation to criteria for quantitative methodologies. For example, I was concerned about whether my sample would be representative or big enough, rather than focussing on concepts relevant to IPA studies like homogeneity and purposeful sampling. I also had to accept that I could only tell one story, not the whole story, nor all possible stories. Already somewhat aware of these issues, I entered each interview with an intention to focus on being present and deeply listening to the person I was interviewing rather than waiting to hear them mention something I could check off my mental list of 'all possible participants and data'.

To counter the dominance of a quantitative research mindset, I immersed myself in qualitative research 'ways of thinking/being' through discussions with qualitative researcher colleagues, and through reading. I also undertook qualitative research and interview training at the start of my doctoral studies. The workshops improved my understanding of the differences between clinical and research interviewing, enabling me to more confidently make use of the extensive interviewing skills and experience from my earlier career in psychology in ways that aligned with my new role as researcher.

2.1.5.2 Influences on the choice of research topic

I have a long standing lay and professional interest in sleep and sleep-related phenomena, including dreams. I never settled on any firm beliefs about whether dreams had any meaning and growing up I had no strategies for responding to them beyond using them for entertaining conversations with family and friends. My specific doctoral research topic

emerged from curiosity around the role of dreams in Australian psychology following my professional experiences of an absence of dreams in the psychology curriculum, an intriguingly diverse range of attitudes towards dreams amongst colleagues, and the introduction of dreams into therapy sessions from a number of clients throughout my career as a psychologist. My limited professional knowledge and the diversity present in my discussions with colleagues and experiences of working with clients' dreams made me want to find out more about dreams in the context of psychological practice.

Prior to the commencement of my doctoral studies I joined the International Association for the Study of Dreams (IASD), a multidisciplinary organisation that supports and promotes dreams, dream work, and dream research across the world and holds an annual multi-disciplinary conference. Through this community I was also able to access dream research expertise that influenced both my resolve to include the client voice in my research and my thinking around the most appropriate type of questions to access the type of data I was interested in.

My primary agenda was to find out something about some of the experiences of dreams out there in Australian psychological practice and what psychologists and clients made of that. I did not wish to promote a particular theoretical or personal belief about dreams or how they should be dealt with in psychological practice.

2.1.5.3 The influence of comparisons between the participants and me

My previous career as a psychologist gave me access to professional networks useful for recruitment and a pre-existing knowledge base about the context of my research. It also meant that I needed to be aware of how my reaction to participants who spoke about experiences and opinions similar or different to mine might influence them, particularly if comments could be interpreted as judgements about my own past practice or current research interests. My professional experience and past supervision around working with people whose values and opinions differed from mine and regular engagement with

feedback about my practice were helpful in dealing with this. Also, my love of learning and enthusiasm for hearing peoples' stories and how they make sense of their experiences and attitudes, especially in relation to a topic I was so curious about, meant that rather than feeling defensive, I found the range of attitudes towards dreams during my PhD application, research proposal process, and interviews, intriguing and I was genuinely interested in finding out more about them.

Another strategy used to address this was to seek close analysis and feedback about my practice interviews from the volunteer 'interviewees' and my supervision team. This included examining how my pre-existing assumptions and expectations might influence the wording of my interview questions or my nonverbal responses when participants expressed opinions or experiences aligned with mine, in comparison to when they expressed ones that did not align with mine. I also examined my thoughts, feelings, and responses to the participants and to my interpretation of the data, in light of my list of experiences and predictions about the research, which I added to throughout the project.

Finlay (2014) described how researchers can draw on and compare their own experiences with participants' experiences and reflect on the emerging relational process between themselves and a participant as a pathway to deeper levels of understanding. My professional experience was useful in this respect, but I did need to regularly check with the participants that I was not assuming that I shared understandings of and opinions about particular terms, events or decisions with them. I also needed to consider how knowledge about my past work as a psychologist might influence how the participants related to me and how the assumptions they might have about my opinions might affect what they chose to say to me during interviews. The potential impact of this on any power differential between the client participants and myself beyond researcher/participant was also something I considered when making decisions about how I could influence the interview experience for participants.

Several other points that I considered in my reflexivity process are included below, for readers to compare with the participant profile data and consider in relation to the data interpretation:

- I grew up in a predominantly white, privileged, middle class, rural Australian setting
- I studied psychology at universities that privileged Western understandings of psychological practice, CBT models of therapy, and quantitative research
- I completed training in Mindfulness-based CBT, ACT, Schema Therapy, IPT, and Lifeline volunteer counsellor training (they teach a client-centred model of counselling)
- I worked as a psychologist and clinical psychologist for over a decade in urban and regional Australia, in private practice and in various medical settings. I have also had other psychology-related jobs, like casual 'sessional' teaching at universities, and jobs in fields unrelated to psychology

A summary of the main assumptions I had identified about this research project and some of the subsequent implications that I identified as things that I would need to consider throughout the research process, can be found in Table 2.1.

Table 2.1
Summary of Assumptions and Implications for Design and Process

Domain	Assumption	Considerations for my Study
Ontology	*Critical realism*	Contextualisation vs limitations
	Middle ground between objectivist/realist and relativist - phenomenon exists, multiple meanings attached to it, so cannot find 'the truth' but can gain valuable insights	Connecting findings to literature and theory provides glimpses
		Reflexivity
		Sit with uncertainty
Epistemology	*Social constructionism*	
	Meaningful reality is constructed through interaction between person and world with influences like culture	Need for reflexivity around the subjective, collective generation of meaning achieved through iterative interpretative cycles of analysis and contextualisation of data
	Intersubjectivity	
	Importance of language	
	Co-construction: researcher – participant relationship produces the current findings, a different researcher with the same participant would produce different data and findings	Accept I can only tell a story, not all the story or every story
Theories	*Phenomenology*	
	Detailed account of people's perspective of their lived experience, assumes one person's 'experience' of an objective experience may differ from another's	Use of semi-structured interview with neutral questions and focus on everyday language to collect appropriate data
	Importance of understanding that there are different levels of language	Transcript analysis
	Idiography	Purposeful sampling
	Focus on the individual to capture rich detail and nuance	Small sample size
	Theoretical rather than empirical generalisation	Locate researcher in research
	Interpretative/Hermeneutics	Need for reflexivity and transparency
	Double hermeneutic	Tie findings back to existing literature
	Understood within context	Iterative process of analysis
	Researcher role of questioner and interpreter	
	Focus on meaning-making	

2.2 Method

2.2.1 Recruitment

Following approval from the Central Queensland University Human Research Ethics Committee (see Appendix A), participants were recruited using what Leavy (2017)

describes as a *purposeful, snowballing* approach. This approach to sampling assumes that selecting the most relevant participants for a study produces better, richer data (Leavy, 2017; McIntosh & Morse, 2015), making it appropriate for IPA research.

In line with the underlying assumption of IPA, that participant accounts need to be understood within context, this study's scope and focus were narrowed down to psychologists' and adult client participants' accounts around dreams in a contemporary, Australian, psychological practice context. The researcher's recent professional roles as a psychologist provided access to relevant professional networks for recruitment and provided a significant knowledge base about contemporary psychological practice in Australia. There were no exclusion criteria around psychologist participants holding non-clinical roles as this is quite common in Australia e.g. university academics who engage in teaching, research, and clinical practice, and therefore a legitimate and relevant practicing psychologist perspective. While this project could have expanded into related professions, non-psychologist therapists were excluded to increase homogeneity as there are a number of professional identity and regulatory issues that differ among the current professions in Australia who may provide counselling and therapy services, which include but not limited to, counsellors, social workers, psychiatrists, and psychologists. In short, this is a study located within the profession of psychology in Australia, with its unique history and characteristics. Of note, to the international reader, rather than a division between clinical psychologists on the one hand and psychodynamic and humanistic therapists on the other, Australian psychologist training has experienced increasing theoretical homogeneity with CBT dominating university programmes (Heatherington et al., 2012) and clinical psychology becoming the dominant area of applied psychology (Di Mattia & Grant, 2016). Further inclusion and exclusion criteria for both studies can be found in Appendix F in the screener questions that participants had to clear to be eligible to participate.

For the first study, practicing psychologists in Australia were the most relevant participants. The research project was therefore advertised in the Australian Psychological Society's (APS) newsletter (emailed directly to APS members) and appeared in the Current Research Projects section of the APS website (https://psychology.org.au/for-members/member-services/Research-Projects/Current-research-projects). The APS has over 23,000 members (APS, 2018), including a significant proportion of 34,230 fully and provisionally registered practising psychologists in Australia (*Psychology Board of Australia Registrant data. Reporting period: 1 January 2018 – 31 March 2018*, 2018). Additional participants were recruited via a snowballing method (Leavy, 2017) with information being emailed through the researcher's personal and professional networks and then by peer referral. Information about the recruitment advertisements for both studies can be found in Appendix B.

To ensure the most relevant participants were found for the second study, the client participants were also recruited via a purposeful, snowballing method. Information about the study was first posted on the university institute's Facebook page, which includes recruitment advertisements for many of the organisation's current research projects, often with a sleep-related focus. Secondly, the same advertisement was distributed via email to the first author's personal and professional networks and then by subsequent peer referral via postings on their social media feeds and emails to their networks. The advertisements were targeting adults who had been or were currently in therapy with psychologists in Australia and who were interested in sharing their experiences and thoughts about dreams in therapy. Clients who had shared dreams in therapy were considered relevant and the option was left open to include clients who wished to share their accounts of deliberately choosing not to share dreams in therapy. Clients who had never thought about dreams in connection to therapy would not have been included, should any have expressed interest in participating in the study.

The idiographic nature of IPA points to the need for purposeful sampling with small, homogenous samples aimed at capturing the individual experience rather than large sample sizes aimed at statistical representation of a wider population about which generalisable statements can be made (Smith et al., 2009). Small sample sizes are also necessary for producing research that achieves the level of detail and nuance appropriate given the complexity of human psychology (Smith et al., 2009). Factors such as practical restrictions and how rich the data from the individual cases are, can both influence sample size (Eatough & Smith, 2011), but ensuring quantity does not compromise quality is the primary focus of decision-making around optimum participant numbers in IPA studies (Smith et al., 2009).

Prior to data collection, a quick and informal sampling of similar published phenomenological studies that focussed on therapist or client experiences (Banerjee & Basu, 2016; Goodman-Scott et al., 2016; Oteiza, 2010; Schwenk, 2019), found that participant numbers ranged from three to thirteen therapist participants with sixteen clients also participating in the therapeutic relationship study. This is consistent with advice that participant numbers in IPA studies generally range from one to thirty participants (Brocki & Wearden, 2006). Similarly, Smith et al. (2009) also recommend that sample sizes in student projects should range from about three to twelve or so participants per study, depending on the degree, the project design e.g. if multiple studies are included in the PhD, and other circumstances. Based on these norms within IPA research, it was expected that a minimum of three psychologist participants and three client participants would be recruited, with a cut off at a maximum of twenty four participants in total across the two studies.

2.2.2 Pre-existing researcher-participant relationships

Prior to recruitment I had discussions about boundaries, multiple relationships, conflicts of interest, and risks, with my primary supervisor, as several people I knew had expressed

potential interest in participating in my research. After careful consideration I chose to allow people already well known to me to participate, with the exception of any of my past clients (none of whom contacted me wishing to participate). This exception was made following careful consideration of ethical issues from the position as their past psychologist, the challenges for us both to switch from engaging in a therapeutic relationship to a research relationship, and the potential impacts of them talking about their past experiences of sharing dreams with me in therapy, on the interview, the data analysis, the participant, and me.

Prior to their participation in this project, I knew one of the psychologist participants as a professional colleague and I also knew two of the client participants personally (they had not been my clients). Several other colleagues had expressed interest in the project but after further discussions with me they chose not to participate. They wished to share their experiences and thoughts on the topic with me through informal, personal conversations instead, explaining that they did not want to add another type of relationship (participant-researcher) onto our existing professional/friendship relationships.

2.2.3 Participants

Sixteen psychologist participants and five client participants, totalling twenty-one participants, took part in the two studies. This was at the top of the expected range for participant numbers. It was made clear to the participants in both studies that it was not compulsory to respond to the profile items they were asked about at the start of their interviews. The profile and interview questions for both studies are in Appendix F.

The sample for the first study consisted of sixteen psychologists who had practised psychology in Australia. Participants were asked to briefly describe their gender, cultural and religious identities, primary location of practice, level of clinical experience, primary theoretical orientation, and usual dream recall. They were asked to describe their identity and theoretical orientation, rather than having to select an option from a pre-determined

list. If a participant described themselves as eclectic, they were asked to specify the therapies they drew on the most in their practice. Participants were asked whether they had fewer than five years of clinical practice, between five and ten years of clinical practice experience, or had been practising for more than ten years. Participants' responses to the question about how often they recalled their dreams, were grouped into those recalling their dreams less than once a week, those recalling about one dream a week, and those recalling their dreams more often than once a week. A summary of the profile data for the psychologist participants is presented in Table 2.2.

Similar to the reasons provided in Chapter One for not pre-defining the term dream, no formal scales or questionnaires were used during the collection of profile data so as not to influence the participants' interview responses and potentially miss out on relevant data. Future research making use of alternative methodologies could include measures such as the Attitudes Towards Dreams-Revised (ATD-R) developed by Hill et al. (2001) or the Mannheim Dream Questionnaire (MADRE) developed by Schredl et al. (2014).

Table 2.2
Psychologist Participants' Profile Data

Gender	Cultural and Religious Identity	Primary Location of Practice	Years of Clinical Practice	Primary Theoretical Orientation	Dream Recall (per week)
Male	White, Christian	Rural towns, regional cities	>10	Eclectic Constructionist, maybe Narrative Therapy	1
Female	Caucasian Australian; non-religious	Regional city	>10	CBT, changed over years, eclectic	<1
Female	Jewish Australian	Regional city	5-10	Eclectic, more psychodynamic; uses DBT and some CBT and ACT	1
Male	White/Caucasian, non-practising Catholic	Rural city	>10	Eclectic, behavioural with a family systems focus	<1
Female	Australian; Catholic	Capital city	>10	CBT and ACT, some DBT and Narrative Therapy	<1
Female	Caucasian Australian; non-religious	Capital city	<5	CBT	1
Female	None	Capital city	<5	CBT	>1
Female	Italian, Roman Catholic (not frequently practicing)	Capital city	<5	Many, mostly CBT and mindfulness based therapies	<1
Female	Caucasian Australian; non-religious/atheist	Capital city	<5	Mostly CBT and Schema Therapy	>1
Male	Anglo-Saxon Australian; atheist	Rural city	>10	CBT	>1
Female	Australian; no religion	Regional city	<5	A combination, mostly CBT and Metacognitive Therapy	1
Female	Australian; atheist	Regional city	5-10	Eclectic, mostly CBT, ACT	>1
Female	Caucasian Australian; atheist	Regional city	<5	CBT and ACT	1
Female	Neither	Both capital city and regional city	>10	Eclectic, mostly CBT, DBT, ACT, CBT-E and family based therapy approaches for eating disorders	>1
Female	New Zealand Australian; none (religious identity)	Capital city	5-10	Integrative, use Schema Therapy, Psychodynamic therapy and CBT	>1
Female	Australian Irish Catholic	Regional city	>10	Eclectic; CBT, ACT, mindfulness-based therapies and Gestalt	>1

Five psychology clients participated in the second study. At the start of their interview each participant was provided with an opportunity to self-identify their gender, cultural and

religious identity, typical dream recall, where they lived, the number of therapists they had seen, and their primary presenting issues for seeing those therapists. They were also asked if they knew the primary theoretical orientation of their treating psychologists. A summary of the profile data for the client participants is in Table 2.3.

Table 2.3
Client Participants' Profile Data

Gender	Cultural Identity	Religious Identity	Location	Number of Therapists Seen	Presenting Issues	Psychologist(s) Theoretical Orientation	Dream Recall
Female	Australian	Mormon	Regional city	>2	Anxiety, PTSD	CBT, EMDR	Most days
Female	Australian American	Atheist	Capital city	>2	Depression, anxiety, trauma, grief	CBT (past), ACT (current)	At least once a week
Female	White, European Australian, Eastern European background	Jesus Christ and King James bible, no formal church or denomination affiliation	Capital city	1	Depression	Psychoanalysis (Jungian, not Freudian)	Every day
Female	Vietnamese	Buddhist	Capital city	>2	Self-harm, ADHD	Mostly CBT	Twice a week
Female	Anglo-Saxon, Caucasian	None	Capital city	>2	Depression, anxiety, OCD	Psychodynamic, integrative (influences include Buddhist & medical model). Also mentioned CBT, RODBT, Internal family systems theory during interview	Every day

2.2.4 Interviews

Each interview lasted approximately an hour. Interviews were conducted via Zoom and each interview was digitally recorded. Video calls were chosen for the interviews because of the advantages of the visual platform for building rapport with participants, more readily identifying social and emotional cues to reduce the risk of misinterpretation, and for greater richness of data (Bowden & Galindo-Gonzalez, 2015). They also limited the cost and time associated with accessing participants across Australia, a large geographical area and

allowed greater freedom for participants to engage in the interview in a location in which they were familiar and felt comfortable, which could contribute to the quality of the data. Fortuitously, it also minimised any disruptions in the data collection process stemming from Covid-19 pandemic related travel and activity restrictions. The increased use of video calls in Australia during the pandemic also meant that at the time of the second study, there was greater familiarity with Zoom and other video call applications within the general population.

Data was collected using *semi-structured interviews*, a commonly employed method in phenomenological work (Eatough & Smith, 2011; Leavy, 2017), which can produce rich, detailed descriptions of the participants' experiences of the phenomenon being studied (Moustakas, 1994). The collaborative nature of semi-structured interviews is consistent with the epistemological foundations of phenomenology (Brocki & Wearden, 2006). The conversational style of semi-structured interviews provides a method with which people are somewhat familiar (albeit generally in a less formal setting) and therefore feel more comfortable engaging in, relative to highly structured interviews (Leavy, 2017). This means that participants are more able to tell their own stories using their own words (everyday language), as recommended by Smith et al. (2009) for IPA studies.

The interviews focussed on two primary questions, which were occasionally modified as appropriate for the situation to ensure the flow of the interview was not compromised. Those two questions were:

1. Please tell me about some of your experiences of dreams being brought up in therapy?
2. What do you think the role of dreams is in Australian psychology?

For client participants, the second question was generally given in both the form above and also in the following form: what role do you think dreams have in therapy?

Brocki and Wearden (2006) note the importance of disclosing the role or approach of the interviewer and describe several possibilities. In this research project, the interviewer engaged in active listening, prompting and encouraged the participants to disclose further details on relevant points or topics.

Notes made before, during, and immediately after interviews included observation notes, content notes which were used as prompts for the interviewer during the interview process and reflective notes which informed the data analysis and reflexivity processes.

2.2.5 Ethical considerations

Following is a discussion of some of the steps taken to minimise negative impacts of this research on the people participating in it and to show respect for the trust and generosity they have gifted the researcher and readers in providing their rich and unique accounts.

Beyond the Human Research Ethics Committee approval (see Appendix A), in IPA research it is expected that informed consent will be for both the data collection and the research outputs and a two-step process of written consent and further clarification to gain oral consent at the interview stage is recommended (Smith et al., 2009). The current study adopted these recommendations and provided written information and consent forms (see Appendices C, D, and E) and then gained oral consent from the participants at the start of each interview, after recapping the major points covered in the information and consent form, and going through the screener questions the participants had completed by email (Appendix F) again verbally.

At the end of each interview, participants were also asked if they had anything else they wished to add to their interview, or if they had any questions or comments about the research. They were explicitly asked again at the end of each interview if they consented to being contacted should any clarifications for the transcription process by required. All participants gave their consent. Post-interview contact was made with several participants

for this purpose and within several days of her interview, one participant also emailed additional comments she wished to add to her interview transcript.

The video interview recordings and their transcriptions were stored in secure, digital storage available to project researchers through Central Queensland University. Data will be stored and later destroyed in accordance with ethical guidelines. This is outlined in the Research Data Management Plan that was developed for this project to comply with Central Queensland University research policies and procedures that address relevant ethical guidelines for research (see Appendix G). Several participants asked for further confirmation about who would see their interview recordings. They were reminded that all transcription would be done by the interviewer and that any identifying names or details would be removed during the transcription process. This included any use of people's names, institution or place names or any other details that could easily be used to identify a participant, their family, friends, psychologists or clients. This enabled the participants to talk more freely without having to censor their thoughts to ensure they were not identifying themselves or anyone else. Participants were also told that their interview transcript would be assigned a number to ensure that no part of their name would be used in the research outputs nor any pseudonym that may accidentally connect their interview to them. They were also reminded of the data management plan relating to the storage and destruction of the interview recordings (outlined in the provided information sheet) and that only the interviewer and her supervisors would see or access them.

Anonymity reduced the risk associated with participants sharing any personal or sensitive content. Participants were also required to respond to the brief screener questions (see Appendix F), intended to identify any potential participants who may experience distress (psychological or emotional risk) in talking about their experiences. No participants identified this as a concern. The participants' right to pause the interview, to choose not to answer profile data questions, or to withdraw at any time during the interview were emphasised. Several participants did choose to take brief breaks during their interviews

to have a drink or something to eat. Several participants were informed that the interview process was being paused to check in with them when they described or expressed stronger levels of emotion. They were offered the observation that what they were discussing could bring up strong emotions for some people, they were asked how they felt they were coping with the interview and reminded that they were allowed to take a break or stop the interview if they wanted to at any point. All participants chose to finish their interviews.

The interviewer checked in with those participants again at the end of their interviews, to ask how they were feeling after the interview, and how they felt that they were coping. They readily provided assurances that they were fine and that they had strong support networks and plans in place should they feel they needed any support after their interview. As a potentially more vulnerable population, given the interviews asked about therapy experiences, which may have therefore have raised topics or feelings about which they had at some stage felt that they needed psychological support, the client participants were also provided with contact details for a free phone counselling service on their information sheet and were reminded this resource was available, should they feel they needed it. All participants were also offered a gift card in recognition of the inconvenience associated with participating in the study, such as the time it required to be interviewed.

Being a qualitative research project, it was particularly important to ensure that the participants' voices were evident in any presentation of their collected lived experiences (Leavy, 2017) and that they have been represented in a respectful, ethical manner. A separate file containing the de-identified interview transcripts was provided to the thesis examiners as a further transparency measure. Plans for providing participant feedback following the data analysis and participant interest in reading any publications arising from the study also kept consideration for the potential impact of the interpretation and representation of participants and their contributions on them, at the front of the researcher's mind when reflecting on each iteration of the analysis and research outputs.

The position of suspicion or interpretation in IPA projects like this one may be seen to raise a number of ethical issues. These include whether interpretation of data implies that the researcher understands the meaning of an experience better than the participant, questions of ownership of the accounts, questions about how much the output reveals about the researcher and/or the participants and their experiences, and the need to consider the potential consequences of particular interpretations on participants and wider society (Willig, 2013). Different researchers address these concerns in different ways, varying from avoidance of interpretative approaches to asserting that a deeper understanding of the experience can justify the interpretation society (Willig, 2013).

Note: I experienced and questioned these ethical tensions throughout the research process. This was in spite of my decision to assume that when research is conducted according to ethical guidelines, insights from such analyses can better our understanding of the topics studied and benefit all stakeholders.

2.2.6 Assessing quality

There are a number of processes that can be employed, throughout the whole research process, to improve and evaluate the quality of IPA studies. Smith et al. (2009) promote the use of Yardley's principles for establishing the quality of an IPA. These principles include sensitivity to context, commitment and rigour (or how thorough a study is), transparency and coherence, and impact and importance.

Smith et al. (2009) explain that sensitivity to context can be in relation to the socio-cultural milieu in which the study takes place, awareness of the existing literature, methodological choices, purposeful sampling, sensitivity to interviews being interactional, and sensitivity to how participants make sense of their experiences. Sensitivity to context is a primary focus of this thesis, with references to various subtypes of it in every chapter. The use of triangulation strategies (discussed later in this section of the chapter) also serve as a way to address this principle.

In relation to rigour and commitment, consideration of the appropriateness of the sample (participants) for the research questions, commitment to conducting a good interview so good quality data can be collected (including developing rapport and other interviewing skills), and a thorough and systematic analysis that is adequately interpretative and provides sufficient extracts to support each theme (Smith et al., 2009). Transparency involves providing adequate detail about the study and research processes to enable readers to understand what has occurred and why and coherence involves presenting the study in a clear and logical way.

As a part of a quality assessment process, I completed my own informal, independent audit as a way to approach thinking about validity within the qualitative IPA research framework. Independent audits involve arranging files related to the research like reflective notes and initial research questions, the research proposal, interview recordings, transcripts, coding and theme analytic notes and draft write ups, in a way that enables a 'chain of evidence' to be followed from the initial project ideas through to the final output documentation (Smith et al., 2009). My approach to electronic backup assisted with this as each time I work on a file I saved it as a new copy with the current date included in the file name. This enabled me to trace the impact of things like new readings, reflective journalling, conversations, and new interview data on my thinking, analysis, and writing up, across time. Another way I checked the rigour of my claims was by following the process outlined in Smith et al. (2009) of identifying a coherent sequence of arguments flowing from the raw data to the final research outputs. As mentioned in the previous section on data analysis, other steps I took to address the trustworthiness and rigour of my claims were the examination of each iteration of analysis against my reflection notes and the raw transcript data, and continued commitment to researcher reflexivity processes.

While a direct, realist phenomenological approach would focus on the surface level descriptions of a transcript and could therefore benefit from member checking, the

interpretive nature of the data analysis process in IPA approaches reflects an understanding that the transcripts are surface level manifestations of underlying structures that may not fall within the awareness of the participants (Willig, 2013). Therefore, participants were asked if they were willing to be contacted to clarify anything about the interview contents, such as checking the accuracy of transcripts if a word or section was unclear, but member checking was not used for the analysis. Instead, other forms of credibility checking were used, such as the triangulation methods described below.

Triangulation strategies are often used as a means to improve the trustworthiness of qualitative research data (Leavy, 2017). Triangulation can occur through the use of multiple types of research methods, the use of multiple sources of data, the use of multiple theoretical lenses to interpret the data or by comparing research findings with those of other researchers (Leavy, 2017). To help improve its trustworthiness, this research project made use of triangulation of findings, particularly in the findings, presented in Chapters 4 and 5, where participant comments were connected back to the existing research literature. Multiple theoretical lenses have also been used and explicitly referred to throughout this thesis for triangulation purposes.

The outcome of hermeneutic phenomenological research is a written document that illuminates the meaning of the human phenomenon being studied and increases our understanding of the experience and the meanings assigned to it by the participants (van Manen, 1990). The research is presented as a part of the researcher's doctoral thesis. Relevant information and sufficient detail were curated and structured within the thesis to ensure the reader could trace the research process from start to finish, for the purposes of transparency and coherence.

The final one of Yardley's principles of research quality considers how useful, impactful, interesting, or important a study is (Smith et al., 2009). Participants were provided with written feedback about the studies, with several expressing interest in being informed of

any further outputs and noting that they felt that more information about the topic would be valuable for psychologists and clients. A number of papers related to this research project have been submitted for publication in peer-reviewed journals to add to the literature base on this topic. Feedback from my supervision team and researchers involved in the formal peer review processes associated with the publication of some of my thesis chapters in academic journals, observational, prompting and reflective note taking also contributed to the quality of this research.

2.2.7 Data analysis

Data analysis was completed separately for each study. This decision was made to maintain the homogeneity of each data set, which enabled each group's accounts to be better captured and understood without risking the loss of potentially valuable insights that may be overlooked due to not being present in the other group.

2.2.7.1 Transcription and initial immersion

Each transcript was read and checked multiple times by the researcher providing an opportunity for *initial immersion* in the data. Initial immersion assists with the development of initial ideas about the data and is helpful in the process of data prioritisation and reduction (Leavy, 2017). The interview recordings were watched multiple times for transcription, to check the accuracy of the transcriptions, and to include any relevant nonverbal communications that could affect the interpretation of the content, such as emotional responses like <<laughs>>, long pauses indicated by …, or nonverbal gestures like <<rolled eyes>>. As IPA uses content analysis rather than a conversation analysis for example, no further details like the exact duration of pauses, were included in the transcript.

2.2.7.2 Coding and Dedoose

The final interview transcripts and profile data were entered into Dedoose, qualitative data analysis software (http://www.dedoose.com) for coding. Being electronic, Dedoose enabled efficient code modification, useful for the iterative coding process used in IPA studies. Dedoose also allowed for immediate access to all excerpts associated with a particular code being examined at any given time and to basic quantitative data about the codes and transcripts. For example, Dedoose can immediately display data like the frequency of applying a particular code within a particular transcript or code applications in relation to profile data, which can contribute to reflections on potential patterns and emergent themes in the data. Dedoose was also used later to quickly identify whether relevant codes associated with a particular superordinate theme had been applied to a sufficient number of transcripts to meet the criteria required for it to be a theme. Tables have been provided in Chapters 4 and 5 with summaries of the final themes from the analysis, the topics included in each theme, and which transcripts showed evidence of each theme.

2.2.7.3 Data analysis guidelines

The guidelines outlined by Smith et al. (2009) and Smith (2011) for quality IPA formed the basis for how this study was designed and conducted. This includes their opinion that guidelines are intended to be applied flexibly and creatively, rather than being seen as a rigid rulebook with approaches to analysis varying across IPA studies. Some common features of IPA analytic processes include a focus on meaning-making in a specific context, commitment to understanding the participant's perspective and the promotion of iterative, inductive cycles of analysis that progress from the particular to the shared and from the descriptive to the interpretative (Smith et al., 2009).

Finlay (2014) advises IPA researchers to remember that participants' accounts are in their natural attitude, so rather than accepting the explicit, pre-reflective description of a

participant's lived experience, researchers need to continue through deeper cycles of interpretative analysis to examine the data for implicit meaning rather than accepting it at face value. A three level approach to analysis can be useful for this, beginning with examining language at a descriptive, explicit level, followed by examining the transcript at a linguistic level, which considers how the participant used language, focussing on less explicit meanings, like allusions and metaphors, and finishing with deeper levels of interpretative or conceptual analysis (Smith et al., 2009). This deepest level of analysis also looks at how and why the participant has a particular understanding in the context of their lived world, making sense of the patterns of meaning in the transcript, including inferences indicated through facial expressions and body language, rather than just taking their spoken words at face value (Smith et al., 2009). Similarities, differences, and contradictions between various comments each participant makes within an interview, are noted. Analyses need to be holistic rather than solely focussing just on cognition in a reductionist manner or just on emotions as solely internal and private rather than recognising our inescapable intertwining with the world (Finlay, 2014).

2.2.7.4 Data analysis process

In keeping with the guidelines above, extensive memos and notes were made and updated throughout the iterative, analytic process to incorporate any new insights, ideas, and questions in light of later data and deeper levels of analysis. Each point was considered in relation to the whole of the data at an individual transcript level and at a whole group level. As a part of the analytic process, summaries of each transcript were made. These summaries included significant ideas, experiences, feelings, and quotes that seemed to capture the individual's voice, noting, as Smith et al. (2009) describe, not just how they talk about their experience, but also ways the participant and researcher understand and think about the issue. Attention was also paid to the level of rapport, intimacy of disclosures, the location of comments within the overall interview structure (e.g. earlier or

later in the interview), and the apparent level of reflection associated with various comments.

This information was useful in interpreting implied meanings and any apparent contradictions within an interview. For example, one participant identified that the comments she was starting to make about what constitutes valid material in therapy contradicted her earlier comments about whether dreams were relevant to therapy, making sense of it by explaining that it was the first time she had thought or talked about dreams. This suggests that the reflective process required to engage in the interview was influencing her understanding and sense-making during the interview. It is an example of co-creation between participant and researcher that occurs in IPA studies, and it demonstrates how the context of the study and the interpretative process could legitimately result in different outputs between two researchers studying the same topic or the same researcher studying the same topic at different times.

The coding tree in Dedoose was used to identify potential micro-themes or emergent themes, in a process Smith et al. (2009) describe as searching for patterns across cases. Over a number of iterations, these micro-themes were clustered together under potential superordinate theme headings, in a diagram which was used to identify the potential structure or connections between them (see Appendix H for example diagrams from various stages of the analysis process). To qualify as one of the final superordinate themes, it was decided that the theme had to be present in all of the transcripts (sixteen for the psychologist study and five for the client study). To qualify as a subtheme, it was decided that there had to be evidence of the subtheme in at least half of the transcripts (eight of the sixteen participants for the psychologist study and three out of the five participants for the client study).

The data relating to each potential superordinate theme were compared to the initial coded transcripts to ensure that each theme incorporated the majority of the available data and

were representative of the participants' reported experiences and sense-making. Finally, the potential superordinate themes were tested against the data to determine their value in what Smith (2011) describes as encapsulating patterns across the data as a whole (convergences) for each participant group in a way that also enables the individual differences in how these themes manifested (divergences) to make sense.

Regular supervision discussions throughout the analysis process helped identify potential researcher influences on the analysis process. The discussions also assisted with switching focus to balance the influence of individual transcripts versus whole group data sets, or the interview data versus contextualisation materials like wider reading, relevant professional experience, conversations, and reflection notes. The final superordinate theme names were also discussed in relation to what words or phrases best encapsulated their essence.

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Chapter 3. Part A

Chapter 3 contains literature reviews that also act as a vehicle for my reflexivity process. The location of this chapter after the methodology chapter came about as a result of my growing awareness that the discourses and methodologies available to me, as a result of my training, did not provide me with the frameworks, 'ways in', and tools I needed to explain my experiences of dreams in contemporary psychological practice. I needed to be able to transcend debates about what is considered *best practice* at any given time within psychology, and look beyond the discipline of psychology to adequately make sense of what was happening within psychology. Looking at best practice cements the thinking in the status quo (the current hegemonic discourse within psychology). Psychology is a recently emerged field within the past century or so and to assist in the process of self-awareness I needed to step out of the 'here and now' by examining something (ancient Greece) that definitely was not here and now. Stepping outside of the hegemonic discourse is difficult, so I needed to find frameworks I could use to examine the situation critically from outside as well as within, to better understand the dynamics at the intersections of the various fields involved in psychology. These include, but are not limited to, the fields of clients, clinical practice, and research. My approach of examining something from both within and from the outside is consistent with the equally valued insider and outsider (position of suspicion or interpretation) stance of IPA that I described in Chapter 2.

My initial examination of the dream literature took me into multiple disciplines, spanning multiple millennia. The extensive presence of dream studies and practices across time and place demonstrated the proportionately small space that psychology occupied within the field of dream studies and practices. The ancient examples of the cult of Asklepios and Hippocratic physicians also showed me the dynamic nature of professions as a social

structure. I discovered a very rich story about the way professions form, which readers can use to understand the later interpretation of the interview transcripts.

My initial reading also led to an intentional examination of the tools and frameworks developed and used by many of the other disciplines interested in dreams. Readers will be able to identify the influence of the 'history of science' and expertise studies, particularly work by Collins (2007), historical and archaeological dream research, professional identity concepts, Mauss (1970), Bourdieu (Bourdieu & Wacquant, 1992), cultural-historical activity theory (CHAT) (Leont'ev, 1978), and modern dream theorists, on this third chapter of the thesis, and on subsequent interpretations of the interview transcripts.

Part A examines the emergence of psychology as a field of practice, and using the example of dreams, potential risks to the field's continued success are identified. This is preceded by a telling of the history of two groups of claimants, the cult of Asklepios and the Hippocratic physicians, during the period from 500BCE to 200CE. This part provides an explanation of the social choices that were made by these two groups around the establishment and impactful development of their custodianship for interpreting the meaning of particular types of dreams in Western medicine. The concept of claiming expertise in dreams goes back even further, as can be seen in ancient Mesopotamian and ancient Egyptian dream beliefs and practices. Part A also introduces the ancient Greek religious concept of reciprocity seen in the idea that favours met favours (Hemingway, 2009), which leads into the first literature review (in Part B), examining Mauss's thinking around reciprocity and its implications for sharing dreams with therapists who are seen as modern Western medicine's dream experts. Transitioning from the broader time periods covered in Part A and the first paper in Part B, the second paper in Part B focusses more on the development of modern dream theories, and the historico-cultural factors that have contributed to the marginalisation of dreams in contemporary psychological practice. The chapter ends with a short post-script, which circles back to the reflexivity process discussed throughout Chapter 3.

Part A of the chapter relies of several key pieces of knowledge. The first is an understanding of the history of science, including that an overly simplistic reduction of science to a single method approach relying solely on the concept of falsifiability quickly became outdated, morphing into a small part of the much greater methodological diversity present in contemporary science. While randomised control trials (RCTs), an approach revered in past narrow positivist understandings of science, remain useful for a very specific group of scientific questions, such as some pharmacological clinical trials, the majority of contemporary science is interested in many other important and complex questions that require a deeper and broader range of methodologies to research them, and which cannot be answered via an RCT. Examples of such complex topics range from weather and climate systems, multi-species eco-systems, many human health issues, and human social systems.

The second piece of knowledge is around identifying sciences in this new era and in particular, how one might go about differentiating them from pseudoscience. Changing societal attitudes towards expertise and the rise of non-biomedical health offerings that have been embraced in contemporary Western society, bring with them the challenge of evaluating effective treatments and avoiding those that may not be helpful, or may even be harmful. To this end, the work by Lilienfeld, Lynn, and Lohr (2015) is referenced, who point to the importance of practising psychologists engaging in evidence-based practice so as to avoid harming clients. Their work identifies ten differences between science and pseudoscience. They understand that falsifiability is insufficient for use as a stand-alone tool for differentiating between these two. Instead, they point to characteristics of pseudoscience like the absence of self-correction, use of obscurantist language, absence of boundary conditions, the mantra of holism, and the absence of connectivity (Lilienfeld et al., 2015).

The argument presented in Part A of this chapter focusses particularly on the need for self-correction and the need for psychology to maintain connectivity with other scientific

disciplines. These require the field of psychology to let go of outdated and overly narrow notions of science and to embrace methodological diversity and an openness to addressing the real, relevant, and complex questions emerging out of contemporary society. The insights from ancient times that are presented in Part A of the chapter demonstrate the value of maintaining alignment with multiple relevant fields, such that psychology would do well to maintain its alignment not just with contemporary science, but also with the field of clients (their market). Both these alignments require psychologists to be aware of and to be able to competently respond to everchanging societal attitudes and interests, as well as changing scientific methodologies to ensure they remain scientific and useful in society.

For ease of reading and for transparency regarding publication status (the papers presented in Part B have both been published), each paper is presented in a self-contained format, including the reference list for that paper. Appendix J contains additional background information about the cult of Asklepios, which is discussed in Part A.

3.1 Summary of chapter introduction

This chapter shows the first step in my research process, when I sought new theoretical frameworks, explanatory models and methodologies, to understand my own experiences of the psychology profession's attitude towards dreams during my past career as a clinical psychologist. Beyond just providing historico-cultural context, this chapter provides conceptual context. This chapter can be read as the first round of data for the project, an essential step in IPA analysis, which forms the basis for the subsequent interpretation of the interview transcripts. Through it I came to see that the formations of psychology are not 'natural' but are driven by social arrangements. The suggestion that truth is not abstract and that it has a social dimension has implications for modern fields of medicine and allied health, especially for psychology and the role of dreams within psychology. I realised that one of the pressures is a need for professions to assert legitimacy within a society. While

psychology as a field has been seeking to maintain legitimacy within the current neoliberal and ‘third wave of science’ policy and social contexts, there is a risk that insufficient attention is paid to ensuring that the field maintains legitimacy in the eyes of clients. The implications of losing legitimacy in the eyes of clients include potentially compromising the continued success of the field of psychology as well as potential negative impacts on clients who may seek support from unregulated and potentially harmful alternatives.

Abstract

In ancient Greece, the Hippocratic physicians and the cult of Asklepios came to be seen as custodians of particular subtypes of dreams. More recently, psychologists have also come to be seen as experts in dreams by many in the general community. The aforementioned two groups of ancient Greek 'dream medicine' practitioners, recognised the cultural context in which they worked, and this contributed significantly to their success. Using concepts from Bourdieu's *Field Theory,* I identify some of the other factors that contributed to their success. The parallels between these ancient Greek medical practitioners and contemporary Western psychologists are useful for drawing out strategies and insights of value for understanding the successful and recent emergence of psychology, as a new field of practice. The second part of this paper examines these insights and strategies, through the lenses of history of science and expertise studies, to identify potential threats to the field of psychology's continued success, and pathways that may enable it to compete successfully in these times of change.

Keywords: Asklepios, Bourdieu, Dreams**,** Hippocrates**,** Psychotherapy

Abbreviations: CBT cognitive behaviour therapy, EBP evidence-based practice, GPs general practitioners (family doctor in Australia)

3.2 Field of dreams: the origins of Western dream and sleep medicine

The increasing interest in the origins of sleep medicine and the different ways that different cultures have used sleep can be seen in key reviews, such as Palagini's and Rosenlicht's (2011) examination of sleep, dreaming and mental health over the past several millennia. In their review, they identified several pivotal developments in the history of sleep medicine that began in the classical Greek world. Two of these are particularly worthy of further examination. The first being the growing popularity of the cult of Asklepios, and the second the emergence of secular Hippocratic medicine. These two claimants on the expert space

of medicine and dreams in medicine, had a significant and enduring impact well beyond their height during the period from 500BCE to 200CE. Secular Hippocratic physicians and the cult of Asklepios created and were able to maintain a space for the dream and sleep expert within Western medicine that has endured through to today.

This historical investigation of the emergence of Hippocratic medicine and the cult of Asklepios draws on concepts from the French sociologist Bourdieu's *field theory* of social practice (Bourdieu, 1977). Key among these is the idea of a 'field' itself. Bourdieu sees the social world as being made up of many semi-autonomous fields in which people (referred to as 'players' or 'agents') are effectively playing a different game from the people in the next field. This could be imagined as a set of sporting fields where a game of rugby is being played on one field, and a soccer game on the next. That is, the rules are different, what is valued is different, and the feel for how one 'plays the game' is different.

These social fields, however, do not emerge from nowhere. They have a history. They emerge from what has gone before, and they are influenced by what is around them. The fields of the cult of Asklepios and Hippocratic medicine were exactly like this. They did not emerge in isolation, but within a diverse and complex world in which polytheistic religious beliefs and practices, and diverse political, intellectual, social, and cultural beliefs and practices, proliferated. For example, at the time Hippocratic medicine developed as a new field religious medicine, such as the cult of Asklepios, already existed in ancient Greece. To establish themselves as new social fields, both the Hippocratic physicians and the cult of Asklepios needed to differentiate themselves from existing fields. They needed to establish new things of value, what Bourdieu would call *capital*, and new ways of playing the game, or *habitus* (Bourdieu & Wacquant, 1992). Habitus can be understood as a person just knowing what, how, and when, to do something. For example, habitus may be seen in a psychologist intuitively shifting between validating and challenging a client in response to where the client is at in a particular moment, rather than just enforcing adherence to a pre-determined script from a manual at a pre-determined pace.

Within a particular social field, everyone accepts the 'rules of the game', and within any game (or social field), particular forms of capital have value. According to Bourdieu, players' or agents' capacity to adapt to the field's rules, determines their success (power and position within the social field). Bourdieu rejected the notion that humans are governed solely by rational logic and money. He argued that social agents have a particular social position as a result of the specific rules of the field, their habitus, and *various forms* of capital (Rawolle & Lingard, 2008). This might be *social* (resources available through relationships, including networks and membership of a group or class), *cultural* (competencies, skills, and qualifications), *symbolic* (prestige, honour, and attention), or *economic* (financial) capital (Bourdieu & Wacquant, 1992).

Cultural capital allows agents to exercise cultural authority or *symbolic violence*. This can be seen in the example of a priest explaining to a patient seeking healing, that they are a priest of the cult of Asklepios, which both the patient and the priest accept as a signifier of a power differential between the two of them. Basically, the symbolic (non-physical) violence occurs when two conditions are met. Firstly, both the priest and the patient must unconsciously agree that there is a difference in power and status between them. Secondly, both the priest and the patient must accept the norms associated with the cult that prevent the patient from attaining more capital, status, and power, in that situation, while ensuring that the priest retains or increases their capital. Those who have a lot of capital tend to be the dominant players or agents in a social field and are therefore invested in maintaining the status quo. They are referred to as i*ncumbents.* On the other hand, *insurgents* are keen to change things, in order to gain advantage for themselves as they are not 'on top' under the existing rules.

The likelihood of change can be influenced by doxa. Doxa is tacit knowledge, including unconscious beliefs and assumptions that make agents, or players, believe that the status quo makes sense, is desirable, and is the natural order of things (Bourdieu, 1977; Bourdieu & Wacquant, 1992). It refers to all those things that it goes without saying or that remain

unquestioned, as they are accepted as the 'truth' or just assumed. Doxa gives incumbents legitimacy. An example of a 'taken for granted assumption' might be a culture's belief that priests have a particular position within religions, which is associated with particular practices, and a special connection with the god(s) of that religion. Therefore, while questions may arise about things like how a priest should perform a particular ritual in a particular religion or how many priests or levels of priesthood there should be, no one would ever question whether there should be a priest or a religion, thereby limiting challenges to the status quo considerably.

When looking at the histories of Hippocratic and Asklepieian medicine, what is noticeable is that they did not differentiate themselves from existing fields of medicine by rejecting what was already around them in the existing social milieu. Rather, the Hippocratic physicians, for example, identified and appropriated pieces of the existing cultural and social arrangements or what Bourdieu (1977) called *doxa*. They did so in ways that did not directly conflict with or threaten incumbents in the wider social field of religious medicine. A good example of this can be found in their appropriation of dreams as a part of medicine, a practice already established by the cult of Asklepios, and supported by the belief system or *doxa* of Greek society. They successfully balanced sensitivity to the doxa associated with ancient Greek religion, medicine, and recent intellectual movements, with insightful sensitivity to the individual medical and cultural needs of their patients.

3.3 Dreams in the ancient Greeks' world

Similar to today, there was diversity in the dream beliefs and practices of the ancient Greeks. Ancient Greek society generally divided dreams into divine dreams and several types of non-divine dreams, including medically significant dreams, non-prophetic dreams, and dreams that closely mirrored everyday waking life concerns and events (Askitopoulou, 2015). Most ancient Greeks believed in the existence of divine dreams, with Aristotle being one of the rare exceptions who generally argued the case for various rationalist and

biological theories of dreams (Hemingway, 2009). Shifting away from the divine/non-divine division, Dodds (c1951, 1973 printing) understood there to be nonsignificant dreams and three types of significant dreams in ancient Greece, namely symbolic, vision and oracle dreams. Gods gave the dreamer details about the future or what to do in oracle dreams, while vision dreams show the future. Symbolic dreams, on the other hand, required interpretation to be understood. This division of dreams into subtypes created a space for a dream expert to appropriate a particular subtype of dream, as can be seen in the *Hippocratic Corpus* where a trained physician is needed to correctly interpret medical dreams (Hippocrates, 2015). Previously, priest-healers in the cult of Asklepios had positioned themselves as intermediaries between incubants and the god Asklepios (Jackson, 1999), securing their claim of expertise or custodianship over a subtype of divine, medical dreams. Both of these groups of dream custodian healers were able to take advantage or the existing 'doxa' or cultural beliefs of the society in which they practiced.

In fact, given the significant role dreams played in so many spheres of ancient Greek life, it would have been difficult for the ancient Greek medical practitioners to ignore them (Laios et al., 2016). Both of the major approaches to ancient Greek medicine (religious and rational) made use of dreams (Laios et al., 2016) in a way that recognised the cultural context in which they were working. These forms of ancient Greek medicine did not require patients to reject either the commonly held belief in the existence of divine dreams, nor other common religious beliefs and practices.

Understanding the wider context of classical Greek thinking in relation to sleep and dreams helps make sense of the successful emergence of the Asklepieian and Hippocratic fields of sleep medicine. Ancient dream beliefs and practices reflected broader Greek culture (Hemingway, 2009). This included some degree of cross-cultural influence. The Greeks inherited the ancient Egyptians' views on the divine origin of some dreams (Palagini & Rosenlicht, 2011) as well as developing a number of their own ideas about dreams and

their relationship with health, illness and healing. There is also evidence of cross-cultural influence in sleep medicine in the other direction, with the influence of some Greek sleep medical practices evident in ancient Egypt, particularly during the Ptolemaic period (Lang, 2013).

Today, people in Western cultures generally refer to the experience of dreaming as *having* a dream. In contrast, the ancient Egyptians and Greeks traditionally held the view that dreams were objective, external events that were *seen* rather than *had* (Barbera, 2015; Giotis, 1997; Hulskamp, 2013). The ancient Egyptians used a combination of the symbols for *bed* (qed) to indicate sleep and an open eye (rswt/resut) meaning *to come awake* for the term *dream* (Asaad, 2015; Teeter, 2011; Tribl, 2011). Those symbols reflected their view that dreams were objective, external events, like a vision (Lang, 2013) rather than of internal origins such as thoughts and images, originating in the subconscious. This view of dreams is also evident in Homer's description of dreams as divine winged beings called Oneiroi who materialised at the head of the bed (Meier, 2012).

Both the ancient Egyptians and Greeks also saw some level of connection or similarities between sleep and death (Barbera, 2015; Flannery-Dailey, 2000). Firstly, there were the obvious similarities in appearance between the two states with bodies appearing to lay still during both sleep and death (Askitopoulou, 2015). Also, similar to their beliefs around what the experience of death was like, ancient Egyptian dreamers were seen to inhabit a different world or state of being (Asaad, 2015). In the Greek world, the land of dreams and people of dreams were located near Hades in Homer's *Odyssey* (Flannery-Dailey, 2000). Hades was the underground kingdom of the dead, ruled by the god Hades and his wife Persephone. Although the veracity of the claim has been questioned, there is some literary evidence that dreams were considered to be chthonic in origin, with them being depicted as emanating from the dead or from the Earth in Greek tragedies (Hemingway, 2009). The term chtonic refers to earth or soil, or more specifically from under or beneath the earth, which is where Hades and the underworld were located.

Euripides also referred to dreams as children of Gaia, the mother Earth (Hemingway, 2009). Gaia, and earth itself, were seen as sources of life, rather than as inanimate and lifeless dirt, the more common perception during post-enlightenment times. There were also connections between dreams, sleep and medicine, with the god of dreams, Oneiros, and the god of sleep, Hypnos, helping to reduce the suffering of mortals (Palagini & Rosenlicht, 2011). Thus, while there were a variety of beliefs about dreams, if viewed over a long period of time there is evidence of an overall trend. This trend saw a shift from dreams being seen as coming from beneath the earth, with potentially divine origins, to the divine sources including gods more commonly located in the sky, like Asklepios, who was placed amongst the stars after his death. Following this, more biological and rational explanations for dreams emerged. Irrespective of culture, there have always been theories about the origins and meanings of dreams, although these were not necessarily connected. That is to say, it is possible for a culture's or group's beliefs about where dreams come from, to change over time, while still retaining the belief that dreams are meaningful.

3.4 Cult of Asklepios

3.4.1 Asklepios

Ancient Greece is often seen as the foundation stone of Western medicine (Askitopoulou & Vgontzas, 2018; Fornaro et al., 2009; Kanellou, 2004; Miles, 2009). Evidence of this can be seen in the etymology of a great deal of contemporary medical terminology (Giotis, 1997; Karakis, 2019), and the continued role and relevance of the Hippocratic Oath (Askitopoulou & Vgontzas, 2018; Miles, 2009). The cult of Asklepios is a famous ancient Greek example of the origins of the relationship between spiritual factors and medicine in Western healing traditions. Asklepieia and incubation practices have continued in various forms through to today with accounts of contemporary incubation practices in some parts

of Greece and Italy providing evidence of the enduring influence of Asklepios's cult and belief in incubation healings (Oberhelman, 2013b; Tick, 2001, 2005).

The enduring impact of Asklepios on Western medicine can also be seen in the numerous modern medical organisations, such as the World Health Organisation (see https://www.who.int/about/licensing/emblem/en/) that still use the Rod of Asklepios in their emblems (Giotis, 1997). It is generally depicted as a staff with a single snake coiled around it. The snake or serpent was widely associated with medicine and renewal with the shedding of the old skin symbolic of the dualities of creation/destruction and life/death (Collins, 2013).

The snake was a particularly prominent feature of the cult of Asklepios. Non-venomous snakes were found at asklepieia (temples dedicated to the god Asklepios) and they often played a role in the healing rituals (Shephard, 2015). Asklepios was known to appear in healing dreams in human form, in the form of a snake or dog, or via an assistant such as one of his family members; and some believe that priests and attendants at some asklepieia were said to have dressed as Asklepios, snakes or dogs during some incubation rituals (Giotis, 1997). It was believed that seeing or being touched by Asklepios in his own form, or that of a young boy, a dog, or a snake could result in healing. There was a widespread belief in the ancient Greek world that touching statues of heroes would bring about miraculous healing and, in keeping with this belief, there were many statues of Asklepios at most asklepieia (Meier, 2012). Dogs were known as guides into the other world throughout the Indo-Germanic area (Meier, 2012) and given the connections between dreaming and death in the Greek world, the connections between Asklepios and dogs provided another relevant association between the cult and dreams. Rather than rejecting it, the cult of Asklepios made use of the existing doxa of Greek society in the form of existing medical, religious, and dream beliefs and practices, to successfully establish their new field and gain valuable capital.

This sensitivity to the existing context, or cultural milieu, in establishing a separate field can also be seen in the choice of Asklepios as the figurehead of the cult. Asklepios was known as the son of the mortal woman Koronis and the god Apollo. Beginning life as a mortal himself, Asklepios emerges as a great physician, and continues on to become a hero before finally becoming the god of medicine (Jayne, 1962). Apollo was the god of healing and diseases (and many other things) and his father was Zeus, the king of the gods. Their position in the ancient Greek pantheon assured Asklepios some level of legitimacy as a god of medicine. His legitimacy and expertise were further bolstered by one of the more common versions of his story, which described Asklepios being raised by the centaur Chiron, a famous healer who taught Asklepios the art of medicine (King, 2003).

3.4.2 Asklepieia and incubation

Asklepieia (sanctuaries connected with the cult of Asklepios) were used by people coming to worship, by visitors who came to use the facilities at some of the more extensive sanctuaries, and by many people seeking healing through incubation. Asklepieia are often portrayed as being akin to contemporary spa/health resorts. Cilliers and Retief (2013) suggest that this may be due to Vitruvius, a Roman architect from the first century BCE, recommending that healthy sites with natural water springs being chosen for setting up shrines to Asklepios and Plutarch echoing this advice a couple of centuries later. They argue though that the archaeological evidence shows that asklepieia were established in a range of locations, varying considerably in their degree of resemblance to contemporary health resort environments. Remains of asklepieia have been found at Kos, Athens, Corinth, Piraeus and Pergamon and other places. One of the earliest is thought to have been the asklepieion at Epidauros that had been established by the sixth century BCE (King, 2003). The hundreds of asklepieia subsequently built throughout the Greco-Roman world were an indication of how popular and how influential the cult became by the first few centuries of the Common Era (Barbera, 2015; Flannery-Dailey, 2000).

Enkoimesis was the Greek word used to described incubation, or sleeping in a temple (Askitopoulou et al., 2002). It involved intentional engagement in a ritual act and sleeping in a sacred place with the explicit objective of receiving a divine dream (Harrisson, 2014; von Ehrenheim, 2011). Incubation provided another domain in the ancient world of sleep and dream medicine in which a role for experts could be created.

Sensitivity to existing doxa or cultural beliefs is also evident in the development of incubation practices in the cult of Asklepios. Many agree that the location and the time period influenced the development and expression of particular incubation rituals (Cilliers & Retief, 2013; Hemingway, 2009). For example, historio-cultural influences on incubation rituals can be traced across the later development of incubation practices in Egypt during the Ptolemaic period (Lang, 2013), with Egyptian features that were not present in earlier Greek examples (von Ehrenheim, 2011). Even within Classical Greece there were local variations in incubation and healing rituals (von Ehrenheim, 2011). The flexibility this created in how the cult could adapt to new surroundings and be easily assimilated into local customs may well have contributed to its portability and widespread popularity, accounting for the widespread acceptance of the cult's expertise in sleep medicine, and its longevity. It has also been argued that particular cultural conditions within societies such as Classical Greece enabled, or even encouraged, incubation rituals to develop. These include features such as the widespread acceptance of the existence of divine dreams, the focalisation of deities within a particular topography like a temple and the history of hero healers, or more generally, a belief that gods can be consulted to solve problems or answer questions (Hemingway, 2009).

Finally, the concept of reciprocity in Greek religion was not only a cultural condition conducive to the development of incubation. It can also account for some of the practices associated with incubation (Hemingway, 2009). The Greeks understood that favours met favours. They therefore accepted that some form of payment and acknowledgement would follow healings through incubation to ensure continued good relationships with the gods.

The dedications found in asklepieia reflected patterns of mutual exchange and assurance of a good relationship and the hope of receiving favours at the time of incubation and in the future (Hemingway, 2009).

3.4.3 The role of the Asklepios expert

Just like the preparatory, incubation, and thanksgiving practices, the role of the Asklepios expert varied from place to place and over time. Evidence suggests that earlier healings, such as those listed in the inscriptions at Epidauros, were more commonly attributed to direct healings during sleep when dreamers met Asklepios or his representative in a dream, or possibly also included an occasional quick surgical procedure (Csepregi, 2007). In such examples, dreams were used not just as diagnostic tools as the Hippocratic physicians used them, but also as the means of treating the incubant (Petridou, 2016). The dream acted as the medicine or cure itself. Direct healing meant no expert in dreams, religion, or medicine was needed as an intermediary during the healing. However, priest-healers still ensured a role for themselves as intermediaries between the incubant and the god, especially as guides for ritual practices (Jackson, 1999). The expert (priests) still had a critical role in providing the place for healing (the asklepieion), the atmosphere, and the rituals that were necessary for healing.

Later, during the Roman period, it was more common for the incubant to receive instructions for a remedy in a dream that they were to follow to be healed (Barbera, 2015; Tick, 2005). The change to incubants receiving instructions for healing in dreams opened up a role for temple experts to assist with the interpretation of these instructions at some asklepieia. They may have begun to offer some opinions on treatments as well as continuing their earlier role as ritual guides, and administrative, financial, organisational and logistical managers (Lang, 2013). Finally, it is thought that in some asklepieia, there were some medical experts who may have performed interventions or treatments whether directly as part of the asklepieion, or as invited experts.

Whatever the mechanics of cures at asklepieia during a particular era, the evidence we have provides insights into the ancient Greeks' beliefs and attitudes towards life, death, health, illness, and medicine, and what they believed was possible, likely, and credible (Blaśkiewicz, 2014). At every stage of the incubation ritual, the authority and the perception of the priests' power as divine, was of paramount importance to the success of the process and the cult (Hamilton, 1906). This association with divinity gave the priests legitimacy and the perception that they had the power and authority to ensure the success of the ritual and the ongoing success of the cult. The priests' role in incubation began with preparing the incubants' minds for receiving a dream, it could include claiming to have received a dream on behalf of the incubant, and their role continued through to the process of ensuring that incubants left with an appropriate remedy from their dream, or the proxies' dreams, if they had not been spontaneously healed (Hamilton, 1906).

Over time, the experts shifted what had been a more spontaneous experience towards a more curated experience. Their control over incubants' environment and ritual practices led to more systematised and commercialised processes that ensured their privileged place as sleep medicine experts. The adaptations of incubation practices show the 'habitus' of the cult of Asklepios. The cult successfully found new ways of playing the game in order to establish and maintain legitimacy and capital amidst the changing doxa of the wider society in which its dream medicine was practised.

Through the use of expert content knowledge(s) and epistemologies, be it surgical, pharmacological, or related to cultural knowledge, these experts were able to shape their practices and ensure their place as dream, sleep, medical and religious experts in their society. The cult of Asklepios also used publicly displayed records and thanksgiving offerings from earlier successes to promote their expertise, which served an additional didactic function (Blaśkiewicz, 2014), along with creating an environment most conducive to healing (Flannery-Dailey, 2000). These examples show that the medical experts of the time carefully managed the meaning making of the experience, helped to induce particular

experiences, and most importantly they managed the cultural designations of meaning that people gave to those experiences.

3.5 The emergence and success of Hippocratic physicians

Hippocratic physicians, often touted as the founders of modern Western biomedicine (Askitopoulou & Vgontzas, 2018; Kanellou, 2004; Miles, 2009), successfully dealt with early societal expectations of their expertise, and then retained legitimacy across culturally diverse times and locations. This section of the paper undertakes a historical investigation of the emergence of Hippocratic medicine and their claim over a subtype of non-divine, medical dreams.

Hippocratic medicine attributed disease to imbalances in the body's humours, consisting of phlegm, blood, yellow bile, and black bile (Campbell, 2007), and the humours, were believed to affect dream content (Askitopoulou, 2015). Dreams that reproduced the previous day's events signalled good health while disease resulted in dreams about other things (Askitopoulou, 2015; Hulskamp, 2013). The physicians' observation skills and description of people's common experiences of dreams, like those reflecting everyday waking life, would have been likely to resonate with their patients' lived experience and therefore would have served to establish their expertise in dreams. This demonstrated their sensitivity to the field of ancient Greek patients, which can be understood as the relationship system between the physicians and their patients. The physicians acknowledged that both divine and non-divine dreams existed (see Hippocrates, 2015) and they claimed expertise and authority over a subtype of non-divine dream, the medical dream. This avoided direct conflict and competition with existing powerful religious medical fields, such as the cult of Asklepios who had laid claim to a subtype of divine dreams. The basis for the Hippocratic physicians' authority lay in the idea expressed in the Hippocratic Corpus, that medical dreams were symbolic and required a trained physician to correctly interpret them (Hippocrates, 2015). The appropriation of specific types of dreams shows

habitus as well as the agents' use of capital and existing doxa to compete for more capital within their emerging and changing semi-autonomous social field. It also provides an example of the field balancing their alignment with both the powerful fields of their time, such as religious medicine, and the field of patients with their need for culturally relevant practices that engaged with their lived experience.

To establish legitimacy, the Hippocratic physicians sought to align themselves with key aspects of the cult of Asklepios, a powerful social field of religious medicine that had well-established authority in relation to a subtype of medical dreams. They leveraged symbolic capital within the existing religious belief systems, rather than rejecting the existing doxa, which may well have resulted in conflict with incumbents in a very powerful field that the Hippocratic physicians would have been unlikely to win. For example, the Hippocratic Oath began by swearing by Apollo Physician, Asklepios, Hygieia, Panacea, and all the gods and goddesses (Askitopoulou, 2015; Hajar, 2017). Association with Asklepios also assisted some powerful individual Hippocratic physicians to gain legitimacy and capital within the field of medicine.

Two of the most well-known Hippocratic physicians were Hippocrates, often considered to be the father of Western medicine, and Galen (Shephard, 2015). Hippocrates came from a family believed to have descended from Asklepios (Jouanna, 2012). As a member of the Asklepiadae of Cos family, people knew that Hippocrates had inherited the healing traditions that were passed down through his family (Brockmann, 2016). Claiming membership of this family, descendants of the hero god Asklepios, gave Hippocrates symbolic, cultural and social capital with access to family connections, medical knowledge, and status, that enabled him to successfully pursue his career as a physician in a society that accepted his legitimacy. The cult of Asklepios was also an important place of religious medicine and worship in Pergamon where Galen was born (Brockmann, 2016). Galen was known to be a follower of Asklepios, often using dreams in his private life and at times in his medical work (Oberhelman, 2013a). His career path as a physician resulted from his

father's dream that Galen should study medicine (French, 2003; Harris, 1916; Hulskamp, 2013). His father's dream gave Galen's career choice support from his family and wider society with the power and symbolic capital associated with divine approval.

As seen above, the Hippocratic physicians drew on social and symbolic capital such as Hippocrates' familial connections with Asklepios, divine approval of Galen's career path, and the acknowledgement of Asklepios and other Greek gods in the Hippocratic Oath. This, however, was insufficient to overcome the reputational issues for doctors in ancient Greece. Greek doctors in the early Classical period were part of a non-regulated group of hands-on craftsmen with the same low level of social status as common labourers (Chang, 2008). It has been argued that the widespread mistrust of doctors at the time was justified (Harris, 2016). There was no regulation or consistency in training (if any) they received, the approaches or techniques they employed, or in patient outcomes. This meant that a doctor could be anyone from physicians who received formal training at a medical school and apprenticeships with other physicians like Hippocrates, through to any charlatan, drug-seller, or other quack claiming medical expertise (Phillips, 1953).

The Hippocratic physicians' alignment with another powerful field in classical Greece also assisted them to gain legitimacy as well as symbolic and economic capital. In this case, the development and promotion of rational medicine harnessed the intellectual movements of the Classical period elite, such as the natural philosophers and sophists. This alignment demonstrated the Hippocratic physicians' ambitions to be accepted into elite social circles and attain financial security through their deliberate focus on the interests and ways of the elite (Chang, 2008).

The Hippocratic physicians' target market is evident in aspects of the Regimen that were only achievable if a patient was wealthy enough, such as having sufficient leisure time to engage in the exercise and sleep prescriptions, and enough money to afford the prescribed diet (Chang, 2008). A focus on reputation and adherence to methods

comparable to the elite intellectual movements, demonstrated the considerable cultural capital of Hippocratic medicine. It would have been likely to result in better profits (economic capital) for the field too. A good reputation also helped physicians compete against each other in attracting patients and students, both of which led to greater wealth (French, 2003). Physicians' ambitions of upward social mobility and wealth were also possible because of the increasing social mobility during this period (Chang, 2008).

Reputation was key for the relationship system between the physicians and their patients. The success of Hippocratic physicians was dependent on maintaining a positive public image and an adequate level of accuracy. They were encouraged to look healthy and take care in the way they presented themselves and behaved, including adhering to advice on leaving discussions about payments to a time after treatment (Phillips, 1953). Accurate prognostic skills were also good for business (Askitopoulou & Vgontzas, 2018; Miles, 2009; Thumiger, 2016). It was challenging to differentiate between the different types of non-divine dreams and to make an accurate diagnosis and prognosis (Askitopoulou, 2015), but it was critical for the establishment and maintenance of the physicians' expertise to both correctly interpret dreams and to identify the appropriate remedy (Hulskamp, 2013). Indeed, the Hippocratic physicians' credibility and authority as healers was established and reinforced through their secret, prognostic skills (Jones-Lewis, 2016; Lang, 2013; Miles, 2009). Their assertion that their special skills and knowledge (cultural capital) was necessary to interpret the subtype of dream they had cordoned off for their new field, ensured that the Hippocratic physicians could retain their power and authority.

The physicians' successful model made use of their prognostic skills, the intellectual styling of their approach, and their emphasis on working respectfully and competently with their patients. Galen noted that Hippocratic physicians did not have the authority of a god to demand that patients adhere to their treatment regimes, so to encourage adherence to prescribed remedies they had to prove their trustworthiness to patients (Brockmann, 2016). Over time, Hippocratic physicians continued to develop their methods and

accumulated further medical knowledge and capital. Their sensitivity to the doxa of their time and place and their ability to balance their alignments with multiple powerful intellectual and religious fields as well as the field of their patients saw the Hippocratic school of medicine emerge as a strong new field in the ancient Greek world.

These factors that enabled success for the Hippocratic physicians in Greece also enabled them to succeed in Rome several centuries later, where doctors continued to be held in low esteem. Rome was a place where the connections and approaches, that the newly arrived physicians could have relied upon for capital in Greece, did not carry the same value. Hippocratic medicine's successful move to Rome demonstrates the power of adaptation and sensitivity to context.

3.6 Breaking into Rome

Upon arrival in Rome, Galen was met with a very different culture. Rather than cultural and symbolic capital, any association with the Greek intellectual movement brought scorn and strongly negative attitudes towards sciences and physicians who were adept at prognosis (Boudon-Millot, 2014). The successful emergence of Greek medicine (both religious and secular) in Rome occurred only after some changes were made to better fit with the needs and preferences of Roman society (Hanson, 2006). To be successful competitors the Hippocratic insurgents had to change their practices, learning to play this different game. It was not a smooth path. Galen experienced particular hostility including accusations of witchcraft, death threats, and attempts to force him into exile in response to his superior prognoses (Boudon-Millot, 2014).

Demonstrating sensitivity to the different doxa of the society in which they now lived, the insurgent physicians adapted their practice to ensure alignment with their new field of patients. Galen was a great example of this, with Boudon-Millot (2014) ascribing his success to his adaptability and skills in developing different treatments for his Roman and Greek patients. This approach made use of Hippocratic physicians' existing cultural

capital, the Hippocratic tradition described by Boudon-Millot (2014), of taking an individual patient's characteristics into consideration including their age, gender, occupation and other environmental factors. Greek physicians, such as Galen, demonstrated considerable sensitivity to the local culture and customs (like the Roman familial power structures) in their practice (Hanson, 2006). Galen's selective use of flattery, his balance between the customisation of treatments and effective interventions, and his connection with some local allies enabled him to successfully interact with and gain acceptance from the wealthy Romans, many of whom considered themselves to be quite knowledgeable about medicine and had initially mocked and rejected his opinions (Boudon-Millot, 2014).

Hippocratic physicians also showed sensitivity to the wider society in which they existed in their choice to address Rome's needs in a way that the incumbent Roman doctors could not. The Romans had ambitions to grow their empire and this required expert surgeons to treat battlefield wounds. The immigrant Hippocratic physicians with their battlefield surgical expertise were able to influence Romans' view of doctors resulting in the field of Hippocratic medicine achieving status, power and respect (Shephard, 2015). For example, Galen successfully reduced gladiator fatalities while employed as their team physician (Shephard, 2015). Galen and other Greek physicians were able to successfully compete as insurgents in the Roman field of medicine because they were able to meet a need that the Roman physicians could not meet, demonstrating their superiority to the Roman physicians in their ability to engage in the game and acquire capital. This also required considerable cultural competence.

The longstanding success of Hippocratic physicians was possible because they carefully balanced their alignment with existing powerful religious and intellectual fields and their focus on building and maintaining trust, reputation and acquiring various forms of capital of value in their relationship with their patients. Operating within the boundaries of their expertise, they adapted their practices to effectively work with the individual and cultural beliefs of their patients as successful clinicians rather than mere technicians.

3.7 Summary of the successes of ancient Greek dream medicine

The cult of Asklepios and Hippocratic physicians created roles for themselves as medical experts in sleep and dreaming in ancient Greece. Both these groups cordoned off specific subtypes of dreams and aspects of sleep, which they then claimed fell within their areas of expertise. They began by working within the existing cultural context of ancient Greek religious beliefs and practices rather than conflicting with or rejecting them. They worked hard to influence perceptions of their expertise and to use their knowledge of sleep and dreams to develop practices that were most likely to produce the results they desired. For example, the Hippocratic physicians demonstrated the importance of balancing alignments with existing powerful fields, like religious medicine and classical Greek intellectual movements, with alignments with the field of patients. This required particular sensitivity to the doxa of the wider society in which they worked. To maintain their alignment with the field of patients they adapted their practice to individual patient characteristics and needs within the context of their time and place.

The ancient Greek healers lived and worked in a pre-enlightenment world without the rigid distinction between religion and science that exists in the modern Western world (Edelstein & Edelstein, 1998; King, 1999). Not only has it been argued that there was not open conflict or competition between the two social fields of religious and rational medicine, but it is also possible that they complemented each other (see Petridou, 2016). King (1998, 1999) goes as far as suggesting that the success of Hippocratic medicine helped the continued rise of the cult of Asklepios which, in a smart career move, may have appropriated the symbols and prestige of the Hippocratic physicians. Hence it appears that both of these medical social fields were able to make use of their association with each other and make use of capital associated with the other field. Eventually, a rational scientific approach to medicine replaced religious medicine as the dominant form of medicine in the Western world.

3.8 Interlude: Relevance for contemporary psychology

At different times, various cultures have allocated responsibility to certain professions for making sense of dreams (Delaney, 1998; Van de Castle, 1994). As Christianity moved into the Mediterranean world, incubation and other healing practices associated with the cult of Asklepios and other chthonic cults, were retained and Christianised, with many of the chthonic gods being refashioned into saints (Hamilton, 1906). Later there came a shift over time from religious medicine to modern bio-medicine, in which physical and spiritual healing became separated between the physicians and surgeons on one hand, and psychiatry on the other. Dreams came to be associated with Freud, Jung, and others, in modern psychoanalytic therapy settings (Freeman & White, 2002) and the *psychologising* of dreams (Nell, 2014) eventually saw psychology assume custodianship for particular types of dreams.

Dreams were instrumental in the early progress of what became rational, Western science. There are obvious parallels between these ancient Greek medical practitioners, the old custodians of medical dreams, and contemporary Western psychologists now seen by some in our society as custodians of particular types of dreams. Both are perceived to hold responsibility for, or at least be capable of, making sense of or interpret the meaning of particular types of dreams. I reflected on whether these parallels are sufficient to be useful in drawing out strategies and insights of value for understanding how psychology has competed successfully as an emerging field or for identifying risks to its future success in these times of change. I realised that just as the cult of Asklepios and Hippocratic physicians were human activities that occurred within dynamic (changing) systems, the activity of psychological practice also takes place within particular social, cultural, historical, political, and economic contexts. Consistent with the IPA emphasis on sensitivity to context, I considered whether it was true that for a social field like psychology to succeed, relevant beliefs, practices, and the context in which it occurs should be identified and engaged with. This points to a need to examine the dynamics at the intersections

between the fields of psychological research and academia, psychological practice, and clients.

The examples of ancient fields of Greek medicine and the theoretical framework of Bourdieu's Field Theory used in the first half of the paper provided me with an opportunity to step outside the field of psychology to develop insights about it from an outsider perspective. In the second half of the paper, below, I use these insights and the framework of 'history of science' and expertise studies to understand the implications of context in relation to the successful emergence of the field of psychology. I consider the risks that the field of contemporary psychology face in the current era of changing cultural landscapes, with a focus on the example of dreams.

3.9 The emergence of psychology and its alignment with the fields of science

Even when it is at odds with wider public perception, there is a tendency around the field of psychology to draw very definitive lines around what is *in* and what is *out* of the field's scope of work. Similar to the Hippocratic physicians and the cult of Asklepios, strategic alignments with existing powerful fields served psychology well during its early days. This began with the fields of biomedicine and the natural sciences and brought some legitimacy and capital, especially economic capital, due to modern policy fields valuing the sciences. In its attempts to be seen strictly as a *real science* though, psychology is now giving up parts of the expert space it once held.

Since its recent emergence and differentiation from psychiatry, just over a century ago, the field of psychology has grown to successfully compete for a stake in Western biomedicine within the domain of allied health. Evidence of this success can be seen in the example of sleep medicine, with the inclusion in clinical guidelines of psychological interventions such as cognitive and behavioural strategies as effective treatments for chronic insomnia in adults (Qaseem et al., 2016; Riemann et al., 2017; Schutte-Rodin et

al., 2008). This could be viewed as a significant achievement for a field that has long sought to be seen as a *real* science, with its fears of failure in this respect evident in papers such as Ferguson's (2015), which explicitly references the field's fear in the paper's title *Everyone knows psychology is not a real science*.

It is easier to understand the choices a field makes when the wider context is considered. An examination of the history of psychology can help explain the desire for an alignment with these particular scientific fields. As an emerging social field in the early twentieth century, psychology had to differentiate itself from existing social fields like psychiatry and compete for various forms of capital. The rise of behaviourism within psychology, which rejected internal, subjective experience (Hill, 1996), formed a critical part of the emerging field's identity separate to psychiatry and aligned it with the natural sciences. Although, it could be argued that there remains a degree of confusion in the public's views on the differences between psychiatry and psychology (Patel et al., 2018).

The history of science will be used as a lens to shed light on psychology's desire to be perceived as a science during the early twentieth century. Scholars of the history of science have identified three distinct waves of ways in which science is used in socio-technical decision-making. These three waves will be described throughout this half of the paper to support sense-making around the field of psychology's development, the risks it faces, and potential ways forward.

In brief, the focus during the first wave was on understanding, explaining and reinforcing the success of positivist sciences; and scientists and technologists were at the top of the accepted hierarchy of expertise (Collins & Evans, 2002). The scientific establishment's unhealthy monopoly on scientific and technological judgment led to some science spokespeople claiming to be custodians of universal truths analogous to claims made by religious and moral spokespeople (Collins, 2007).

Psychology wished to gain the advantages associated with this era of positivist, natural science fields (Pilgrim, 2010), which helped it compete successfully for cultural, symbolic and economic capital in an increasingly neoliberal world that valued the natural sciences. In many countries, like Australia, biomedicine became an essential field to government and the community, resulting in power, status and financial gain for the field, which was reinforced by the state through licensing and other regulation of the health fields (Kenny & Duckett, 2004). Legitimacy in many academic fields engaged in knowledge production, also became closely associated with financial success, even up to the present day. For example Davies (2019) described a trend in the early twenty-first century towards securing research grants, being the principal measure of excellence in academia.

Scholars in some of the other fields of knowledge production with which psychologists could align themselves, such as the social sciences and humanities, have often faced challenges and obstacles in gaining legitimacy and subsequent economic capital in medical research environments. While the field of biomedicine worked to secure its authority and acquire capital, it did not provide much space for social science- or humanities-based perspectives (Kalitzkus & Twohig, 2006).

Albert et al. (2015) explore this in their Canadian study that examined the existing doxa and epistemic habitus of the medical research environment. The set of tacit assumptions about the nature of science and how it should be done, and the legitimacy of evaluation standards and definitions of academic excellence both resulted in over half of the social science and humanities scholars in the study changing their research practices to secure some degree of legitimacy, despite the resulting dissonance experienced by many of them (Albert et al., 2015). This study built on earlier research examining biomedical scientists' perception of the social sciences in health research. That research had found limited receptiveness and reservations about qualitative methods, concluding that the growth of the social sciences in health research would continue to be met with obstacles in the near future (Albert et al., 2008).

There are a number of topics that are not, at particular times in history, deemed to fall within the boundaries of the natural sciences and biomedicine. For researchers interested in these topics, the need to pursue scientific legitimacy and protect their reputation with colleagues and position in scientific fields, is critical to institutional and economic survival in a world where success is so tightly connected with peer-reviewed grant and publication awards (Polich et al., 2010). Hence the field of knowledge production in psychology has sought to align itself with fields like the natural sciences and biomedicine to win legitimacy and capital, especially funding, in the field of policy, which is dominated by science.

Over time a narrowing definition of positivist science successfully gained power in psychology (Breen & Darlaston-Jones, 2010; Butler, 1998). Additionally, the field of psychology saw the development of a scientist-practitioner identity (Richards, 2001) and the promotion of a narrow interpretation of evidence-based practice (EBP) (Heatherington et al., 2012). Adherence to these trends assisted the field to maintain legitimacy and secure economic capital from the government and from an alignment with general practitioners. Australian doctors (general practitioners or GPs), act as gatekeepers in the publicly funded health care system (Sanderson et al., 2006). This makes an alignment with their field advantageous for Australian psychologists. Australian psychologists were able to secure significant economic capital through government funded programmes such as the Medicare Better Access programme (Littlefield, 2014), and receive the required client referral from a medical practitioner.

This has resulted in tensions between privileging the influence of the field of psychology on deciding appropriate topics and modes of therapy for clinical practice, and privileging governmental boundaries around funded and legitimate topics for therapy (eligible diagnoses), and approved evidence-based practice (EBP) therapy modalities. This may also be positioned as tensions between focussing on whatever is seen to fall within the boundaries of practice by psychologists and other factors such as ethical codes, in contrast to only focussing on what is paid for (Politis & Knowles, 2013).

Overall, this economic success for psychologists has reinforced the decision to remain loyal to a particular phase of scientific understanding, namely a reductionist, positivist approach to science. In reality, the field of science has continued to evolve, expanding to recognise more complex and ecological views. These views include ones such as Collin's position, that science is a social and cultural practice (Collins & Pinch, 1993), and the promotion of non-linear approaches to science, like Capra's (2015), that are capable of dealing with subjective phenomena and complex problems. This means psychology's almost fundamentalist adherence to an outdated understanding of science may leave the field in danger of losing a genuine alignment with the contemporary field of science and behaving like a pseudoscience, the very thing it wishes to distance itself from the most.

Lilienfeld et al. (2015) advocate the use of several characteristics to differentiate between science and pseudoscience including the need for self-correction, an emphasis on refutation rather than confirmation, and continued connectivity with other relevant fields. These suggest that psychology needs to continue to adapt and develop over time rather than grip fast to a single epistemology or modality (as seen in the privileging of CBT), or a decreasing number of topics. Such trends only reduce the capacity of the field to engage with any topics that may emerge as relevant in the future. The field needs to build capacity to balance its alignments with multiple, varied and dynamic fields, such as the natural sciences, social sciences, and humanities, within the field of knowledge production. The Hippocratic physicians demonstrated such multiple and varied alignments are possible over a long period. However, they do require flexibility and adaptability that comes from a sensitivity to changing doxa within broader society.

Researchers in the science of complex systems, like Greco (2004), argue that phenomena that do not fit within narrow requirements of a particular experimental method cannot just be dismissed as irrational and in turn be rejected as invalid topics of interest for researchers. The implications of this for the practice of various fields within medicine, such as psychosomatic medicine, could include a shift from asking when and how such fields

will become scientific, to whether claims of rationality and legitimacy can only be attained through references to science. This ties the need to recognise that science has evolved, to the need for psychologists to recognise the changing societal attitudes towards expertise. The public's perception of and attitude towards science and expertise, has changed considerably over the past century.

Psychology risks becoming another example of the trend that Collins (2007) describes as science losing legitimacy with certain parts of the community. A quick look again at the history of science studies reveals these changes in attitudes towards science and expertise reflected in the second wave of science studies. The earlier belief that science could solve all problems through logic and experiment began to fail and the later part of the twentieth century saw an increasing distrust in science in response to disasters stemming from failures of technologies, the politicisation of scientific debates, and risks of new agricultural practices (Collins, 2007). Psychology appears to desire a continued alignment with the earlier period of science. The loss of confidence in experts and expertise bolstered by the claim that ordinary people are wiser than experts in some technical areas, resulted in folk wisdom gaining a hold and an increasing acceptance of the fallibility of all judgements (Collins, 2007).

The second wave of science studies points to the potential risks of failing to acknowledge and respond to changes. Such risks arise from psychology holding fast to a narrow interpretation of scientific legitimacy and ignoring the changing public attitudes towards the credibility of science and credibility of folk wisdom. Folk wisdom is often associated with many of the complementary and alternative medicine fields, whose success could well be attributed, at least in part, to these changing attitudes around expertise. This is not to say that psychology should reject science and align itself with folk wisdom. Rather, psychology needs to respond to changing societal attitudes to ensure it retains credibility.

As a profession, psychologists are located at the intersection of researchers' knowledge production and clients' application of knowledge. While alignments with particular fields have been advantageous to psychology's knowledge production in the past, there is the risk that it has resulted in both the failure to recognise the evolving nature of those fields and the neglect of alignments with other important fields. This includes the field of the application of knowledge by psychology clients. In other words, attempts to adhere to a narrow interpretation of science has had both a positive impact on the acquisition of certain forms of capital and legitimacy, and a negative impact on psychology's capacity to adapt to changing doxa of broader society and the dynamic nature of the field of natural sciences. This compromises the field's capacity to maintain legitimacy and acquire further capital.

3.10 Risks to psychology's continued success

While psychology's rigid alignment with a specific era of the natural sciences made good sense within the logics, or what Bourdieu would call *doxa,* of the field itself, the field would be wise to remain mindful of the logics of the society it serves. Despite psychology's success in securing legitimacy and various forms of capital through its alignment with a particular phase of the natural sciences and the pursuit of an increasingly narrow interpretation of positivist science and EBP, the field's future remains at risk. Times have changed, and as the Hippocratic physicians did, the field of psychology needs to adapt or risk future success and questioning of its wider legitimacy as the key provider of expertise in mental health.

Often topics of a more subjective or spiritual nature are considered to fall on the boundaries of the field of psychiatry and psychology or outside them altogether. However, while some psychologists may be failing to engage with these topics, the reality is that their clients are continuing to see them as relevant. This can be seen in the example of clients initiating dream sharing with their therapists (Crook & Hill, 2003; Keller et al., 1995; Schredl et al., 2000). Consistent with this, clinical psychologists are anecdotally reporting

increasing numbers of clients seeking alternative treatments and rituals such as astrology, tarot cards, and support from psychics, which raises the question of what it is that clients are getting from these practitioners and practices that they are not getting from biomedicine and psychologists (Yar, Published Aug. 28, 2019; Updated Aug. 29, 2019). While psychologists do not need to agree with any and every trend in wider society (although the longstanding interest in dreams over time and place suggest this is not a topic that is merely a passing trend), they cannot afford to neglect their alignment with the field of clients. This requires a sensitivity to changing doxa and an awareness of the needs and interests of their clients. It points to a need for both improvements in psychologist capacity to engage with clients around topics of importance to them and the development of bodies of quality research on topics that are likely to be a focus of concern for clients, to ensure psychologists can provide informed and professional responses to clients.

Psychology's failure to adapt to the changes in the philosophy of science has drawn attention to some of the limitations of an outdated phase of science. Ferguson (2015) argues that psychology continues to emphasise a mechanistic, rigid and narrowly focussed explanation for human behaviour that does not correspond to lay people's lived experience, running the risk that people will seek psychological expertise from pop psychology and other unscientific outlets. An awareness that clients may well be seeking something in alternative treatments and rituals that they are not getting from mainstream psychological therapy presents psychology with an exciting opportunity to identify what this *something* may be and adapt their theories and models of practice to address this apparent need of their clients.

There appears to be a recurring theme that consumers believe complementary and alternative health fields provide a holistic approach in which physical health is seen as a part of a broader or more inclusive and subjective conception of wellbeing (Sointu, 2006). Over the past few decades, the consumer movement has introduced similar changes in definitions of health and wellbeing, as well as changes in expectations of the medical

profession. These changes can be seen in the decreasing rates of adherence to doctors' prescriptions and the rates of complementary and alternative health contacts increasing, coinciding with patients seeking more satisfying relationships with their doctors, more information, more autonomous decisions, and greater accountability on the part of doctors (Tousijn, 2002). Furthermore, some within the complementary and alternative medicine fields suggest that Western medicine takes a technical problem solving approach to medicine, limiting its capacity to deal effectively with deeper emotional, meaning-making and spiritual aspects of human experience, illness and suffering (Aakster, 1986). Improving capacity to deal effectively with these broader aspects of human experience, illness and suffering can assist in ensuring consumers access the most up-to-date and medically sound advice rather than avoiding the regulated medical and health professions and seeking support elsewhere.

While motivations for using these alternatives to contemporary Western biomedicine appear to vary considerably, various studies have found that they include spiritual seeking, meaning-making, and a response to the perceived failures of biomedicine to achieve the desired outcomes (Sointu, 2006). Studies of complementary and alternative health use also suggest that factors such as being listened to, additional time with practitioner, emotional support and lower power asymmetries between the patient and practitioner were important for female consumers (Keshet & Simchai, 2014). All of these motivations can be connected back to the broadening and more wholistic definitions of physical health to include subjective wellbeing. Western biomedicine may wish to consider researching the role these factors play in patient wellbeing, but more importantly, practitioners need to consider whether embracing these factors is crucial for patients to continue to engage with their field rather than rejecting biomedicine for alternatives, compromising the continued success of their field and their societal status as experts.

3.11 Working with clients who live in the wider society beyond psychology

Consumers' desire for a broader, subjective notion of wellbeing is an important factor for the field of psychology to keep in mind in its attempts to compete successfully for future capital. As the Hippocratic physicians' approach to reputation showed, client experience is important in ensuring the reputation and credibility of practitioners. Psychologists cannot just rely on acceptance by legislative and funding bodies such as governments, and academic and business organisations, they need to maintain their alignment with multiple fields, including the field of clients. This idea is given further credence through the argument that a trusting relationship between a health care provider and a patient can have a direct therapeutic effect and that such a trusting relationship has a foundation in specific expectations and personal behaviours both between (Gilson, 2003). Engagement with these types of factors could well be important in psychology maintaining a successful alignment with the field of clients so that clients continue to seek their expertise.

The rise in client engagement in alternative treatments and rituals has highlighted the possibility that there is a need for cultural sensitivity from therapists in relation to some of the more spiritual practices (Yar, Published Aug. 28, 2019; Updated Aug. 29, 2019). Rather than distancing themselves, there is a need for psychologists to identify appropriate responses to clients introducing topics around the boundaries of their practice just as they would in response to their choice to share any other personal and intimate, inner experience or cultural practice. Widely seen by society at large as central to the work of psychology, for instance, the idea of working with dreams is often derided by those within the field as *woo-woo* (see for example Hill's (1996) description of her colleagues' response to her research interest in dreams). This means that there is a real possibility that clients sharing their dreams in therapy may be perceived to be in the same category as clients reporting use of some of the aforementioned alternative and spiritual treatments and rituals.

Research on the tacit rules about how doctors view and relate to their patients is also relevant here. For example, medical practitioners acquire and perpetuate messages about patient worth that contribute to the reproduction of inequality in medicine, emotional distancing and judgement, interacting with social stereotypes and shaping practitioners' distinctions between good and bad patients (see Sointu, 2017). This also means that health interactions are navigated more easily by patients who share understandings with their health practitioners (Sointu, 2017). This has implications for psychologists. If psychologists are focussing on their alignment with the fields of biomedicine and the natural sciences and see distancing themselves from working with dreams as a part of this, it is very possible that this will be conveyed in their response to clients' shared dreams.

If psychologists fail to follow the example of the ancient Greek dream medicine practitioners, and maintain sensitivity to the doxa of the wider society in which they practice, they may risk becoming increasingly irrelevant. Such contextual sensitivity involves maintaining awareness of how the public and clients perceive psychology, current beliefs, and trending topics of interest that they are likely to bring to therapy. For example, many people in contemporary Western society believe that some dreams have psychological or personal meaning (Morewedge & Norton, 2009; Nell, 2014), and there is an expectation from clients that psychologists will be interested in their clients' intimate and inner experiences. Due to the psychologising of dreams (Nell, 2014), the broader community sees dreams as belonging within the field of psychology. This results in psychologists having symbolic capital in relation to dreams in the view of others, especially their clients expect them to be dream experts. However, a number of historico-cultural factors, including the scientific identity that psychology has attempted to develop for itself, have contributed to the marginalisation of dreams in contemporary Western psychological practice, despite the empirical support for their use in therapy (Leonard & Dawson, 2018).

Dreams have been marginalised in contemporary Western psychological practice to the degree that studies are finding that clinicians feel incompetent and unconfident to respond to their clients introducing dream material into therapy (for example Crook & Hill, 2003; Freeman & White, 2002; Keller et al., 1995; Pesant & Zadra, 2004; Schredl et al., 2000). This has significant implications for the incumbent psychologists. The marginalisation of dreams could well result in psychologists' legitimacy being questioned, not just in relation to dreams but in other areas of practice in which clients expect them to be competent, effectively reducing their ability to compete successfully in all areas of practice within their field. This shows a misalignment with the field of clients and an insensitivity to the doxa of wider society, which is unnecessary on the part of psychology given the growing body of empirical research and theoretical development around dreams (see for example, Eudell-Simmons & Hilsenroth, 2005; Hill & Knox, 2010; Schredl et al., 2000; Skrzypińska & Szmigielska, 2018).

Alignment with a narrow, outdated manifestation of science at the expense of a growing distance from the field of knowledge application, where psychology clients are located, may not be what best serves psychology in the current cultural milieu. In fact, it may risk the very scientific identity that psychology has attempted to secure during the emergence of its field, along with its perceived expertise in responding to people sharing intimate, inner experiences.

3.12 Potential ways forward

For a group of experts to be successful in a social field and to practice as experts, they require more than a particular knowledge set. In the case of psychology, failure to appreciate existing and changing doxa and failing to maintain a close alignment with the field of clients could potentially open psychology up to competition over all aspects of their core business, not just dreams.

This is not to say that psychology should reject any alignment with biomedicine and the natural sciences. Outright rejection of science and scientific expertise can be seen in the anti-vaccination movement and climate change denial that are threatening the advances of the enlightenment. To avoid the devastating consequences associated with outright rejection, a new approach to thinking about science that transcends the epistemological weaknesses of past eras of science is crucial to ensure the continued acceptance of psychologists as experts in their discipline. Clinical psychology is a complex professional practice with dimensions in addition to the implementation of therapy protocols. As such, it is imperative that psychology explores the wider dimensions of clinical practices such as rapport, trust, the therapeutic alliance, and meaning-making, that are present in the sharing of intimate human experiences such as dreaming, rather than reducing practice to a technical manual.

There are several options available to psychology in addressing the need for a balance between scientific and client credibility at the intersection between knowledge production and the application of knowledge. Understanding and addressing the changing perceptions of science-based health and allied health fields in contemporary Western society is crucial for psychologists to compete successfully in the changing cultural landscape. The third wave of science studies provides a viable alternative for psychology. It provides a way to balance the desire for an alignment with contemporary, evolving, science and policy fields and associated success in competing for capital in the form of funding within the current political climate, with the cultural and future symbolic capital related to psychologists' relationships with their clients. This balance requires psychologists to achieve legitimacy or acceptance of their expertise from multiple and sometimes quite varied groups.

In contrast to the second wave's replacement of the first wave, the start of the twenty first century saw the emergence of a third wave of science studies with a continuation of the second wave (Collins & Evans, 2002). The third wave of science studies focuses on who

should or should not be contributing to decision-making based on their expertise, importantly distinguishing between experience and expertise (Collins & Evans, 2002). Being clearer on what psychology's core business is, and doing it well, and in a way that is culturally relevant, is necessary. This helps to avoid reducing the field's boundaries in a way that limits core activities and prevents psychologists from being able to respond flexibly, adapt to broader cultural changes, or competently customise their response to individual client needs.

Therefore, the end of biomedical dominance or sovereignty does not have to spell nihilism and the end of rationality (Tousijn, 2002). Psychology could choose a way forward that enables psychologists to maintain the advantages of scientific credibility while not alienating the other aspects of therapy and human interactions and experiences they are seen as experts in. Aspects such as meaning making, and engagement with subjective, lived experiences of psychology clients. The narrow manifestation of EBP needs to be expanded to address limitations such as the exclusion of minority groups and culturally relevant outcomes, multiple ways of knowing, and the importance of cultural context (Kirmayer, 2012). This is not unachievable as models for a broader understanding of EBP already exist (see Hamill & Wiener, 2018), which would also align better with the core competencies that psychologists are expected to have, as can be seen in the example of Australian psychologist registration standards (Registration standard: General registration, 2016). There is still a public perception that psychologists are trustworthy, understanding, accessible, reassuring, capable of forming a therapeutic alliance, and easier to speak to about issues that are personal and possibly associated with stigma, than some other professions, such as general practitioners (Patel et al., 2018). This existing capital and legitimacy should not be squandered.

Contemporary psychologists have no need to appropriate a sub-type of dream as the ancient Greek medical fields did to establish perceived expertise. Clinical competence can be achieved by educating psychologists about the extensive body of existing dream

theories, empirical research, and models of practice (Eudell-Simmons & Hilsenroth, 2005; Hill & Knox, 2010; Schredl et al., 2000; Skrzypińska & Szmigielska, 2018). Furthermore, encouragement of continued research and theoretical development in this area could assist psychology to avoid the pitfalls of a pseudoscientific fundamentalism that disallows advancements and adaptation within a field of knowledge production. These areas of dream content knowledge, therapeutic skills, and reputational characteristics, make gaining cultural capital around responding to dreams in a culturally sensitive manner, very achievable. This can be seen in the case examples provided by Schubert and Punamäki (2016), in which they describe using a culturally sensitive integrative psychotherapy approach that respected the cultural meanings of dreams held by their clients, who had presented with post-traumatic stress disorder.

Broadening narrow positivist approaches to research, and challenging processes and groups that inhibit the inclusion of a broad range of theoretical orientations and topics, are essential for psychology's continued success. This is because increasing diversity within the field enables greater flexibility and relevance for psychology in the future (Breen & Darlaston-Jones, 2010; Heatherington et al., 2012; Levy & Anderson, 2013). Psychologists can choose to 'play the game' and adapt, which will reduce the risk of them becoming irrelevant and being rejected by clients, who are seeking something more.

The procurement of further capital would be possible if psychology embraced new and broader understandings of science and scientific research. Amid changing perceptions of science, truth and expertise, the third wave of science studies has been offered as a potential pathway for psychologists to continue to be recognised as experts. Embracing the ideas around expertise from the third wave of science studies and a broadening definition of both evidence-based practice could assist psychology to remain relevant and adaptable. Additionally, balancing the field's alignments with contemporary scientific, biomedical and policy fields associated with the production of knowledge, and the field of knowledge application associated with psychologists' clients, would easily accommodate

the inclusion of topics like dreams in the field, and strengthen psychologists' capacity to adapt flexibly, ethically, and competently to the changing doxa of broader society.

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Dreams as Gifts: A Maussian Perspective

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In The Gift, Mauss argues that people in many cultures have engaged in what appears to be a voluntary giving of gifts, but which in fact carries obligations at each point in the exchange—in the giving of, receiving of, and response to each gift. Moreover, these exchanges of gifts are an integral part of both building connections between individuals and groups and maintaining social hierarchies. Using the Mauss view of gifts as a framework for examining the social practice of sharing dreams, this article demonstrates the obligations present in the giving of, receiving of, and responding to dreams. It then identifies the implications of this understanding of dreams as gifts, for clients offering their dreams in psychotherapeutic settings.

Keywords: anthropology, dreams, the gift economy, therapeutic relationship

Mauss (1970) argued that although all gifts appear to be given freely, they actually come with an obligation to give, an obligation to receive, and an obligation to reciprocate. Although this is implicitly understood by each party involved, by its very nature it is also unverifiable. This is because any explicit reference to the exchange changes the nature of the exchange, stopping it from operating as a gift and changing it to another form of exchange. In this way, the very nature of the gift requires a certain level of trust between parties and implies a certain level of intimacy. This can account for the consequences associated with any rejection of a gift or failure to reciprocate.

We are obliged to give gifts because they help to develop and maintain relationships, and the social bonds this forms are the very foundation of human society (Mauss, 1970). The concepts of respect, reputation, honor, and credit are closely connected in many such exchanges, which is why gifts are such a powerful and effective method for developing and maintaining relationships. Mauss believed that the giving of a gift creates a hierarchy between the giver and receiver that is most clearly seen in the obligation to receive. The refusal to receive a gift is analogous to a public statement of fear of an inability to reciprocate and an associated potential loss of status (Mauss, 1970). By accepting a gift, you are putting yourself in debt to the giver. Rider (1998), in a game theoretic interpretation of *The*

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Gift, argued that the practice of the gift originated from attempts to avoid conflict and bring about cooperation. Once this form of exchange was established the other aspects of it such as social norms, customs, and reciprocity emerged through reinforcement. He argued that it is in the interest of each person involved to engage in the exchange of gifts.

In *The Gift*, Mauss (1970) demonstrated how not only physical possessions and wealth but also social practices such as courtesies, entertainments, ritual, dances, and feasts can be understood to be gifts. These gifts come with associated cultural obligations around giving, receiving, and responding to them (Mauss, 1970). The possibility that sharing dreams may be seen as a form of gift has been proposed before. Wagner-Pacifici and Bershady (1993) use Mauss's conceptualization of gifts to describe the sharing of dreams as "an intimate, if strategic, revelation with an expectation of a return in kind" (p. 139).

This idea of the dream as a gift is worth pursuing further to understand the dynamics of clients offering their dreams in psychotherapy. This article will begin by demonstrating that the obligations associated with the longstanding social practice of giving, receiving, and responding to dreams is analogous to the obligations Mauss described in relation to the exchange of other gifts. This will be shown to hold over a diverse range of cultural dream beliefs in which dreams may be seen as real, not real, having psychological meaning, or having no psychological meaning. Once the use of the framework of *The Gift* for understanding the sharing of dreams has been established, the implications this has for sharing dreams in psychotherapy will examined. In particular, consideration will be given to the therapeutic alliance, differing expectations between therapists and clients, and the consequences of failing to understand the sharing of dreams as a gift.

Demonstration of the Obligations Associated With Sharing Dreams

Culture has shaped humans' dream beliefs and practices for millennia (den Boer, 2012; Laughlin, 2011; Tedlock, 1987; Vann & Alperstein, 2000). There is an assumption implicit in many cultural dream beliefs that someone other than the dreamer is, or should be, involved in the dreaming process. This involvement may occur during the creation or experience of the dream. It may also occur during the dreamer's waking life when they take action in response to the dream, such as sharing the dream with someone. People may choose to share dreams with others in their waking lives because of cultural dream beliefs such as a belief that dreams are meaningful (Ijams & Miller, 2000). They may also share dreams due to a belief that there is someone who understands more about the dream than the dreamer (Hill, 1996). Additionally, waking life sociocultural practices around the disclosure of personal information within relationships influences the sharing of dreams (Ijams & Miller, 2000). Cultural obligations, conscious or tacit, may be inherent at any points of exchange. These points include when a dreamer receives a dream experience, when the dreamer shares a dream narrative with someone in waking life, when someone receives (listens to) someone's dream narrative, and when the listener responds to the dream narrative that has been shared.

The Gift of External-Origin Dreams

Within many cultures there is a belief that some dreams come from an external source or origin, such as a spiritual being or ancestor communicating with the dreamer. Such beliefs bring a host of obligations for the dreamer. To begin with, these external-origin dream beliefs assume that someone other than the dreamer is already involved in the dreaming process at the point of the dream experience itself. Within external-origin dream beliefs, the dream itself can be seen to be a gift to the dreamer. The dreamer therefore already has obligations around reciprocity just in having received the dream during sleep. For instance, throughout history many in China have held the belief that some dreams contain guidance from ancestors (Giskin, 2004). Such dreams bring obligations analogous to waking life experiences in terms of how the receiver of such guidance should receive and respond to it. Another example of this is that many 19th-century Zulu dreamers felt obliged to take particular actions to keep ancestors happy following dream communications from them (Laughlin, 2011).

Some dreamers in Africa believe that spiritual or ancestral agents use dreams to communicate messages not just for the dreamer but for other people too (Nwoye, 2017). This creates an imperative for the dreamer (in waking life) to pass the message on to the intended recipient (Nwoye, 2017). This example shows the emergence of a gift chain. Not only is the dream itself a gift to the dreamer, but the sharing of the dream is a gift to the person with whom the dreamer shares it. In fact, it becomes a bidirectional gift chain in which the dreamer, in sharing the external-origin dream, both *pays it forward* and *pays it back*. It can also become a means by which the transmission of cultural knowledge occurs. This is evident in Aboriginal Australia, one of the world's oldest continuing cultures, in the obligations to share certain external-origin dreams with someone else in waking life. Some dreams in some Aboriginal Australian cultures are believed to be revelations about ritual elements from ancestors or deceased people (Glaskin, 2011; Laughlin, 2011). The dreamer is obliged to disseminate the ritual elements received during a dream to the broader community. They in turn are obliged to receive them and respond appropriately to them, consistent with Mauss's (1970) description of the obligations inherent in waking life exchanges.

A final manifestation of the obligations associated with external-origin dreams can be seen in dreamers seeking guidance from dream experts to understand their dreams. For thousands of years, people have shared at least some of their dreams, often seeking guidance from their dreams and/or about their dreams (Boyd, 2005; Hill, 1996). Such cultural traditions can be seen as far back in human history as the ancient dream interpretation guides from Ancient Mesopotamia and Ancient Egypt (Boyd, 2005; Delaney, 1998; Palagini & Rosenlicht, 2011) and Ancient China (Giskin, 2004; Yu, 2016). One of the many dream guides from Ancient Egypt is a papyrus translated by Chester Beatty, which includes example dreams as well as dream practices for addressing the impact of bad dreams (Hughes, 2000). A widely known collection of writings from Ancient Egypt, referred to as the *Book of the Dead*, also contains prayers for dispelling bad dreams (Hughes, 2000). These guides are a manifestation of the expert's obligation to receive and respond to dreams people share with them and to assist the dreamer through translation, interpreta-

tion, or intervention (cure). This is consistent with the mutual obligations involved in the giving, receiving, and reciprocating of a gift as described by Mauss (1970).

The obligation to share dreams with a dream expert may relate to a belief that the dream expert is needed to discern the nature, origin, and accuracy of the dream message, or to translate or interpret the symbolic nature of the dream content that is beyond the ken of the lay dreamer (Hill, 1996; Hughes, 2000; Neil, 2016). For example, beliefs held by some in Christian and Islamic cultures that dreams have either divine or demonic origins (Mittermaier, 2007; Neil, 2016) compel the dreamer to discern whether the source of the dream is good or evil to understand and respond appropriately to it. This creates a space for the religious expert to be a dream expert, being the best qualified to correctly identify the true origin of the dream, translate, or interpret it, and determine how the dreamer should respond to it. Wagner-Pacifici and Bershady (1993) asserted that priests won jurisdiction in relation to dream expertise in Christianity, particularly around any need to respond to dreams of demonic origins. Thus, religious beliefs and religious hierarchies can and have created obligations on the part of the dreamer to share dreams and on the part of religious leaders to accept and respond appropriately to the dreams they are told.

The obligations associated with sharing external-origin dreams with experts can be understood through the gift chain that external-origin dreams create. In receiving the gift of a dream, the dreamer is obliged to try to understand it, discover its value or instruction, and respond appropriately to it. At the next stage of the gift chain, the expert in receiving the shared dream in waking life is obliged to provide the expertise to the dreamer so the dreamer is able respond appropriately to the dream. Many who hold external-origin dream beliefs might well consider obligations to share certain waking life information no different to obligations to share certain dream information. Thus, it is not a stretch to compare the obligations associated with waking life gifts that Mauss described with the obligations associated with sharing these dream events. However, it is not as immediately obvious that the same obligations would apply to sharing dreams for dreamers who hold internal-origin dream beliefs.

The Gift of Internal-Origin Dreams

Interestingly, in Hartmann's conceptualization of cultural and psychological dream beliefs, whether of internal or external origins, dreams are seen to fall into a category of *otherness*, which he labeled a *meteorite* view of dreams (Hartmann, 2010). He argued that both cultural beliefs about dreams as communications from ancestors or spiritual beings and modern psychological theories that claim dreams have internal origins like the unconscious, view dreams as foreign to us and categorically different to our ordinary mental functioning. This discussion of alterity is important because in some cultures dreamers do not distinguish dreams from waking life events in a dichotomous *real* versus *not real* manner as often occurs in contemporary Western culture (Laughlin, 2011).

It is beyond the scope of the current article to do justice to an exploration of the diversity of theories of mind and beliefs about consciousness. However, it is worthwhile examining whether the framework of *The Gift* is applicable to a range

of cultural dream beliefs. This means extending the framework beyond dreams that are deemed *real* events to examine the sharing of dreams as private, internal occurrences that are *not* real, as is the belief of many in contemporary Western culture (Meyer & Shore, 2001). Beyond seeing dreams as not being real though, Meyer and Shore (2001) included the idea in their study that dreams are psychological events. This enabled their view of dreams to be categorized as a psychologically meaningful, internal-origin dream belief. Hartmann (2010) would therefore most likely categorize this as a belief that deems dreams to be foreign to us.

Wagner-Pacifici and Bershady (1993) argued that Freud shifted the tradition of interpreting dreams as messages from external origins to interpreting dreams as messages received from the mostly unknown unconscious. Consistent with Freud's Jewish forebears and many other cultural traditions (Askitopoulou, 2015; Delaney, 1998; Neil, 2016) such as Cabalistic, Hellenistic Greek, Ancient Egyptian and some African, Christian, and Muslim traditions, Freud took the position that an expert was needed to interpret a dream. Jung extended some of Freud's ideas about the unconscious origin of many dreams, with an explicit focus on the extraindividual, cultural origins of dreams. He developed the concept of the collective unconscious, which is part of the unconscious that is common to all humans (Read, Fordham, & Adler, 2014). Related to this, Jung described archetypal dreams in which universal forms capable of producing similar mythical ideas are expressed in a way that is colored by the individual's personal unconscious (Read et al., 2014). Similar to Freud, Jung's view that dream content is symbolic makes it unsurprising that he assumed an expert is needed to assist the dreamer to understand and respond appropriately to it (Jung, 1974; Van de Castle, 1994).

The alterity view sees dreams as originating outside the individual's consciousness. With external-origin dream beliefs, this may be that dreams come from someone else, such as an ancestor or god. With psychologically meaningful, internal-origin dream beliefs, this may be that dreams come from something else, such as the unconscious or collective unconscious. These dreams require a dream expert, such as a psychoanalyst or religious leader, to translate or interpret them so as to glean any valuable information they may contain (Hartmann, 2010). The same gift chain associated with external-origin dreams can apply to psychologically meaningful, internal-origin dreams. Here, the dream experience is a gift from the unconscious or collective unconscious. The dreamer is obliged to share the dream with an expert, who in turn is obliged to translate or interpret the symbolic dream content so its value can be understood.

Other psychological dream theories do not see the mental activity in dreams as particularly *foreign*, in Hartmann's (2010) terms though, and an expert is not required to interpret symbolic dream content. For instance, Beck's cognitive theory of dreaming is interested in the cognitive distortions evident in the conscious dream narrative rather than the actual dream experience (Doweiko, 2002; Freeman & White, 2002). However, although clients are encouraged to identify and challenge their own unhelpful cognitions, the therapist (expert) is still needed to teach clients these skills (Beck, 2002). Thus, there remains an obligation on the part of the therapist to provide expertise for clients when they share dreams during therapy whether or not their dreams are seen as symbolic and whether or not clients take an active role in working with their dreams.

The framework from *The Gift* therefore applies to psychologically meaningful, internal-origin dreams and external-origin dreams. Furthermore, this framework for understanding dream sharing is relevant across a diverse range of dream beliefs from meaningful to meaningless. This will be demonstrated in an examination of the role of waking life social practices around self-disclosure and social bonding in dream sharing.

Sharing Dreams and Social Bonding

Wax (2004) argued that dreams should be seen as intrinsically social and cultural in the same way as poetry, dance, and music. Certainly sharing a dream with someone in waking life makes dreaming a social phenomenon (Stefanakis, 1995). Although many dreams are shared, the reasons for this and the obligations associated with it vary. In addition to the influence of cultural dream beliefs, obligations associated with sharing (or not sharing) dreams can relate to waking life social norms around entertainment, cultural connections, and self-disclosure in different kinds of relationships.

One of the most commonly reported reasons for sharing dreams in contemporary Western culture is for entertainment purposes (Hilbert, 2010; Laughlin, 2011; Olsen, Schredl, & Carlsson, 2013; Szmigielska & Holda, 2007; Vann & Alperstein, 2000). Nell (2014) noted in his South African study, that even many participants who believed dreams to be meaningless shared dreams for entertainment purposes, often for their humor or bizarreness. Sharing dreams for entertainment purposes brings obligations in several forms, including an obligation to adhere to waking life cultural rules for social interactions. There is a tacit obligation on the part of the giver to only share particular dreams with particular people. In turn, there is an obligation on the part of the receiver to behave in a manner that demonstrates they understand that the dream was shared for the purpose of entertainment. Often the language used to introduce a dream can cue the listener to their obligations around how to respond to a dream in an appropriate way (Vann & Alperstein, 2000).

Additionally, sharing dream content containing cultural references, such as a TV show that both the dreamer and the listener are fans of, is a way to be entertaining while building cultural connections (Vann & Alperstein, 2000). The obligation on the part of the listener (receiver of the gift) in this context is to affirm the cultural references and affirm both the giver's and the receiver's sense of belonging to a common group. The obligations associated with sharing dreams for entertainment purposes is therefore analogous to the obligations associated with sharing waking life experiences and imaginings for entertainment purposes. Sharing a dream reinforces social bonds and social hierarchies, consistent with what occurs in the exchange of gifts as described by Mauss.

After entertainment purposes, one of the most frequently reported reasons for sharing dreams is relational (Olsen et al., 2013). Dreams are often shared with romantic partners, relatives, and friends (Ijams & Miller, 2000; Nell, 2014; Szmigielska & Holda, 2007; Vann & Alperstein, 2000). Ijams and Miller (2000) found that dream sharing choices were consistent with waking life choices around self-disclosure in relationships. Of the 51 participants in their study, 59% of

participants attributed their choice to share those dreams to relational reasons such as preexisting feelings of closeness, trust, and understanding, or to increase feelings of closeness with the person they told. This suggests that at least some dream sharing involves a sense of it being an intimate activity for which a feeling of safety was a factor in revealing dream content. These findings are consistent with the framework of *The Gift*. Sharing dreams with people the dreamer is close to creates an obligation for the person receiving the dream to provide a safe, nonjudgemental, interested, and supportive place in which the dream can be shared. The building and strengthening of social bonds that Mauss (1970) described as inherent in the exchange of gifts is evident in the sharing of dreams for relational purposes.

Ijams and Miller (2000) pointed to some dream beliefs and psychological dream theories that assert that dreams reveal information about the dreamer and the dreamer's life. These beliefs can lead dreamers to seek advice around interpreting or understanding a dream. These beliefs could also account for the perception that dream sharing involves some level of self-disclosure and is therefore seen to be an intimate activity. The first assumption here is that dreams may be symbolic rather than literal and therefore need interpretation. The second is that dreams have meaning and because of this there is an obligation for dreamers to try to understand the meaning of their dreams and glean any insights possible from the dream content. The listener is obliged to reciprocate by assisting the dreamer to translate, interpret, or discern meanings in the shared dream so as not to deprive the dreamer of the dream's value.

Tedlock (1987) suggested that because dream sharing is not a common social behavior in American society, conflicting beliefs about the nature or function of dreams bring the challenge of identifying the appropriate people with whom to share a dream. Although in apparent contradiction to the results of studies showing that dream sharing is in fact a fairly widespread practice in contemporary Western culture (see Ijams & Miller, 2000; Olsen et al., 2013; Vann & Alperstein, 2000), this proposal by Tedlock (1987) draws attention to an important issue. If dreamers believe that the social practice of sharing dreams is inconsistent with the dominant dream beliefs and practices in their culture, it suggests that sharing dreams is a sensitive and at times high-risk activity. This aligns with studies in which the disclosure of sensitive dream content is seen to be an activity that should either be done within the safety of strong, close relationships or with someone the dreamer wishes to be closer to (Ijams & Miller, 2000). Certainly, Wagner-Pacifici and Bershady (1993) argued that when it comes to sharing dreams, people control the degree of self-imposed censorship on the basis of perceptions of safety.

Finally, it is relevant here to explore the dreams that are not shared and whether this is also consistent with the framework of *The Gift*. Several studies have found that some dreams are not shared (Ijams & Miller, 2000; Szmigielska & Holda, 2007; Vann & Alperstein, 2000). Participants in some of these studies reported a hesitancy to share dreams that focused on topics considered socially taboo or considered high risk to disclose in the dreamer's waking life culture. This seemed to relate to a belief that dreams reveal something about the dreamer or the listener (Ijams & Miller, 2000; Vann & Alperstein, 2000) or that the dreamer was somehow responsible for some of their dreams. People reported choosing not to share dreams about topics or behaviors that may be considered culturally taboo in waking life. Mostly these were sexual in nature, including engagement in some form of sexual

behavior the dreamer saw as deviant or inconsistent with their waking life values or identity, such as infidelity (Ijams & Miller, 2000; Vann & Alperstein, 2000).

Another type of taboo dream was those containing content that the dreamer would consider to be harmful in waking life conversations (Ijams & Miller, 2000). This harm could be in the form of harm to self, for example, through embarrassment, humiliation, a risk of losing respect, or a risk of being judged (Ijams & Miller, 2000; Vann & Alperstein, 2000). Alternatively, some dreams were not shared to avoid harming someone else. This could be a concern about hurting a partner's feelings or creating unnecessary fears about something from a dream that was inconsistent with the dreamer's choices in waking life, such as infidelity (Ijams & Miller, 2000). Finally, it could be not telling someone about a dream in which that person was in danger so as not to frighten the listener (Vann & Alperstein, 2000). The pattern of not sharing dreams was described as being consistent with decisions about self-disclosure in areas of waking life interactions to avoid harm to the self, other, or relationship (Ijams & Miller, 2000; Vann & Alperstein, 2000). In this way, the dreamer, as giver, is obliged to only share dreams that are culturally, socially, and emotionally appropriate to share.

The Gift of Dreams in Psychotherapeutic Settings

The Psychologizing of Dreams

The obligation of the dream expert to receive and respond appropriately to dreams has existed for a long time. As mentioned earlier, there were professional dream interpreters in all ancient civilizations, and many of these experts were well respected and well educated, like the specially educated temple priests in Ancient Egypt (Hughes, 2000). This leads to the need to identify who the dream expert is in contemporary Western culture.

Both sociology and cultural anthropology have laid claim to the realm of dream beliefs and practices in the modern era (Hilbert, 2010; Nell, 2014; Tedlock, 1987). Tedlock (1987), for example, argued that dreaming is a universal part of the human experience and inseparably and universally linked to cultural dream beliefs and practices. Yet, although some of these researchers see dreams as a legitimate focus of research in their respective fields, they claim that dream research has been marginalized within sociology and anthropology (see Hilbert, 2010; Nell, 2014; Tedlock, 1987).

In the 1980s, Tedlock (1987) despaired that few ethnographers in the anthropology community were interested in dream research. She attributed this to earlier dream research that had reduced this cultural experience into a mere psychological tool. Nell (2014) claimed that the *psychologizing* of dreams led to the marginalization of dream research in sociology as well. And Hughes (2000) noted that the literature within psychoanalysis and related fields is the only exception to the change from ancient times when all important examples of literature mentioned dreams. Michael Schredl (2011) pointed to the publication of Freud's book on dreaming at the turn of the 19th century as the emergence of an era in which dreaming was seen to fall within the domain of psychotherapy in Western culture. This view seems to persist in both lay and nonpsychological academic fields, that

dreaming and dream interpretation have been appropriated by the field of psychology (Dombeck, 1991; Nell, 2014).

Hartmann (2010) asserted that many psychological dream theories point to a need to share dreams with others. Laughlin (2011) accounted for the role of the psychotherapist through the discussion of the monophasic orientation toward dreaming in Western culture. This orientation creates a need for dreamers to have their dreams demythologized or be interpreted to create a rational meaning in waking life for their dreams to make sense or to be of value (Laughlin, 2011). The earlier examination of psychologically meaningful, internal-origin dreams showed the obligations of the dreamer and psychotherapist in relation to both psychological dream theories in which dream content is seen as symbolic and for those in which it is not.

Therapeutic settings have become another context and relationship in which dreams are shared in Western culture (Boyd, 2005; Hill, 2017; Keller et al., 1995; Schredl, Bohusch, Kahl, Mader, & Somesan, 2000). Wax (2004) went as far as to suggest that the therapy room is the equivalent to the ritual dream sharing of hunter-gathering groups. Intimacy, safety, seeking support and insight into dreams, and conveying messages or information have all been identified as reasons for people to share dreams with others (Ijams & Miller, 2000). These factors are just as relevant to sharing dreams in therapeutic settings as in social settings. Both psychotherapists being seen as dream experts and the validity of the framework from *The Gift* for understanding the social practice of sharing dreams across a range of cultural dream beliefs, point to a need to examine the implications for sharing dreams in psychotherapeutic settings.

The Implications of *The Gift* for Psychotherapy

Just as the development and maintenance of relationships is at the core of *The Gift*, the therapeutic alliance is at the core of therapy. The implications of *The Gift* for sharing dreams in psychotherapy can be most clearly seen through the impact on the therapeutic alliance.

In their review, Eudell-Simmons and Hilsenroth (2005) identified several uses for dreams in psychotherapy, including the use of dreams to facilitate the therapeutic process. The Ijams and Miller (2000) study reported several relational reasons for participants sharing dreams in personal relationships. Applying these findings to the psychotherapeutic context, clients may share dreams in therapy to enhance the closeness of the therapeutic alliance or because of already established feelings of safety and closeness within the therapeutic relationship. Due to the implicit understandings of the therapeutic setting and alliance, these relational reasons for sharing dreams do not even need to be a conscious decision.

Wagner-Pacifici and Bershady (1993) argued that self-censorship around sharing a particular dream is determined by the dreamer's judgment about whether it is safe. The introduction of the dreamer's judgment may suggest that decision-making around whether to share a dream is a conscious choice. In fact, this judgment could occur at a level anywhere along the continuum from a conscious choice to what Christopher, Wendt, Marecek, and Goodman (2014) would describe as falling into *folk psychology*—implicit expectations about what a person ought to

do or experience in a specific situation. Culture involves members of a group sharing meanings, assumptions, and understandings that are so commonplace they are rendered invisible and go mostly unquestioned by members of that group (Christopher et al., 2014). In this way, the nature of gifts is such that the process of exchange and the associated obligations can occur unconsciously.

The therapeutic setting is seen as a safe place to disclose sensitive, personal information. The therapist is obliged to receive and respond to shared dreams in a way that is safe for the dreamer, recognizing the intimate nature of this social practice (gift). The giving and receiving of gifts fosters a social bond and connection between the giver and receiver, strengthening the therapeutic alliance. In accepting a client's dream, the therapist confirms the safety, trust, and intimacy of the therapeutic alliance and is in fact offering acceptance of the client. If obligations are recognized by both the therapist and client, sharing a dream in therapy can be positive. Stefanakis (1995) presented it as an opportunity for the client and therapist to negotiate an understanding of the socially constructed meaning of a dream, which has the potential to elicit therapeutic change.

Looking at the social practice of dream sharing in personal relationships, the capacity to share a dream in a manner in which the dreamer is positioned as a passive recipient means that the dreamer can reduce responsibility for the dream content (Stefanakis, 1995). Boothe (2001) referred to this as using naïve self-distancing. The stance of passive recipient would allow clients to *test the waters* with particularly sensitive, potentially damaging, embarrassing, or humiliating dream content. Vann and Alperstein (2000) described how this distancing can be used to absolve the dreamer of any responsibilities they would have if this was an account of a waking life event. This could provide a safe *out* for clients if testing the waters does not go well. In fact, Fine and Leighton (1993) noted that people often declare a detachment from their dreams or a lack of ownership of their dreams, absolving themselves from any content that may reflect poorly on them. Although this only makes sense within some cultural dream beliefs, it could be particularly important both early in the therapeutic alliance when trust and a sense of safety are still being developed. Similarly, sharing dreams in therapy could provide clients from cultural backgrounds in which there is shame in sharing personal problems with a stranger, with a safe path in to accessing therapeutic support they might well benefit from (Tien, Lin, & Chen, 2006).

Additionally, dream work can provide clients with an option in therapy that is less psychologically threatening than working with real-life events (Cohen, 1999). Certainly, there is some support for the notion that trauma victims seem to prefer working with dreams over more direct approaches to therapy, finding it less threatening (Cohen, 1999; Schubert & Punamäki, 2016). In this way, working with dreams can help clients to defuse from the emotional intensity of a particularly sensitive topic. This allows the client to explore the topic and avoid feeling overwhelmed. Here the therapist's obligation is to recognize the appropriate pace of therapy.

Tedlock (1987) included psychotherapy in her list of viable low-risk options for American dreamers interested in their dreams. Similarly, Wagner-Pacifici and Bershady (1993) asserted that although clients may use the sharing of a dream to test solidarity and thereby recognize some degree of risk is involved, they would generally expect such a gift to elicit solidarity rather than punitive authority. These

statements are worthy of further exploration in trying to understand the consequences of not accepting an offered dream (gift). When therapists are not aware of the significance or meanings associated with giving such a gift and their obligations around receiving and responding appropriately to the dream gift, therapy may in fact shift to a high-risk option for some dreamers who share their dreams.

When a dream is shared, the hau (spirit or essence), which Mauss (1970) argued is embedded within all gifts and which serves to safeguard the likelihood of acceptance and reciprocity, is left with the therapist. In other words, clients are not just offering stories about a dream, but they are offering part of themselves. Until the gift is accepted and reciprocated, the power dynamics of the relationship are not returned to the status quo. This has significant implications for psychotherapy. The rejection of both a client's gift of trust in the therapist and the client's offer to share intimate, sensitive information (in fact offering him or herself) shifts the very foundation of therapy. It reduces the client's power by rejecting the client and retracting the safety and intimacy of the therapeutic alliance previously promised in the unconditional acceptance of the contract of therapy. Moreover, in psychotherapeutic settings the power differential means the therapist is seen to be the dream expert (Stefanakis, 1995). The therapist's failure to accept and respond appropriately to the client's gift changes the power dynamics of the therapeutic alliance, lowering the therapist's standing or authority as expert in relation to the client.

Wagner-Pacifici and Bershady (1993) used Foucault's work to explain how the powers imbedded in institutional disciplines, such as psychology, enable particular individuals to decide the nature and meaning of others' dreams and what their interpretations say about the dreamer. They did note though that dreamers must first share their dreams with various authorities or institutions for them to be able to have this power. Sharing a dream with someone exposes dreamers to the consequences of any interpretation the listener chooses to impose on the dream (Fine & Leighton, 1993; Wagner-Pacifici & Bershady, 1993).

The Eudell-Simmons and Hilsenroth's (2005) review noted that dreams could be used in therapy to facilitate insight and self-awareness and to provide clinically relevant and valuable information to therapists. Many people believe dreams contain important information (King & DeCicco, 2009), and many choose to share their dreams to understand them (Ijams & Miller, 2000; Nell, 2014). The therapist in this context is obliged to discern any valuable data around meanings stemming from the dream. Boothe (2001), in giving clients a voice to describe their experience of dream work in short-term therapy, found that some clients used dreams as a way to tell her something or to correct a misunderstanding. Here, the therapist is obliged to either share or be aware of the client's dream beliefs to the extent that the message that the client is trying to communicate by sharing a particular dream can be received and understood.

Any failure on the part of the therapist to understand these obligations could impact negatively on the therapeutic alliance and on any sense of a shared understanding around what should occur in the therapy. Here, clients would view themselves as fulfilling the obligations of their role by sharing rich data. However, they would perceive therapists as failing to fulfil their obligations by failing to respond as dream experts. Not recognizing the significance of the intimacy associated with sharing dreams and the intimate, possibly hidden information they may contain could result in therapists responding to this gift as if it is of no value.

They would not see the emotional risk the client has taken nor the trust that the client has placed in them. This may damage the safety of the therapeutic alliance and the credibility of the therapist as an expert on other matters in which the client had previously believed the therapist to be an expert.

There is, however, a problem with therapists accepting and responding appropriately to dreams in therapy. Many therapists report having no training in how to work with dreams and feel they lack the confidence and competence to respond adequately to their clients' dreams (Crook & Hill, 2003; Dombeck, 1991; Freeman & White, 2002; Keller et al., 1995; Pesant & Zadra, 2004; Schredl et al., 2000). This finding can be accounted for by the marginalization of dreams in psychology due to a range of sociocultural factors (Leonard & Dawson, 2018). It has given rise to a schism between lay and therapist expectations around sharing dreams in therapy. For clients, sharing dreams is the continuation of a longstanding social practice, but therapists are surprised by their clients sharing dreams in therapy. The framework of *The Gift* (Mauss, 1970) identifies the potential damage that this schism in expectations can cause and a need to take this matter seriously.

Conclusion

This analysis of the social practice of sharing dreams demonstrates the obligations associated with the giving, receiving, and responding to dreams across time and cultures. The use of *The Gift* (Mauss, 1970) as a framework for understanding the sharing of dreams points to the important role that dreams play in society and in relationships in particular. There is an expectation, as Boothe (2001) noted, that the rules of dream-telling are known and followed. Failing to be aware of or accept the obligations associated with sharing dreams has potential negative consequences for relationships of all kinds and particularly for the therapeutic alliance. Understanding the sharing of dreams in psychotherapy through the framework of *The Gift* can enable therapists to avoid the negative consequences that may arise from a failure to respect the obligations of gifts.

This article points to a need for both lay people and psychotherapists to be mindful of the diversity of cultural dream beliefs and practices and the obligations associated with sharing dreams. Awareness of these factors enables people to avoid negative consequences and benefit from the positive consequences associated with the gift of dreams. Specifically, the framework of *The Gift* suggests that psychotherapists should recognize the significance of their clients sharing dreams in therapy as an act of intimacy and trust. Therapists can extend the safety of the psychotherapeutic setting to include the acceptance of clients sharing this intimate part of their inner experience. Additionally, therapists can explore clients' motives for sharing a dream and their expectations around how the therapist will understand and respond to a dream. Then any conflicts arising from the schism between client and therapist understandings of the role of dreams in psychotherapy can be addressed in a way that avoids or minimizes harm to the therapeutic alliance, the therapist's status, or the client.

This article points to a need for further research into contemporary, lay dream beliefs and practices and in particular, clients' views on the role of dreams in psychotherapy. Such research could inform guidelines for psychotherapists on

culturally competent, gift-informed practice in relation to the introduction of dream material in therapy. Additionally, building on the growing body of dream research could provide psychotherapists with the expertise they are seen by much of society, to already possess. This could help bridge the gap between perceptions and reality while providing deeper and broader insights into this cultural and psychological phenomenon. Finally, this analysis provides support for the multidisciplinary approach to dream research advocated for by Ijams and Miller (2000) so as not to miss the unique perspectives each field has to offer to our understanding of the gift of dreams.

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CLINICAL REVIEW

The marginalisation of dreams in clinical psychological practice

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SUMMARY

The longstanding human interest in dreams has led to a significant body of psychological and philosophical discourse, including research. Recently, however, dreams have been relegated to the periphery of clinical psychological practice. This is potentially problematic as clients continue to bring dreams to therapy and many psychologists lack the confidence or competence to respond effectively to dream material. Building on the structural, professional and research cultures surrounding psychology using a *cultural-historical activity theory* framework, we argue the marginalisation of dreams is due to cultural-historical factors. These factors include the political and economic context in which psychology developed; psychology's early attempts to differentiate from psychoanalysis by identifying with behaviourism and the natural sciences; and a discipline-specific definition of what constitutes evidence-based practice. These factors led to professional discourses within which dreams are seen as of little clinical or therapeutic value, or that dream work is only for long-term therapy and requires extensive therapist training. However, there are diverse models of dream work consistent with most theoretical orientations within contemporary psychological practice. We conclude with recommendations on how to rebuild clinical confidence and competence in the use of dream material within the current professional environment.

Introduction

[1]Dreaming is a significant part of the human experience. The importance of dreams in society can be seen in the ubiquity of writings, artworks, theories, beliefs and practices associated with dreams across time and culture [1–4]. Humans have long sought to create understanding of their life and experiences; and interest in dreams has been one manifestation of this search for meaning and understanding.

Human interest in dreams has been reflected in the development of psychiatry and by some within psychology, leading to numerous theoretical models and the investigation of a diversity of practices associated with dreaming. There is also evidence that many therapists work with their clients' dreams, although this may be irregular and is often initiated by clients [5–10]. Despite this interest however, dreams have been pushed to the periphery in clinical psychological practice. A consistent finding in the literature is that many, perhaps most, therapists have no training on how to work with dreams in therapy and do not feel competent and confident to adequately respond to dream material [2,5,6,8,9,11]. Significant consequences of this gap in expertise may include a negative impact on the therapeutic alliance and a misinterpretation of the therapist's response as an indication of disinterest in the client's inner life. As some psychologists believe dreams are psychologically meaningless and unimportant (as noted by Hill [12]) they may reject offered dream narratives and dismiss clients' cultural beliefs about dreams without realising the impact this could have on clients and therapy [13]. This points to the need for psychologists to develop greater capacity to respond competently and sensitively to dream material in therapeutic settings whether or not they have a personal interest in dreams. This is particularly so given the notion of psychological intimacy associated with sharing dreams [14] and the diversity of dream beliefs and practices.

This paper begins with an outline of how dreams have been understood and valued in society. It shows that the dominant discourses around dreams within psychology do not reflect broader community interest. Using the *cultural-historical activity theory* (CHAT) framework, the paper will then argue that this separation, and the resulting limited use of dream work in clinical psychology,

Abbreviations: CBT, cognitive behaviour therapy; CHAT, cultural-historical activity theory; EBP, evidence-based practice.

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[1] The term dream work in this paper is used to refer to any use of dream material in a therapeutic setting, including using a theoretical model to explore meanings in dream narratives, using dream material as a source of clinical information or responding to sharing of dream narratives to build rapport.

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is not because dream work has no value. Rather, it is an unintended result of cultural-historical factors in and around the field that have privileged positivist ways of knowing at the expense of other practical epistemologies.

The paper will then describe the theoretical development of dream work that has continued to occur without widespread acknowledgement within the psychological discourse. This development has occurred in diverse ways that lay the foundation for therapeutic responses consistent with most of the theoretical orientations used in contemporary clinical practice. Furthermore, we suggest that dream work is possible and useful within existing psychological practice without extensive training or theoretical reorientation. However, to do so there is a need for further development of guidelines to assist psychologists in making appropriate decisions about how to respond to dream material, initiate dream work in their therapeutic practice, and minimise or avoid potential negative consequences associated with choosing not to engage with dream material.

Dreams in society

Dreams have long played an important role within the broader community and a diverse range of dream-related beliefs and practices have been reported [1,3,4,15–17]. Despite the emergence of some theories suggesting that dreams are merely epiphenomena, as reviewed by several authors [4,18], many people believe that dreams provide meaningful insights about themselves or their world [19,20]. Across time and cultures, dreams have been shared with others for a variety of purposes including entertainment, seeking personal advice from a dream expert, and providing the wider community with prophetic guidance, warnings and inspiration from gods or ancestors [14,16,17,21].

The dream expert has played a respected and often central role in many cultures [1,21]. During the Middle Ages for example, experts from the Jewish Cabalistic dream decoding system had many dreamers travel to see them, seeking expert interpretations of their dreams [1]. They even caught the attention of some in modern times, such as Freud and Jung, who built on their knowledge of ancient cultural and religious dream traditions in developing their psychoanalytic approaches [1,22]. Freud proposed that dreams are internal and external at a personal level, so dream imagery is as likely to be influenced by stimuli such as sounds or thirst, as by unconscious and unacceptable wishes [23]. He saw dreams as the body's way to preserve sleep and safely release emotionally or culturally unacceptable desires disguised in the dream imagery and he outlined techniques like free association to work through identified unconscious conflicts [23,24]. Consistent with his Jewish forebears as well as Cabalistic, Ancient Egyptian, Hellenistic Greek and many other cultural traditions [1,21], Freud believed an expert (a psychoanalyst) was needed to interpret a dream [24].

Jung agreed that dreams were important and to a greater extent than his teacher Freud, he acknowledged earlier cultural and religious dream influences on his work, such as Cabalistic traditions [22]. Unlike Freud, he believed dreams to be a normal, creative expression of the unconscious that revealed, rather than hid information. He believed dreams are a way to restore our psychological balance and compensate for aspects of personality that aren't allowed in waking life [25]. Dream work continues to be a major focus of Jungian therapy with techniques including the amplification of dream images and the use of personal associations arising from dream images along with the identification of universal symbols or archetypes that are understood to be part of the collective unconscious [3,25].

Adler, another early psychoanalyst, differed from Freud and Jung in many of his views. He proposed that dreams reflect the dreamer's personality and waking life concerns, just as waking life thoughts and imaginings do. He argued it was possible for dreams to serve a problem-solving function, assisting dreamers to rehearse future waking life situations [24]. His work paved the way for many future dream theories, including Beck's cognitive therapy approach to dreams. The rehearsal aspect of his theory is also present in the Threat simulation hypothesis, within evolutionary-psychology, which asserts that dreams are a means to practice identifying dangers and rehearse possible avoidance or responses to them, thereby increasing our chances of successfully surviving similar threats in waking life long enough to reproduce [26].

The use of dreams in therapy

There have been several studies asking therapists about their use of dreams in modern therapy. Survey-based studies have been conducted by Keller, Brown, Maier, Steinfurth, Hall and Piotrowski [9]; Schredl, Bohusch, Kahl, Mader and Somesan [8]; Crook and Hill [5]; Hill, Liu, Spangler, Sim and Schottenbauer [7]; and Huermann, Crook-Lyon, Heath, Fischer and Potkar [27]. Of the 228 psychologists (members of the Florida Psychological Association) who responded to Keller et al.'s survey [9], 17% never used dreams in therapy, 53% used dreams in therapy occasionally, 17% moderately, 9% frequently, 4% nearly always used dreams in therapy. The authors noted that many of the psychologists surveyed did not initiate dream work, only engaging in dream work when their clients introduced dreams into therapy. In Schredl et al.'s [8] study, 79 German therapists in independent practice completed surveys about the use of dream in therapy. These therapists reported that they had worked with dreams in around 28% of their sessions and that they worked with at least one dream of around 49% of their clients. Respondents reported that around 64% of the dream work in therapy was initiated by clients. In Crook and Hill's study [5], 129 members of the American Psychological Association's Division 42 (Independent Practice) were surveyed about their use of dreams in therapy. Nearly 92% of therapists reported engaging in dream work at least occasionally, spending a median of 5% of their time on dream work. Therapists reported that around 25% of their clients had brought dreams into therapy. Of the 49 public school mental health practitioners surveyed in Huermann et al.'s study [27], 55% of respondents reported at least one client (school student) bringing a dream to therapy.

These results show that while many therapists do not necessarily initiate dream work in therapy, or use dreams in therapy very often, many are going to engage in dream work at least occasionally as clients will introduce dreams into therapy. This suggests that while clients look to their therapists for assistance with dreams and that some therapists are interested in dream work, overall there is a fairly low incidence of dream work in therapy, indicative of it not being a central part of mainstream therapy. Further nuances in the data can be been seen when considering other relevant factors such as theoretical orientation and training.

There appears to be a relationship between the use of dreams in therapy and the theoretical orientation of the therapists. Psychoanalytically-oriented therapists in Hill et al.'s [7] study reported engaging in more dream work than the more theoretically diverse respondents in Crook and Hill's earlier survey [5]. Hill et al. note that the results of their study may not be representative of the wider psychoanalytic community due to both the sample size and the respondents being in attendance at a workshop on dream work, suggesting a particular interest in dream work. However, the pattern can also be seen within the results of the earlier Crook and Hill study in which CBT-oriented therapists engaged in less dream work. Likewise, in Germany, therapists in Schredl et al.'s study [8] identifying more closely with psychoanalytic approaches to

therapy reported a greater level of dream work in therapy than therapists with other primary theoretical orientations. Despite the lack of empirical research about the use of the dreams in the psychoanalytic community [7], this pattern is not surprising when considered in the context of the historical association between dream work and psychoanalytic approaches to therapy and behaviourists distancing themselves from dreams [24,28]. Nor is it surprising given that even in the cognitive and CBT dream literature, there is an acceptance that CBT-based approached to dream work are not widely used [11,29]. The implications of this are that any increase in the proportion of CBT-oriented therapists within the psychology workforce might well be associated with lower levels of engagement in dream work, which is of relevance in the later discussion around theoretical trends in psychology.

Therapists were also asked about their training in dream work in several of the surveys. In Crook and Hill's study [5], therapists reported only a moderate level of training in dream work with 19% reporting that they had no training in it; and 16% of respondents reported that they felt no competence engaging in dream work. They found a strong relationship between the amount of training and the amount of dream work they engaged in, as well as a strong relationship between the amount of training and feelings of competence around engaging in dream work. Furthermore, in Huermann et al.'s study [27], 49% reported having no training in dream work and only one reported having had extensive training. The authors reported that most respondents did not feel competent to respond to the children's dreams. Most of the respondents in the Keller et al.'s study [9] who had training in dream work had sought it out themselves rather than it being a part of their university training curriculum. The suggestion that CBT training does not generally focus on dream work [11] may well account for the results of Schredl et al.'s study [8] that while psychoanalytic therapists tended to use Freudian-based approaches to dream work, humanistic and CBT-oriented therapists tended to use Jungian and other non-CBT approaches to dream work. There was also little evidence of therapists using CBT approaches to dream work in Keller et al.'s study [9]. While they did not gather data about the general theoretical orientation of the therapists in their study, they did gather data about which theoretical approaches to dream work the therapists used. They noted that despite the recent interest in CBT approaches to dream work in the literature at the time, the most common approaches to dream work reported by the therapists were Gestalt, Freudian and Jungian approaches. These results do not show any evidence of a wide-spread use of CBT-based approaches to dream work in clinical practice. Furthermore, these survey results suggest that many therapists feel incompetent and lack training on how to respond to their clients' dreams, which is a concern given that clients do initiate dream work in therapy, necessitating a response for their therapists.

Dreams and modern psychology

While there has been a continuing interest in dreams by many factions of society and a theoretically diverse range of psychological approaches to understanding the role and importance of dream work has developed, dream work has shifted to the periphery of clinical psychological practice. As shown in the surveys about the use of dreams in therapy, this has left therapists feeling inadequately trained and unconfident to respond to their clients' dreams [2,5,6,8,9,11]. An explanation for this marginalisation of dreams can be found in the cultural-historical factors surrounding the field. This section argues that psychology's cultural-historical context has led to a limited vision of scientific evidence based on an, at times, evangelical adherence to positivism [30].

In making the culturally-driven choice of an over-reliance on a single epistemology, psychology stands apart from the scholarship and thought of the wider world of science. There are exceptions to this within psychology, such as recent efforts in contextualised positive psychology [31] and systems-based therapies [32] that use new waves of thought in science [33] to develop more holistic and interconnected approaches to human experience. By and large though, and seemingly in search of wider legitimacy, psychology has sought succour in the apparent certainty of positivism [30,34,35] and mechanistic philosophies built on Descartes' philosophies. Thus, the dominant discourse within the field has become one in which the only phenomena that can be discussed and valued are those that are directly measurable and dreams have not found a place within this discourse. In other domains, more flexible and complex understandings of science have been found. Collin's demonstration of science as a social and cultural practice [36] and Capra's non-linear approach, which can consider complex problems with no need to avoid subjective, non-material phenomena [33] are just two examples of alternative epistemological choices. A more detailed review of the history of science is beyond the scope of the current paper, but can be found in the aforementioned examples and in the scholarship of authors such as Collins [36,37]. This scholarship has reconceptualised science as an endeavour involving competing epistemologies, which is deeply embedded within a subjective cultural and historical matrix [37].

An analysis using the CHAT framework developed by Leont'ev [38] was used to understand how cultural-historical factors influenced clinical psychological practice. Leont'ev built on Vygotsky's work, who argued that interactions between subjects and objects are culturally mediated. That is, we interact with the world through the tools and signs available to us through human cultures. While other scholars such as Engeström [39] have developed more complex ways to use the CHAT approach, the analysis reported in this paper made use of the so-called *second generation* of CHAT associated with Leont'ev. CHAT offers a structure for analysing human activity systems within their historical and cultural context [40]. Activity is anything humans do with a purpose. In this case the activity system analysed is clinical psychological practice. This framework calls for an analysis of the object of the activity, the rules, tools, communities of practice and divisions of labour relevant to the activity. The analysis reported here considered the activity system only at a macro level to assist in understanding the ways in which the activity system has valorised some actions, while marginalising others.

The changing perceptions about dream work and the marginalisation of dreams in clinical practice have occurred within a cultural-historical context that can be understood through the application of the CHAT framework. The development of psychology as an independent field, for example, can be understood through CHAT to be a new division of labour. To create this division of labour, psychology sought out a set of tools, such as behaviourism and privileging particular kinds of evidence in their definition of evidence-based practice (EBP), to differentiate it from other disciplines like psychoanalytic psychiatry. Similarly, the political and economic context can be understood to influence the rules and the available tools for the activity of clinical psychological practice. Through examining such relationships and tensions, the dynamics of the activity system can be identified. It is important to note that small changes within the activity system can lead to large changes in how the system operates. A small reduction of members of the community of practice with an interest in a particular aspect of

practice such as dreams, for instance, can lead to a larger decline as there are fewer experienced mentors and trainers within the community to teach newcomers about that aspect of practice.

The emergence of modern psychology

Psychology began to develop into an independent discipline and profession and to create a new division of labour with an identity separate from psychoanalysis. For the purpose of this paper, we are focussing on the development of modern psychology from the late 19th century. In the UK, psychologists distanced themselves from an *interpretive* science approach and rejected the study of phenomenology [34]. Instead, psychologists aligned themselves with a positivist, natural science approach in order to secure the certainty, authority, status and salaries associated with the natural sciences [34]. This tied in with the rise of behaviourism, which also rejected internal, subjective experiences [24]. It heralded a move away from the psychoanalytic approaches favoured by psychiatry. Meanwhile in the US, the government's desire to expand effective mental health services for veterans following World War II pressured the scientist-psychologists to lead the expansion of professional/applied psychology or risk losing the opportunities for funding and for controlling the training of clinicians [41]. This culminated in the historic 1949 Boulder conference, at which numerous aspects of the training and identity of psychologists were debated and a decision was made to follow a scientist-practitioner model. The intention to adhere to EBP and a scientist-practitioner model of training spread throughout psychology training and practice in places such as the UK, Canada, New Zealand and Australia [42–44]. These decisions all shaped the tools of practice.

From the outset, the behaviourists distanced themselves from working with dreams in an attempt to differentiate themselves from psychoanalysts who were closely associated with dream work [45]. Dreams were also pushed aside due to behaviourists rejecting unverifiable, internal, subjective experiences as a valid focus of clinical or research attention [11,24,46]. Sleep and dream researcher Cartwright [47] agrees that psychology's love affair with science during the reign of behaviourism, along with advances in pharmacological treatments for mental illness (rather than a focus on the creation of meaning), contributed to dreams being seen as an unreliable data source and unrelated to clients' waking life concerns; and therefore irrelevant to clinical practice during this period. Indeed, it has been claimed that pharmacological treatments for mental illness became the primary treatment modality in psychiatry by the end of the late 1970s [48]. It is worthwhile at this point, to consider the theoretical trends within psychology given this is likely to influence the field's relationship with topics such as dreaming. While there is some debate about theoretical and research trends within psychology, there is agreement that multiple schools of thought have had significant influence on the field [49]. Spear's findings in his 2007 analysis of psychological publications are similar to others in several respects. He found there to be fewer psychoanalytic publications than in the past, a decrease in behavioural publications since the 1970s and an increase in cognitive publications over the later part of the twentieth century [49]. It is within this wider context of trends in psychology, that the role of dreams must be considered.

The increasing dominance of positivism, behaviourism, the scientist-practitioner model and a narrowing/shifting interpretation of EBP in psychology, all influenced the way in which new psychological theories and therapeutic techniques (tools of practice) were received and adapted. This is evident in the failure of dreams to return to a central role in mainstream psychological practice following the development of cognitive therapy, which overtly states an interest in internal experiences [29]. Beck emphasised the integrative potential of the model of cognitive therapy he founded. This was an effective means to promote and demonstrate the efficacy of his therapy and gain acceptance from proponents of behaviourism (the existing dominant theoretical orientation); and it successfully led to the rise of CBT [28]. Despite Beck's conviction of the validity and value of working with dreams in therapy, he put aside his interest in dreams for a period [45]. This was due in part to his experience of dream research being expensive and in part to his desire to align himself with behaviourism by distancing himself from his psychoanalytic roots and its association with dream work [28,29,45]. Rather than emphasising subjective, internal experiences, CBT approaches were defined, researched and promoted in ways that aligned with demands of positivist-oriented EBP [30]. As the path that Beck took illustrated, the shift in theoretical trends away from pure behaviourism did not bring about a sufficient renewal of interest in dreams to make them a central part of mainstream clinical practice.

Technological and scientific advances in sleep science and dream research had the potential to pave the way for a renewed interest in dreams [18,47]. The discovery of REM sleep in the 1950s certainly did lead to a new era of dream theories [4,46]. It also led to funding for a multitude of studies using REM sleep approaches to dream research [50] that is evident in the subsequent rise (and peak around 15 years later) in dream publications, similar to the rise (and peak around 15 years later) in psychoanalytic dream papers, following the release of Freud's work on dreams [51]. However, rather than the advent of REM sleep approaches to dream research encouraging an exploration of the potential value of dreams in psychological practice, the prevailing historical-cultural factors contributed to the development of a dominant discourse within psychology that dreams are at best just cognitive epi-phenomena or by-products of the brain and therefore not of psychological importance or clinical value [4,18,46]. Palagini [4] describes this dominant discourse as psychological dream theories being superseded by physiological dream theories. This discourse took hold despite the continued decline in physiological dream research since around 1970 [51]. It also continued despite some REM sleep/dream researchers, such as Foulkes, advocating that dream research now be approached from a cognitive-psychological perspective given that the neurobiological approaches to dream research failed to produce substantial evidence of neural correlates of dreaming and could therefore no longer justify research funding [50].

Crick and Mitchison's *reverse learning* cognitive theory of dreaming was one such theory that reinforced the dominant discourse within psychology that dreams are meaningless. They proposed that the brain prunes away unneeded memories in REM sleep, describing the process as people dreaming in order to forget what they don't need to remember [3]. Their view of dreams, which they equate with REM sleep, leaves no space for any psychological or spiritual meaning.

Hobson and McCarley's activation-synthesis model of dreaming had a profound influence on the shift away from psychological theories of dreaming towards physiological ones [4]. They proposed that activity stemming from the pons/brainstem *activates* REM sleep and the random stimulation of the forebrain prompts a comparison of this input with stored memories or data which is then *synthesised* into dream narratives [3,4,46]. This theory was interpreted within the dominant discourse as evidence that science had eliminated any possibility that dreams had psychological value or meaning.

Hobson and colleagues further developed these ideas about dreaming some years later leading to the AIM model (Activation, Input/output, Modulation) with a focus on the sleeping brain processing internal input only in contrast to the waking brain

processing more external input [52]. The Modulation part of the model seeks to account for dream characteristics such as dream bizarreness. However, the nuances and developments in Hobson and colleagues' dream theory and their comments that their theories did not preclude the possibility of psychological meaning in dreams [53] did not enter the dominant discourse. Instead, these theories are often reduced to a view that dreams are meaningless, random, neural firings. Indeed, this dominant perception of these models is so powerful that it has expanded beyond mainstream psychology to influence some lay people's beliefs [20].

Outside the dominant dream discourse in psychology, theoretical development in dreaming continued. The growing diversity in psychological theories of dreaming began to more closely reflect the diversity of dream-related beliefs and practices in wider society. More consistent with Adler's views rather than Freud's, many of the psychological dream theorists from the 1950s–1970s rejected the idea that dreams relate to the unconscious or the past and argued instead that they were all about the *here and now*. Examples of present-focused approaches to dream work include French and Fromm, Faraday and Perls, the founder of Gestalt therapy. French and Fromm [54] proposed a psychoanalytically informed, logical reasoning approach to testing hypotheses about possible meaning of dreams, focussing on the problem-solving function of dreams. The Gestalt approach used active techniques such as dialogue with or roleplaying various dream characters/images which were seen to be aspects of the dreamer's personality or self that needed to be integrated [55]. Faraday [56,57] borrowed some clinical Gestalt techniques, such as topdog/underdog to identify gaps in the personality that had been alienated and needed to be reclaimed. She proposed that dreams could be interpreted at multiple levels so dreamers should first check for literal, *reality* level meanings such as dreaming they need a haircut when they need one in waking life and then look to interpret the dream at a more *subjective* level of meaning. Faraday, like Ullman [58] (who developed a group approach to exploring dreams) suggested that lay people could use these techniques to explore their dreams themselves, rather than requiring a trained professional, such as a psychoanalyst. Their position acknowledged and tapped in to the broader community interest in dreams and some lay dream practices.

The increasing marginalisation of dreams in modern psychology

Psychological theories and practice do not develop in a cultural vacuum. The past few decades have seen the emergence of neoliberalism and what Foucault would describe as a shift away from institutional governance to contractual governance [59]. The impact of this political and economic climate can be seen in our healthcare systems, such as in the NHS in the UK [60]. Services previously provided by the state, are increasingly contracted out to private providers who compete for their share in the market. The effects of neoliberal governance can be seen in contractual requirements in the UK that are generally consistent with governments' political and economic policy goals, seeking to quantify therapy outcomes and minimise financial costs by keeping therapy as short as possible [61]. From a Foucauldian perspective, this requirement establishes a form of self-regulation where psychologists are pressured to conform to the government's economic and political goals from within. While established through contractual penalty, the very definition of good practice is quickly linked to the contractual targets such as waiting times and short therapy durations [62].

In the pursuit of cost-effective solutions, many of the funding and referral sources for psychologists set limits on the number of therapy sessions allowed, restrict which therapies are to be used and what issues may be focussed on [43,63]. There is pressure for professional decision-making processes to align with external definitions of EBP and therapy outcomes. A narrow interpretation of the terms of service for therapy and restrictions on particular psychological service programmes may act as a further deterrent for psychologists in choosing to work with dreams in therapy. Psychologists may be less likely to respond encouragingly to clients introducing dream material into therapy if they fear a loss of income or breach of contract due to their choice to focus on something not explicitly related to the diagnoses and therapies approved by a referrer/programme. Additionally, the time-limited nature of many funding sources for therapy acts as a deterrent to including dream work in therapy for those who feel they cannot afford to digress in the limited time they have available [11]. The belief that dream work involves long term, traditional psychoanalytic approaches can account for some of the reluctance to work with dreams in the time-limited clinical setting of contemporary psychological practice [12,64–66].

In countries with this regulatory approach, such as the UK and Australia, CBT was identified as one of the few preferred EBP interventions approved for some government funded programmes [34,67–69]. Additionally, late 20th century and early 21st century had seen a trend towards less diverse theoretical orientations among practicing psychologists in a number of countries including Canada [70], the US and Australia with CBT also becoming one of the few favoured approaches to practice for proponents of EBP within psychology [67,71]. Psychology's close association with approaches such as CBT, that were empirically validated in a positivist framework, shorter-term (cost-effective), and with quantifiable outcome measures, meant psychologists were well placed to compete for a market share in the neoliberal political and economic environment [72].

Recent decades have also seen a decreasing diversity within postgraduate psychology programmes with CBT-oriented programmes and approaches to therapy dominating clinical discourse [68,73]. Additionally, the proportion of random control trials and comparison studies including CBT rather than other therapies was a barrier to the same level of evidence being established in relation to other therapies, reinforcing a monoculture of CBT [44] and risking the field being equated with a single theory or technique. This seems inconsistent with the original intention of proponents of EBP as the existence of multiple theoretical approaches with a good empirical basis should point to greater theoretical diversity [73].

The dominance of CBT and the shift away from topics in psychology that are inconsistent with positivist approaches may have significantly impacted the role of dreams in clinical psychological practice in other ways. The fewer topics and methodologies people are trained in, the fewer experts in diverse topics and methodologies there are to act as teachers, supervisors and mentors for future generations [73,74]. A lack of training in how to work with dreams has been noted by a number of dream researchers and practitioners, particularly in CBT-oriented programmes, which generally feature less dream-related training than others such as psychodynamic-oriented ones [5,11]. The relative lack of resources, such as training manuals and guidelines for working with dreams, in non-psychoanalytic approaches have impeded training for CBT-oriented therapists and may have led to the perception that dreams are less central to these other theoretical orientations [8,11].

The end result has been that many therapists trained in CBT approaches do not receive training to adequately prepare them for working with dreams in therapy or to even realise that there are approaches to working with dreams consistent with their

theoretical orientation [11,75,76]. Clients look to therapists for assistance with dreams that puzzle or frighten them and they also bring creative and recurrent dreams to therapy, which is a problem if the therapist does not have training that enables them to feel prepared and competent to respond to dreams [77].

As previously discussed, the formation of psychology as a new 'scientific' discipline led to a model of practice that must vigilantly guard against the intrusion of anything that may be seen as unscientific as it would threaten the field's legitimacy and truth claims. Thus, psychology finds itself in a position where it must be seen to stridently distance itself from dreams and any other aspects of practice that it deems inconsistent with positivist science. The marginalisation of dreams within psychology training coupled with psychology's fear of losing status and not being taken seriously as a *real science* [78] may be contributing to a lack of knowledge about dreams within mainstream psychology that reinforces misperceptions about dream work. Hill [12] identifies two such misperceptions: that any work with dreams requires formal knowledge about how to do 'dream interpretation' and that dreams are trivial and unscientific and that's why they are not included in the psychology curriculum.

The stigma against dream research within mainstream psychology [12,50] can be seen in Hill's description of some of her colleagues' reactions when they discover her professional interest in dreams [24]. She attributes this to some academics categorising dreams as *hippy-dippy-trippy*, belonging in the alternate realms of parapsychology and New Age therapies [24], rather than *real science*. Given Hill, a highly respected researcher in the field, experiences this type of response from colleagues, it is reasonable to assume this attitude may well be a deterrent to pursuing an interest in dreams for early career psychologists trying to establish their professional reputation and credibility.

The marginalisation of dreams in clinical psychological practice can be understood as an unintended consequence of the cultural-historical factors that have shaped psychology. However, this trajectory does not mean that dreams should be of no interest to the field. While dreams have been pushed to the periphery within the field of psychology, throughout recorded history they have been seen to have meaning and have clearly been of great significance to human society. As a significant part of human experience, dreams are in this way, of relevance to psychology. Furthermore, as evidenced by clients introducing dream material into therapy [5,8,9,27] and reported in anthropological work [79], society sees psychologists as dream experts.

Contemporary dream work

Due to the dominant dream discourse in psychology, there is little awareness of the diversity of psychological dream theories. Instead, it seems many believe dream theories have developed in a linear way from traditional spiritual approaches, followed by early psychoanalytic approaches that sought to interpret symbolic meanings in dreams, through to modern scientific advances proving dreams have no psychological or spiritual meaning, nor clinical value [4,12]. This may be both a reflection of as well as a maintaining factor in the marginalisation of dreams in clinical psychological practice. Stepping outside this discourse, a recognition of the actual diversity in pathways to dream work provides a foundation for action for the contemporary clinician, irrespective of theoretical orientation. While Freud's psychoanalytic approach [28] may be the most widely known in both professional and lay communities, psychological dream theories and techniques have been developed within many theoretical orientations. These include a range of psychoanalytic, humanistic, phenomenological, existential, cognitive, CBT, evolutionary, family systems, narrative and other constructivist approaches to dreams, and lucid dreaming training (learning to become aware that one is dreaming while still asleep) [1–3,24,80–82]. To illustrate the diversity of contemporary dream theories and models of dream work, several examples of contemporary dream work theories and potential uses for dream material in therapy will be highlighted below.

Hill's [24] cognitive-experiential model of dream work is one of the more frequently researched models of dream work developed for contemporary practice. Her work shows the potential value of a collaborative approach between therapist and client when working with dreams in both shorter- and longer-term therapy. Like many lay and psychological dream theories, it assumes there is a relationship between dreams and waking life concerns. This relationship is referred to as the *Continuity Hypothesis* and was put forward by Hall and Nordby in the 1970s before being developed into a more precise, predictive model by Schredl [83]. Hill proposed a three-step process to working with dreams: *exploration* of aspects of the dream, the facilitation of *insight* via associations with waking life concerns and a call to *action* based on the insights gained from exploring the dream [24]. Her model suggests that dreams are both psychologically meaningful and potentially valuable for psychological practice.

Beck saw working with dreams as a valuable tool for cognitive and CBT therapists. After initially distancing himself from dreams during the development of CBT, he recently confirmed his belief that dreams can be a valuable therapeutic tool [45]. The influence of Adler is reflected in his view that dream themes can directly relate to waking life. Beck does *not* advocate searching for symbolic meanings in dream imagery that may relate to waking life concerns. Rather, he believes there is a continuity between the cognitive distortions expressed in the dream narratives (given while awake and conscious) and the cognitive distortions expressed in the narrative clients give about waking life events [11,75].

As dreams are seen as non-symbolic dramatizations of a client's waking cognitive triad (thoughts about a person's view of self, the world and the future), Beck's approach to dream work involves identifying and changing the cognitive distortions expressed in dream reports to promote generalised changes in unhelpful thoughts and behaviours in waking life [84]. There is therefore no need to ascertain the accuracy of dream reports, eliminating any need for training in interpreting the symbolic meaning of dream imagery and issues around secondary elaboration, both of which have been a deterrent for some therapists to engage in dream work [11,28]. The client is encouraged to learn to identify and challenge cognitive distortions rather than remaining dependent on the therapist (*expert*) for support in relation to future dreams. Building on Beck's work, some guidelines have been developed for therapists using a CBT approach to work with dreams [11]. Consistent with CBT in general, this approach to dream work focuses on symptom reduction rather than finding deep psychological meaning in human experiences, or in this case, in dream experiences. Hence Beck's model of dream work is an example of dreams being seen as clinically valuable but not phenomenologically meaningful.

There is a rapidly emerging body of empirical support for the use of dreams in psychotherapy [5,11,85]. Uses include facilitating therapeutic processes (building rapport and improving the therapeutic alliance) and assisting the client to develop self-awareness and insight into issues or him/herself. For instance, dream work can be helpful in encouraging clients at high risk of early termination from therapy to stay in therapy longer [85] This may be due to the positive impact it has on therapeutic processes. This can be

seen in one study where clients in the dream condition reported keeping fewer secrets from their therapists than those in the control group; and both clients and therapists in the dream condition gave higher working alliance ratings [86].

Dreams can be a source of useful clinical information about clients, their issues, and progress in therapy [85]. The relationship between nightmares and suicidality for instance, points to dreams being a potential source of data in the assessment process [87,88]. Therapists may also be able to glean information from dream narratives (secondary elaboration) about a client's self-view and patterns of thinking, relating and emotional responses that they are unable to or feel uncomfortable to directly disclose. Changes (or a lack of change) in dreams throughout the course of therapy may also indicate a client's degree or stage of progress [85]. Additionally, some clients may find working with dreams less threatening than working with real life events [89]. For example, Beck's cognitive approach to working with cognitive distortions from dream narratives may provide an accessible means for these clients to begin to identify and work on these waking life issues.

Finally, dream work may provide effective treatments for distressing dreams. In client groups such as sleep clinic patients, there is interest in accessing more information about nightmares and there are potentially effective extant treatments for them, such as imagery rehearsal therapy [90,91]. Imagery rehearsal therapy is a short-term, CBT-oriented approach developed by Krakow and colleagues. It is designed for working with bad dreams and nightmares and requires the dreamer to rewrite the nightmare narrative with an altered/improved ending and then rehearse the new version [[24] [92]]. Using dream work methods that are effective in reducing nightmares in clients who have experienced trauma may also improve sleep and nightmare symptoms for these clients to a point where they are able to engage more effectively in subsequent therapy focussing on the remaining trauma symptoms and issues [93].

Some of the dream work models outlined consider dreams to be psychologically meaningful and potentially valuable to clinical practice. They connect with the longstanding human interest in dreams and the search for meaning in human experience. Alternatively, others, such as Beck's CBT approach, suggest that while dreams don't have any psychological meaning they are still a potentially valuable clinical tool. This diversity in dream work models and the view that dream work is of potential value to psychological practice is in stark contrast with the dominant discourse that dream theory has progressed in a linear fashion from dreams being perceived as psychologically meaningful and clinically valuable to meaningless and of no clinical value. This selection of dream work models and potential uses for dream material is by no means exhaustive. It does, though, speak to the potential for a new dream work discourse to gain traction. Indeed, it has been suggested that dreams have significant potential to regain their status in psychiatry; that further technological advances are revealing dreams' therapeutic potential [18] and that this could well spread to psychology. The beginnings of such a possibility can already be seen in the psychological literature. Examples of this include published case studies in which dream work is a significant part of the therapeutic intervention for two refugees who have experienced trauma [13] and the novel approach taken by Carr and Nielsen in their psychological conceptualisation of nightmares [94].

Conclusion

This paper has provided an exploration of the value of dreams to society and psychological practice. It discussed an analysis of the cultural-historical context of the activity of clinical psychological practice, arguing that this context has led to an over-reliance on positivist epistemologies and in turn, psychology has not fully engaged with new waves of thought on the nature of science. The central contention of this paper has been that it has been the cultural-historical factors and resulting beliefs and professional discourses, rather than a lack of practice models, that has led to many contemporary psychologists struggling to respond competently to their clients' dream material.

This paper also highlighted the dominant discourse of a linear progression in dream theory development, that has been contributed to by the cultural-historical factors that have influenced the development of psychology. This discourse fails to consider the nuances of the theories on which it is based or the diversity of extant dream theories. The danger is that it fails to equip clinicians to respond sensitively and competently to the introduction of dream material in therapy. Additionally, it deprives clinicians of the potentially valuable therapeutic tool of dream work and is not conducive to therapists being able to pursue a professional interest in dreams. This dominant discourse of dreams having no psychological meaning or clinical value is only one side of the story in a short chapter within humanity's long history of fascination with dreams.

In our view, the theoretical diversity in dream theory offers multiple pathways for contemporary psychologists to engage in dream work in ways that are achievable within the constraints of contemporary practice, including time limits and preferences for particular theoretical orientations. As dream work can be incorporated into existing approaches to practice, a separate ‘dream analysis’ competency is not required. Effective ways to work with dreams can be successfully included in the existing psychology training and professional development landscape of contemporary clinical psychological practice. Moreover, professionals can also choose to use models, such as Ullman's widely used approach to dream work [58], that require no ‘competency’ or professional training and was in fact designed to be suitable for use by lay people. These factors will assist in addressing the lack of more experienced psychologists able to teach, supervise and mentor any newcomers interested in dreams. Thus, while bringing dreams back to a more central role in psychological practice will require a broadening of concepts of practice, a complete restructuring of the cultural-historical factors outlined in this paper is not required before significant steps can be taken.

While there is great diversity in dream theory, there clearly remains a need for further scholarship in this area of clinical psychological practice. Knowing more about lay people's dream-related beliefs and practices as well as the experiences of psychologists and their clients around the use of dreams in therapy may well be clinically valuable. It could inform the development of psychological guidelines, work begun by Pesant and Zadra [2], and Freeman and White [11], for not just working competently and confidently with dreams in therapy but also minimising or avoiding harm to clients that may arise from incompetent or insensitive responses to their dream material.

Client demand and the range of valuable and empirically supported uses of and approaches to working with dreams in both shorter- and longer-term therapy indicate that barriers to the development of adequate psychological training and competence in this area must be addressed [77]. Addressing the cultural-historical factors that have inadvertently resulted in the marginalisation of dreams in clinical psychological practice could accelerate the movement toward a new dream work discourse gaining traction in mainstream psychological practice.

Practice points

1) Clients bring dreams to therapy but many psychologists feel ill-equipped to respond competently to dream material.
2) Due to a number of cultural-historical factors associated with the development of psychology and the political and economic context in which this happened, particular beliefs about clinical dream work have developed. These include the idea that dreams are of limited value in psychological practice and they are not a legitimate focus of interest for psychologists. Misperceptions about dream work have also spread e.g., that dream work requires long term therapy or extensive training in psychoanalytic approaches.
3) There are diverse theoretical approaches to psychological dream work consistent with the more common theoretical orientations of contemporary psychologists.
4) There may well be significant benefits to using dream material in clinical practice. These include:
   - facilitating therapeutic processes
   - assisting clients to develop self-awareness and insight
   - using dreams as a source of useful clinical information
   - addressing distress or dysfunction associated with nightmares and bad dreams.
5) Creating a core group of experienced staff to act as teachers, supervisors and mentors in psychology training programmes and professional development activities may assist to address the misperceptions about dream work and help reinstate dreams as a legitimate focus of clinical practice.

Research agenda

1) Further development of clinical guidelines for working (or choosing not to work) with dream material would be of value in increasing psychologists' feelings of confidence and competence and in minimising potential negative consequences.
2) A better understanding of the following dream work processes could inform the development of these guidelines and be useful in shifting the professional discourse around the value of working with dream material in therapy:
   - the expectations and experiences of psychologists around the use of dream material in therapy
   - the expectations and experiences of psychologists' clients around the use of dream material in therapy
   - lay people's dream-related beliefs and practices
   - the efficacy and effectiveness of various dream work models
   - who is most likely to benefit from dream work

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.smrv.2018.04.002.

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Postscript to Chapter 3

From within practice, the logics of practice look very different. I stepped back from this and engaged in an IPA interpretive process of valuing the outsider and insider perspectives. I did this via an examination of the historical context of psychology and dreams looking at the literature through multiple theoretical frameworks or lenses. In doing so I have developed a very different, more critical or outsider (sceptical) stance to balance my earlier insider view. As this third chapter of my thesis draws to a close, I am aware that the new frameworks and tools I discovered throughout my examination of the literature, have provided me with new ways into understanding my experiences around dreams during my past career as a psychologist.

I better understand the value that IPA places on sensitivity to context. Nothing can be understood in isolation, outside of the context in which it exists, and this applies to both the sharing of dreams in therapy, and the practice of psychology. In particular, I have come to understand how the field of psychological practice might be able to increase its adaptability and resilience in times of change through the adoption of a broader identity, than its alignment with a particular short-lived era, or manifestation, of the natural sciences, allows for; and through embracing methodological and epistemological diversity.

These new frameworks have provided me with new lenses through which I can approach my project, which in turn will enable me to achieve a more critical and useful interpretation of the interview data I will collect.

Chapter 4. Study one

4.1 Chapter outline

This chapter reports the findings of the first study in this research project, an interpretative phenomenological analysis of how psychologists understand their lived experience of dream sharing in psychotherapeutic settings and the role of dreams in contemporary Australian psychological practice. An expanded coverage of the methodological issues and details about the methods, including a summary of profile data about the participants (see Table 2.2) can be found in Chapter 2.

This chapter begins with an extended introduction, which forms part of the transparency process, as outline in Chapter 2. Each section of the introduction identifies and briefly discusses key ideas from readings, or IPA guidelines, that have particularly influenced aspects of the analysis or interpretation processes. Following the introduction to the chapter, the findings from the psychologist study are presented.

4.2 Introduction to Chapter 4

This chapter reports on the findings of the interpretative phenomenological study investigating contemporary Australian psychologists' experiences of dream material being introduced into therapy, and how psychologists make sense of both these experiences and the role of dreams in therapy. The excerpt below encapsulates core concepts present in the data at two different levels:

> *you're showing some part of yourself that you don't understand to somebody else and that's a risky thing to do, so you need that kind of safe environment that you get with a good therapeutic alliance (interview 12)*

Firstly, this excerpt is taken from a participant's interpretation of their clients' experience of dream sharing as a vulnerable, revealing, and risky activity that requires a safe therapeutic relationship. The connection between sharing dreams and vulnerability is attributed to the belief that some people hold about dream imagery being symbolic. This suggests that dreamers take the risk of revealing more about themselves than intended or perhaps realised when they choose to share a dream.

This excerpt also echoes the researchers' interpretation of the participants' experiences in their interviews for this study. The importance of safety and rapport also applied to the interactions between the interviewer and the psychologist participants during their interviews for this study. These participants generously and trustingly took a risk, making themselves vulnerable by discussing their personal and professional experiences, concerns and sense-making, potentially revealing more about themselves and their everyday practice than intended in the surface level comments they offered about working with dreams.

4.3 Triple hermeneutics and transparency around influences

In the second chapter of the thesis, I introduced the concept of hermeneutics in some detail. This included the 'double hermeneutics' assumption of IPA, wherein it is recognised that participants' accounts of an experience are their interpretation of their experiences (rather than a pure, objective description), and then researchers interpret the participants' accounts through the lenses of their own personal experiences, values, and knowledge of research and theory (Smith et al., 2009). I also discussed the concept of the triple hermeneutic wherein readers of this thesis will, in turn, interpret the research findings through the lenses of their own personal experiences, values, and knowledge of research and theory.

Of note, the concept of multi-level hermeneutics aligns well with a similar concept in some dream theories, such as Freud's concept of 'secondary revision' (Freud, 2010) or

secondary elaboration. Similar to a first level of hermeneutics or interpretation, Freud (2010) differentiated between the literal dream content (which he referred to as manifest content) and the latent content of dreams, which is the underlying meaning or the symbolic content of a dream. He then introduced an additional level of interpretation, called secondary revision, which occurs when a dreamer attempts to translate a dream experience into a verbal narrative (Freud, 2010). This process by its very nature, requires the dreamer to apply a degree of interpretation, such as fudging inconsistencies, summarising or editing some details, while emphasising others, to create a verbal narrative that makes sense to the listener. These concepts create a neat link between dream sharing in therapy and the IPA methodology used in this research project.

A third idea I discussed in Chapter 2 was the use of triangulation strategies to improve trustworthiness, such as the use of multiple sources of data, or the use of multiple theoretical lenses to interpret the data (Leavy, 2017). Acknowledging the triple hermeneutic assumption for readers of this thesis, and noting my use of triangulation strategies, the following information is provided for readers to increase transparency and trustworthiness of the analysis.

4.3.1 Boundaries

One of the key concepts emerging from the data and the influences discussed below is *boundaries*. Many sociological approaches have conceptualised professionals as a collective group (Hotho, 2008), for example describing psychology's or psychologists' position on a particular topic or question as if they were a unified group. That group approach to professional identity is used when discussing boundaries, with the areas of knowledge that are sufficiently connected with a profession either being claimed or rejected by that profession at any given time. Boundaries are understood to change over time as trends come and go, or as new areas of knowledge emerge or are superseded. This means that a particular skill or topic might be seen as belonging to that profession, or

falling within the boundaries of that profession at one stage, but then falling outside the boundaries of that profession during another point in time.

Hotho (2008) disagreed with certain aspects of those earlier sociological approaches, arguing that individuals within a profession are not necessarily all the same or aligned with the collective group identity of a particular profession. This could mean that a particular treatment, like the use of leeches by doctors during one era in the UK, might have been seen as falling within the boundary of medicine and been seen as standard practice for UK doctors during that era. But, during that same era in the UK there may have been a few doctors who did not use leeches to treat those same conditions, instead choosing to use other interventions.

The influences of these ideas on my thinking were threefold. Firstly, I concluded that topics could change their location in relation to the boundary of a profession, across time and place. This connected with the sensitivity to context issues that Smith et al. (2009) identify as important in IPA work (see my discussion in Chapter 2). This means that my findings may be different to someone researching the same topic in a different time or place. Secondly, there were a number of patterns in the data reminiscent of the reading I was doing around boundaries. One example of this was the tensions between the presence and absence of dreams and dream work in the interview transcripts. There were also other boundary characteristics that participants spoke about such as receiving limited dream training for psychologists and differing opinions between psychologists and lay people or clients about whether dreams do or should belong within psychological practice. Thirdly, the idea that Hotho (2008) raised of distinguishing between individuals and the collective profession's identity appeared highly relevant to the accounts discussed by the psychologists participating in the interviews.

4.3.2 Liminality

Following on from the anthropological literature I had begun to delve into with my earlier reading of Mauss and his work around gifts and social exchanges, during this period of data analysis I began to read into ideas like liminality and rites of passage.

Turner (1967) described three phases from Van Gennep's (1960) *Rites de passage*. The first phase is *separation* or detachment from a set of cultural conditions or social structure. The second is *limen*, the liminal period of ambiguity without attributes of either the past of future state. The third is referred to as *aggregation*, a new stable state in which there are clearly defined rights and obligations, norms, and standards.

Similar to the work that was begun in a paper by Silber (2018), I began to make connections between the Gift theory work by Mauss (1970) and Van Gennep's (1960) *Rites de passage*. Of particular interest was that some of the participants' comments appeared to support the notion that a sense of liminality was present in the exchange of a shared dream from a client, and the response from a therapist. This appeared to be even more evident in the client participant data (presented in Chapter 5). However, the psychologist participant data alone, still suggested that the mere introduction of dreams into therapy was sufficient to force psychologists into a liminal space, aligning with Turner's (1967) descriptions in his work *Betwixt and between: The liminal period in Rites de passage*, due to dreams falling on the boundary of psychological practice.

This led me to consider how the boundary location of dreams forces psychologists to leave pre-determined 'manualised' scripts and familiar evidence bases, as there are none available for working with dreams. Issues of credibility and identity are called into question for the psychologists as they are forced to respond to something (dreams) outside their usual experience and the accepted, scripted norms for their profession. This is a taboo and silenced space, in which dream work occurs but is not spoken about, neither being acknowledged publicly with colleagues nor in training. Once psychologists make a

decision to privilege particular influences on their practice over others and, in doing so, decide whether to initiate, respond to or reject dream sharing and dream work, they generally enter a more stable and structured state again. This can manifest in multiple ways. For some it is in retreating to safer, pre-existing scripts (technician approach) such as working through imagery rehearsal therapy (IRT), rescripting instructions for a recurring nightmare, or referring the client on and explaining to them that dream work falls outside the scope of the programme they have been referred through or outside their theoretical orientation or training. For others it is integrating dream work into their practice and the multiple influences on it in a way that they feel a little more comfortable with, but that may vary considerably between any two psychologists (clinician approach).

While these responses generally reduce or resolve the discomfort of the liminal experience, some remain in the limen phase. Turner (1967) explains that we can only see categories that we have been taught to see and that those in these phases of betwixt and between are structurally invisible and denied membership or belonging to a group. Turner relates this to the work of Douglas who observed that things that are not categorised as being seen are considered ritually unclean so that cherished principles and categories are protected from contradictions (Douglas, 1966). This can make dreams a very threatening and uncomfortable phenomenon for many psychologists. It brings challenges for the psychologist community with its silencing or taboo around dreams, as bringing dreams into the open may force psychologists to respond to them and categorise them as belonging or not belonging to psychology to end the ambiguity.

4.3.3 CHAT

The influence of liminality on my interpretation of the data was filtered through the Cultural-historical activity theory (CHAT) readings that I engaged with during that period. CHAT provides a framework through which human activity systems can be analysed within their historical and cultural context (Roth & Lee, 2007). The record of using CHAT with data

from real-world, complex learning environments to augment understandings of how individuals, activities and context influence one another (Yamagata-Lynch, 2010) made it an ideal methodology to apply to the current examination of psychologists and dream work in the context of contemporary Australian psychology. Additionally, CHAT analyses can provide thick descriptions that assist readers to attain a participant perspective through the sharing of participant experiences, including interview data and rich contextual information (Yamagata-Lynch, 2010). This is consistent with the phenomenological approach taken in this project in that it allows for participants' voices to be heard.

The development of CHAT has been divided into three generations. The first generation of CHAT refers to Vygotsky's (1978) original work centred around the idea of mediated action or that idea that interactions between individual subjects and objects are culturally mediated through the use of tools and signs. CHAT was a reaction to the early behaviourist movement stemming from Pavlov's (Gantt, 2022) work. Some Russian psychologists had seen Pavlov's work as a way to help psychology gain credibility as a scientific field that embraced hypothesis testing in controlled environments and distanced psychology from the earlier, more introspective methods that were perceived by some to as more pseudo-scientific (Yamagata-Lynch, 2010). The second generation of CHAT is associated with Leont'ev (1978). This generation of CHAT saw a shift from Vygotsky's focus on the individual to a focus on the collective nature of human activity positioning activity as a system and requiring an analysis of relevant *rules*, *tools*, the *subject* and *object* of the activity, the *divisions of labour*, and the *communities of practice* around the activity. A third generation of CHAT, associated with Engeström (2000), is sometimes referred to as *activity systems analysis*. This further development of CHAT made possible the analysis of multiple, interacting activity systems, examining the changing interaction and multi-directional influences between individuals or groups and environments.

The influence of CHAT on the data analysis in this chapter came particularly from the considering the data in relation to eight questions developed by Mwanza (2002), emerging

from the third generation of CHAT. Toth-Cohen (2008) provided clarification of how questions, such as those developed by Mwanza (2002), could be applied in an allied health setting. Yamagata-Lynch's (2010) work has also influenced the way in which the data in the current study have been analysed, with its focus on the systemic contradictions that are bringing tensions into an activity, the historical relationship one activity has with another and how one activity interacts with another. When considering the data from the perspective of the eight questions developed by Mwanza (2002), the process identifies where tensions are located within the activity system, compatible with the IPA approach of examining divergences in addition to convergences. For the benefit of readers, these eight questions developed by Mwanza (2002) are included below:

1. Activity: What sort of activity am I interested in?
2. Objective: Why is this activity taking place?
3. Outcome: What is the desired outcome from this activity?
4. Subjects: Who is involved in carrying out this activity?
5. Tools: By what means are the subjects carrying out this activity?
6. Rules and regulations: Are there any cultural norms, rules and regulations governing the performance of this activity?
7. Divisions of labour: Who is responsible for what, when carrying out this activity and how are the roles organised?
8. Community: What is the environment in which the activity is carried out?

The conceptualisation of dream work as overlapping activity systems appeared to work well as a model for understanding both psychologist and client participants' experiences and explanations. Also, the idea that dreams were on the edge or boundary of psychological practice aligned with the concept of tensions within divisions of labour, which in turn linked back to the ideas from readings in the area of liminality.

These readings led to exploration of literature in the areas of higher education and training, professional and personal identities, epistemic fluency, complexity theory and associated tools. These additional influences are discussed in detail later in this chapter.

4.4 Coding and the identification of themes

This final note about the following findings focusses on another aspect of the data analysis. Many excerpts had multiple codes applied during the coding process. This is typical in IPA research, which takes an iterative and multi-layered to analysis. It indicates that comments contain multiple levels of meaning. For example, one comment focussed on the importance of the therapeutic alliance and safety for dream sharing. This comment was also coded for its reference back to an earlier comment that the participant had made about dreams being meaningful and revealing, which explained why the participant saw the therapeutic relationship as being important for a client to be willing to share their dream. Appendix H contains a screenshot of another instance where multiple codes were applied to a comment in Dedoose. The application of multiple codes for so many comments within the transcripts was further evidence of the complexity of working with dreams and of psychological practice in general and contributed to the emergence of complexity as an explanatory theory in the discussion section of this chapter.

4.5 Findings from study one

Note: Medicare Better Access initiative refers to an Australian government funded programme, which provides rebates for eligible people to access eligible mental health services, via Medicare, Australia's universal health insurance scheme (Australian Government, 2022)

4.6 Summary of findings

Sixteen Australian psychologist participants completed semi-structured interviews via video call as a part of an Interpretative Phenomenological Analysis (IPA) study interested in the following two questions:

1. How do psychologists understand their lived experiences of dream work in psychotherapeutic settings?
2. How do psychologists make sense of the role of dreams in Australian psychological practice?

In summary, the findings reveal considerable diversity in psychologists' experiences of dreams in psychological practice. The amount of dream work and the ways dreams are used vary across jobs and between participants. Dreams were seen to play a valued role in therapy by some, but not all participants. Generally dreams were associated with a sense of disquiet, even if this was only at a professional, public level, rather than at an individual client-interaction level. Some participants described feeling that they lack the confidence and competence to respond appropriately to dreams themselves, while others identified it in other psychologists they knew or in the profession as a whole. Looking at the data as a whole, dreams appear to have a boundary role in contemporary Australian psychological practice, with individual participants' perceptions of their actual or preferred role (these two sometimes differing) varying among participants.

As shown in Table 4.1, four superordinate themes were identified in this study, each contain a number of subthemes. The superordinate themes have been characterised as participants' perceptions of an underlying *Sense of disquiet around dreams*, which were seen as having a number of *Boundary characteristics,* locating them on the edge or boundary of psychological practice. The participants attributed their diverse experiences and varied choices around dream work to a lack of consistent formal training, professional conversations or widely agreed upon scripts. This lack of scripts, in turn, required

psychologists to negotiate the *Multiple influences on practice* when choosing how to view and respond to dreams. The data support previous assertions around the influence of a host of historical socio-cultural and political factors on whether dreams are deemed to be relevant to psychological practice (Leonard & Dawson, 2018). These include theoretical trends, the context in which psychological practice occurs, and the influence of regulation, including policy makers and funders. Also consistent with the pre-existing literature (Carcione et al., 2021; Lempen & Midgley, 2006), the *Importance of the therapeutic relationship* was evident in the participants' decision-making or comments about working with dreams and/or about psychological practice in general.

These themes encapsulate the *why* (sense-making) around *what* psychologists think, do and feel in relation to dreams in contemporary Australian psychological practice. They give insight into the challenges that dreams can create for participants as they seek to be *good psychologists* in their everyday practice. The superordinate themes, and a brief summary of each subtheme within them, are presented in Table 4.1, along with a list of the interview transcripts in which they were present. All themes met the criteria set in the method (see Chapter 2). That is, each theme was present in all transcripts and so qualified as a superordinate theme. They were also present in at least half (eight) of the transcripts, qualifying as a subtheme. After the table, an examination of each theme and examples of it in the data are presented in order, with each set of findings connected back to previous research findings, for triangulation purposes (see Chapter 2 for a more detailed explanation of triangulation strategies).

Table 4.1
Summary of Themes

Superordinate Themes	Subtheme Summaries	**Incidence** (X indicates presence of a theme in each of the sixteen transcripts)															
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Boundary Characteristics	Diversity in the incidence of dream work (tensions between presence and absence)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Training about dreams largely absent in psychology	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Idea that some in society may see dreams as belonging within psychological practice	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	No unified script for how to respond to dreams results in idiosyncratic and diverse responses to dreams [all participants provided examples of various uses/approaches, X's in following columns indicate explicit comments about this theme]	X		X	X			X	X	X		X					X
Multiple Influences on Practice	Theoretical orientation and theoretical trends	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Job and programme/service parameters	X	X	X	X	X			X		X		X	X	X	X	X
	Governance and governmentality issues	X	X	X		X		X	X	X	X	X	X	X	X	X	X
	Client influences and assumptions about clients	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Psychologist dream beliefs and experiences	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Importance of the Therapeutic Relationship	Therapeutic relationship valued as core to psychological therapy and/or important for dream work, often due to underlying assumptions like dreaming can be revealing, meaningful or taboo, so can require, indicate, or be used to strengthen the level of the therapeutic relationship	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sense of Disquiet Around Dreams	Learning disquiet: dreams as taboo	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Credibility: science vs woo woo	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
	Ethical disquiet: dreams are dangerous and raise many ethical issues	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
	Life and clinical experience as mediators of disquiet	X	X		X	X	X	X		X		X	X	X		X	X
	Clinician versus technician approach to psychological practice as mediator of discomfort, including imposter syndrome, in the pursuit of being a good psychologist (explicitly discussed or examples of technical vs clinician approaches described)	X	X		X	X		X	X	X	X	X	X		X	X	X

4.6.1 Dreams are a boundary topic

The first superordinate theme of *Boundary characteristics* focussed on some of the characteristics of dreams and dream work, identified by participants, that are consistent with dreams being an example of an area of knowledge on the boundary or edges of psychological practice. According to Hotho (2008), sociological approaches tend to see professionals as a collective group with the boundaries of any one profession constantly changing as areas of knowledge closely enough associated with that profession are either rejected or claimed by that profession. Something may therefore fall within the boundary of a profession at one point in time but not at another. Hotho (2008) argued though that individuals within a profession are not always aligned with a single profession identity.

The interview data supports both ideas. Firstly, the data supports the idea that dreams are located on the boundary of psychological practice due to historico-cultural reasons. This supports the first idea that a particular area of knowledge closely enough associated with a profession, may be claimed or rejected by that profession at any given time. Secondly, tensions between individuals' and the collective profession's positions on dreams were evident in the data, supporting Hotho's (2008) idea that individual professionals' positions on a topic may vary from their collective profession's position. Evidence of dreams being a boundary topic for psychology include tensions between the absence of dreams in the core psychology curriculum and society's perception that dreams belong in therapy, and tensions between the presence and absence of dreams in psychological practice in terms of varying incidence of dream work, with dream work being initiated or rejected sometimes by the client and sometimes by the psychologist. The idiosyncratic and diverse approaches to working with dreams also reflected what several participants described as the absence of a widely agreed upon script for how to respond to shared dreams; further evidence that dreams fall on the boundary of psychological practice.

4.6.1.1 Diversity in the incidence of dream work

Variation in the incidence of dream work amongst participants shows that dreams are at times considered to fall within the boundaries of the profession by some psychologists, but not by others. At one end of the spectrum were the following two participants:

> *So clients will mention dreams quite a lot. Look I'd probably say at least four or five times a week I'd have someone mention their dreams and their experiences (interview 14)*

> *probably 25% of them I guess. But I don't keep those statistics (interview 1)*

At the other end of the spectrum, some psychologists and clients avoid or reject dreams as belonging in psychological practice, rarely or never working with them and explaining they would refer clients on if they wished to engage in dream work:

> *To be honest I cannot recall a single occasion where dream interpretation has been applied within the therapies that I've delivered (interview 10)*

Despite the apparent absence of dreams from his practice, the same participant did differentiate between working with dreams and nightmares. At other points in the interview he described his biological- and CBT-oriented approach to working clients who have experienced trauma-related nightmares, which he differentiated from working with dreams. He explained:

> *Certainly dreams or nightmares in the context of trauma has come up, but that's seen as something that you want to change or minimise rather than tap into and talk about (interview 10)*

This differentiation between dreams and nightmares is discussed later in relation to understandings of valid or relevant material for therapy (see the section about client influences and assumptions).

All participants believed that it was likely that some clients might share their experience of a dream or nightmare with their psychologist even if this was a rare occurrence. This is consistent with previous therapist surveys in which many therapists report that while they at least occasionally encounter clients' dreams in their work, they do not appear to be an everyday, core component of their work (Crook & Hill, 2003; Fox, 2001; Huermann et al., 2009; Keller et al., 1995; Schredl et al., 2000).

4.6.1.2 Training, competence and confidence

The following responses to the question about whether the participants had received any formal training on dreams during their university studies were typical of the broader group:

> *No, not whatsoever (interview 15)*
>
> *Around dreams, not that I can remember. We did do a little bit around nightmares but that was in the context of PTSD symptoms (interview 14)*

Participants located dreams on the boundary of psychological practice by pointing to dreaming being largely (but not completely) absent in the core psychology curriculum, and to psychologists' lack of competence and confidence around dream work:

> *I think it's just an area that maybe a lot of psychologists don't feel comfortable exploring because they just don't have that experience or training behind them (interview 5)*

These findings were consistent with previous research (Crook & Hill, 2003; Fox, 2001; Freeman & White, 2002; Keller et al., 1995; Lempen & Midgley, 2006; Pesant & Zadra, 2004; Schredl et al., 2000) and are discussed later in the paper in relation to the sense of disquiet and discomfort around dreams.

4.6.1.3 Society's location of dreams within psychological practice

While participants did not all agree that psychologists see dreams as definitely falling within the bounds of psychological practice, all believed that broader society did or at least

were aware of there being a stereotype about dreams being a part of therapy. This supports previous findings that many in Western society have come to see dreams as falling within the realm of psychology or psychotherapy (Dombeck, 1991; Hughes, 2000; Nell, 2014; Schredl, 2011; Tedlock, 1987). Some participants suggested that this could result from society's belief that psychologists receive training in dream work. For example, the fifth participant described there being a perception that Freud, Adler and Jung were connected with both psychology and dreams, adding that clients seek psychologists' opinions about dreams as they are considered to be trained dream experts:

> *they wouldn't approach a mechanic about their dreams because a mechanic hasn't had that sort of training…it's about getting that validation from someone [a psychologist] they perceive to be a professional who would have skills in that [dreams] (interview 5)*

When making sense of the perception that dreams belong within the realm of psychology, some participants offered more than one explanation. For two of those participants who offered multiple explanations (interview 11 and 12), their first explanation related to the idea that there was a disconnect between the *pop culture* view of psychologists as Freudian psychoanalysts and the realities of typical contemporary psychological practice:

> *all of the movies and tv shows in the past that have depicted psychology have had people lying on a couch talking about their dreams in a very kind of Freudian way. So I would imagine that that may have something to do with maybe a generational thing about actually understanding what psychology is and what we do perhaps? (interview 11)*

The twelfth participant's alternative explanation for why some people may see dreams as falling within the realm of psychological practice focussed back on other aspects of therapy:

> *[psychotherapy] is a place where I can talk about whatever I want, including those strange experiences I have while I'm asleep and can I*

> *find some meaning about that or can this space be useful for me to understand myself better (interview 12)*

4.6.1.4 No script results in idiosyncratic responses to dreams

Within the CBT-dominant context of Western psychological practice, CBT has been seen to privilege technical adherence to a replicable, manualised script (Noble & Rizq, 2020). However, participants' views of dream work were consistent with the description by Schön (1987) that there is no pre-existing script or technical solution or procedure for responding to areas of knowledge on the boundaries of a profession:

> *I think it's the lack of training, the lack of a unified approach whereas other things have that protocol that most people would generally follow (interview 6)*

The absence of an agreed upon approach was seen to result in a lack of readily available resources or manuals for psychologists to use when working with dreams:

> *there's a multitude of handouts that you can use in CBT and ACT as well. There aren't a multitude of handouts you can use in dream therapy. Not that I use handouts, but you know what I mean, there's all those resources out there that you can look at and you can implement in therapy be it CBT and ACT perspectives, versus dreams in therapy (interview 5)*

This results in diversity in psychologist dream beliefs and ways in which dreams are used in clinical practice. Several participants spoke about clients using dream sharing as a way to talk about hard stuff, whether it be difficult to articulate or due to distress levels, embarrassment or shame associated with the topic. Using dreams as a part of the diagnostic process was also mentioned, like asking about nightmares when assessing PTSD. Other participants used re-storying, rescripting, EMDR, or grounding exercises to reduce the intensity, frequency or impact of nightmares on a client or provided psycho-education around dreams and nightmares.

Consistent with empirically supported uses for dreams (see Eudell-Simmons & Hilsenroth, 2005), thirteen participants spoke about using dreams as a source of clinical information, for example:

> *this [dream] says something about our relationship, this says something about our process and trauma (interview 4)*

Ten participants mentioned using a client sharing a dream as an opportunity to provide validation or to normalise clients' experiences and fourteen spoke about using dreams to increase insight. For example, one participant who identified as a constructionist psychologist said:

> *Dreams help us make meaning, understand ourselves, what's happening in our life and how we're reacting. And yeah, I think that's quite a helpful and validating sort of thing to get that (interview 1)*

The excerpt below also discusses the value that one of the participants sees in another use of dreams (for gaining insight), that fourteen of the participants spoke about:

> *it's important because it can be a real turning point for clients. As I said earlier, that first experience I had, it was a real sort of lightbulb moment, just sort of realizing what this dream could potentially mean and the client (interview 5)*

4.6.2 Multiple influences on practice

The second superordinate theme focussed on the *Multiple influences on practice*. Due to the absence of a unified approach and pre-existing script, responses to boundary topics like dreams require psychologists to privilege particular influences, values, or aspects of their identities, over others. In this respect, participants' negotiation of the multiple, often conflicting influences on their dream work reflected the complexity of their everyday practice. The importance of historico-cultural context was also evident in discussions around the changing role of dreams in psychology.

4.6.2.1 Theoretical orientation and trends

The data was consistent with the literature that identified theoretical orientation as a potential influence on therapists' dream work with CBT-based dream work techniques seldom being used (Freeman & White, 2002; Montangero, 2009) and CBT training rarely including dreams (Freeman & White, 2002). Rigid adherence to a particular theoretical orientation was offered as an explanation for why some psychologists may not work with dreams while others felt they could be incorporated into any model of therapy. CBT was the most common theoretical orientation among the participants and consistent with the literature (Hill, 1996b; Rosner, 1997), dreams were frequently associated with non-CBT, psychoanalytic theoretical orientations and names like Freud and Jung, as can be seen in the following two excerpts:

> *mostly dreams in psychology are used by psychoanalysts and people who do psychodynamic type therapies (interview 8)*

> *perhaps if anything I'm a little, well in fact I'd be very hesitant to utilise dream interpretation and to place a lot of emphasis on dreams and as I've alluded to in my kind of 'bio' [biological] background, I come from a cognitive behavioural, more of a biological model than a neo-Freudian approach (interview 10)*

Psychology has seen particular theoretical models of practice being more or less popular at particular times than others (see Robins et al., 1999). This idea of theoretical trends was offered by participants as one explanation for why dreams do not currently have a larger role in Australian psychology compared with other times in history:

> *Psychology, like every other discipline seems to go in phases and fads. In the 1970's Psychology was working hard to convince itself that it was a hard science and dreams just were too hard to research in that way.....and there was a reaction to all things Freudian (interview 1)*

These changes over time were also associated with there being a desire for psychology to be seen as a medical profession embracing Medicare funding and the medical model (interview 14) and as a scientific discipline:

> *It's all about CBT and facts and more scientific, so I suppose being Freudian, psychodynamic is not considered to be scientific (interview 3)*

Psychology's desire for credibility manifesting in a desire to be accepted as a *real science* and fall within the medical, or at least allied health fields, was seen to have contributed to some psychologists' adopting a narrowing definition of evidence in their interpretation of EBP (equated to acceptable practice) that affected views of dream work:

> *the research, doing kind of the randomised control, double-blind studies seems to be the strongest and you know and…you look at that gold standard for the Cochrane studies and that seems to pull the most weight. (interview 10)*

This finding aligns with the American experience as described by Dombeck (1991). Her research found that the hierarchy of mystical capacity (expectation that a practitioner can know human nature, analyse what people are thinking, read their minds, and interpret dreams), and the hierarchy of entitlement and responsibility to care for people's biological needs, resulted in participants feeling uncomfortable about being put in the same category as people with only a mystical capacity. In that system the biological and physical aspects of medical care were the most valued components of Western medicine. Due to this, the psychiatrists, as qualified physicians, were seen as higher on both capacities and more closely aligned to what she described as being seen as a *real* doctor than the psychologists or social workers.

4.6.2.2 Jobs

Situational dimensions, or the context in which psychologists worked and the client group with whom they worked, were identified as one of the dimensions that made up the

professional identity of counselling psychologists in a study by Verling (2014) and can be seen in the current data. Twelve of the participants made reference to the influence of a psychologist's job context on working with dreams. For example, when asked about contraindications for dream work, one participant explained her job impacted dream work:

> *my role at community health, we still have guidelines on who and can't access our service. So that limits who I see more than anything (interview 12)*

Income influenced psychologists' choices around dreams, whether they were employed and restricted by their employer's conditions or self-employed and reliant on various referral pathways for income. Many sources of income for contemporary psychologists in Australia, such as EAP work (Kirk, 2003), drug rehabilitation programmes, Medicare, and other government funded programmes, have stringent session and content restrictions. The influence of time constraints on dream work appeared to be consistent with previous research that found some therapists assume dream work requires long term therapy (Hill, 1996a; Widen, 2000):

> *I guess it's about, for me, balancing that with time constraints. […] because I work in private practice, you've got ten sessions with the Medicare rebate (interview 14)*

Similarly, a participant for whom EAP work was their primary source of referrals, explained that she saw the short term nature of her work as a contraindication for working with dreams:

> *it might not be appropriate with clients I was only seeing for very short term, so some clients I might only have three sessions with. I don't know? Maybe I'm thinking is it going to open a can of worms that we don't have time to deal with in our small, short amount of sessions? (interview 13)*

4.6.2.3 Governance and governmentality

Psychologists train and practice within a wider historico-cultural, political, and economic context, which for the past several decades has meant being subject to neoliberal influences (Keast, 2020; LaMarre et al., 2019; Sugarman, 2015; Thomas, 2016). In places like the UK, short-term, manualised, often CBT-oriented protocols that minimise costs are privileged over other approaches (Noble & Rizq, 2020). Greater levels of state regulation and top-down policy prescription requiring professionals to meet proxy measures of competence, encourage professionals to meet the requirements of performativity rather than defer to their professional judgement (Osgood, 2006). Foucault's work on governmentality suggests that such influences can result in self-regulation by professions to adhere to these norms (LaMarre et al., 2019; Thomas, 2016). Psychology is not exempt from this.

The development of an identity for psychology that includes the promotion of particular therapeutic models like CBT, narrow interpretations of EBP, and definitions of success that align with the government's agenda have been portrayed as having made a positive contribution to the profession's success in lobbying for further funding from the government. This can be seen in references to APS's advocacy for Australian government funding of the Medicare Better Access initiative on the basis of psychology offering efficient, effective, cost-effective, evidence-based interventions (see Littlefield, 2014). One participant noted that unlike other psychologists who will not step outside Medicare approved focussed psychological strategies, she practises according to what the client in front of her needs. She added:

> *Medicare's had a big influence and if Medicare's all about CBT and GP's are trained in only CBT for example and that's all they think exists in the therapy world then again it's like dreams just don't have a place in there (interview 15)*

Another participant referred to the controversial two tiered funding model for Medicare counselling services in her response to being asked about her use of the term credibility and who decides what is credible in Australian psychology:

> *if you're paid for by Medicare, it's credible. So they pay for psychologists, they pay more for clinical psychologists, so they're more credible. […] Who decides what's credible? Maybe the universities and institutions that do all the research. Not the clients […] same as anything else in society, the big organizations that have the money, the government (interview 3)*

Legislative requirements for registration and regulation of the training have increased the status of the psychology profession (Smith & Lancaster, 2002). Many participants alluded to governance influences on psychological practice and dreams in Australia including funders, policies, AHPRA's compulsory registration process which is also influenced by the APS and the Australian Psychology Accreditation Council's (APAC) psychology course accreditation. Moreover, dreams were not seen to be important to the dominant professional association, the APS, which promotes and advocates on the behalf of psychologists and the profession and is a major provider of accredited professional development workshops and conferences for practising psychologists. The interconnected influences of funded programmes, regulation of registration and curriculums, and performativity requirements in academia was seen to produce a self-reinforcing bias where CBT gets funding because it is already proven:

> *a lot of people who are exploring cognitive behavioural therapy get funding because it's also proven kind of thing. It's already in place, so therefore there's more research about how effective cognitive behavioural therapy is, so there's a reinforcing bias even there (interview 10)*

4.6.2.4 Client influences and assumptions

All of the participants spoke about the influence that their clients have on their practice around dreams. They explained this through references to client-centred or collaborative models of therapy or endorsing the view that psychologists should consider client preferences. When asked how they determined whether a dream was relevant to therapy, what constituted valid material for therapy, or who held the authority for the meaning of a dream, very few privileged their professional opinion over the client's input.

The majority of participants described privileging client-centred or collaborative views around determining what constituted valid material for therapy:

> *in terms of therapy, well I guess what I said, if they're bringing it up [a dream] then it's relevant for them (interview 13)*

An exception to this can be seen in the excerpt below, in which the participant was influenced more by their professional opinion than their client's opinion when it came to determining what was valid material or what was important to focus on during sessions:

> *if it's something that then has ongoing impact on them, then I think that's relevant (interview 6)*

The above comment may reflect the emphasis that some psychologists place on a more medical model or pathology-focussed view of therapy wherein the only material seen as relevant to therapy is that which is related to symptoms or distress. A similar distress-focussed view of therapy was evident in some participants' division of dreams into various categories or subtypes, some of which were not seen as relevant nor valid material for therapy. For example, as discussed earlier in relation to the incidence of dream work, one participant differentiated between nightmares, which he sought to change or minimise for his clients, and dreams, which he described as pleasant. He noted that working with dreams is:

> *not something I guess that psychologists would see as their primary role. Our primary role is to help people who are in distress (interview 10)*

Like the aforementioned participant, some others also differentiated between dreams and nightmares. While their definitions varied, nightmares were generally associated with waking life trauma or differentiated from dreams according to the intensity of negative feelings associated with the experience. It did not always follow though that all psychologists would see nightmares as more relevant to therapy than other dreams and some participants also identified different subtypes of dreams, such as meaningful or significant dreams and meaningless dreams. For example, one participant identified three subtypes of dreams and observed that:

> *I find it interesting that psychoanalytic therapy sees all dreams as being type 2 – expression of subconscious, while 'modern' therapies tend towards type 1 explanations [physiological, neural network clean-up process] while entirely accepting that type 3 dreams [PTSD dreams] have clinical validity as a symptom of trauma (interview 2)*

Other participants saw all experiences of nightmares and dreams as:

> *the one kind of phenomenon. It just depends on what happens that day, if that makes sense? So depending on what your dream or your nightmare is based on what you've experienced that day (interview 14)*

Conceptualising dreams as a single phenomenon obviously prevented these participants from using dream subtype as a means of identifying valid or relevant material for therapy.

The client influence or valuing of the client's beliefs were also evident in discussions around potential meanings of dreams. For example, when asked who determines the connections between dream imagery and meanings, one participant responded:

> *the client's view is predominate and how they understand it and how they think. Because it's their dream and their perspective (interview 4)*

Based mostly on prior experience, participants assumed that certain client groups were more likely to be interested in dream work than others. These included clients experiencing trauma and nightmares, grief and loss (interview 15) and those with *'more extreme mental health conditions*' (interview 13). One participant identified four client groups he has worked with around dreams: young people with nightmares within the developmental norm, young adults with histories of trauma, clients with drug and alcohol issues, and clients in general therapy who introduced dreams like casual conversation (interview 4).

Several participants spoke about the capacity of particular client groups to engage in dream work, citing the ability to use signs, symbols and understand metaphors. One thought people who are '*incredibly pragmatic people, black and white people with a limited emotional range*' (interview 8) were likely to struggle with dream work. Consistent with previous findings (Dombeck, 1991) another participant believed the decision to do dream work with a client '*would be dependent on their level of functional capacity*' (interview 3):

> *if I deemed them as quite unwell, I'm certainly not going to add something else into the mix, because these people are just barely surviving, they're just you know. I've got to think about getting them out of bed and having breakfast and going for a walk and washing some dishes and getting through the day without something major occurring or managing whatever is occurring. Whereas people I'll readily dive in, these people are a lot better. They are far more well, and they are open and they have the cognitive capacity to deal with that sort of stuff (interview 3)*

For some participants the interest in dream work was linked to other characteristics, such as spiritual and cultural beliefs or sociodemographic data such as class and occupation. Some thought more city clients were interested in dream work than practical, rural clients:

> *to my way of thinking, there'd be a strong resistance to dreams and dream interpretation in rural, regional Australia (interview 10)*

while others thought city clients were more likely to hold scientific and secular views and therefore be less interested in dreams than spiritual, rural clients:

> *I would say I have noticed that in a rural area that people do tend to talk more about dreams and I think probably place more emphasis or focus on them. So for example I've had more clients talk about seeing psychics or those kind of people in a rural kind of area than I have had in a city kind of area. And I guess that kind of translates to people talking about their dreams as well and what they feel the content of their dreams is and their purpose (interview 14)*

4.6.2.5 Dream beliefs

Participants responded to their clients' dream beliefs in different ways. One participant (in interview 15) described getting curious about her client's cultural beliefs, understanding them and integrating them into her practice with them as the way she manages the influence of this ethical issue on her practice in relation to any topic. One participant spoke about her privilege, education level and beliefs in contrast to some of her clients' and her desire to be ethical and respect her clients' beliefs and understand where they are coming from rather than imposing her own beliefs on them:

> *so you just have to be really careful about trying not putting upon them what you think about things, but more kind of my role I guess is to understand where they come from and how their pathology fits in that and drawing a line between correcting things that you shouldn't be correcting because then that's a breach on their kind of human rights or respect, or it's unethical (interview 9)*

Ideas about dreams are influenced by language, social values and cultural symbolism, with therapists influenced by popular cultural beliefs about dreams, although often unaware of such influences (Dombeck, 1994). Australia as a whole was seen to be disinterested in dreams:

> *I don't know this for a fact, but I'm assuming that some cultures place more emphasis on dreams, so perhaps in some cultures it's more an accepted part of what we do, you know how we interpret thing [than in Australia] (interview 13)*

Despite this the participants held as diverse dream beliefs as their clients. They ranged from dreams being seen as interesting and meaningful through to one participant describing herself as a '*science sort of thinker*' who does not see dreams as significant or important (interview 9). While all the participants thought that psychologists' dream work practices were influenced by their personal and professional dream beliefs, experiences or interest levels, views varied on how this manifested. In relation to connections between the personal and professional, one participant said '*I think my personal view of dreams is my clinical view of dreams*' (interview 1). Another explained: '*I have my own personal feelings and thoughts about it but I don't bring that into session*' (interview 3). Another, unsure what influence her personal beliefs had on her professional approach to dreams, explained her wariness of any connections in a way that connects the role of multiple influences and discomfort in dream work:

> *Maybe the reason I'm a little bit ambivalent about them is because that's a more comfortable, safe place for me to be. Because if they're meaningful, then why are mine always so horrible? <<laugh>> (interview 7)*

4.6.3 The importance of the therapeutic relationship

The influence of the therapeutic alliance was pervasive throughout the interviews. Participants described it as being core to dream work, to psychological practice, or to their professional identity. Thus, rather than locating it as just another influence on practice, I positioned it as an extra superordinate theme. The therapeutic relationship was seen as core to being a *good psychologist*. Participants saw the therapy room as a safe space with legal and ethical requirements to maintain confidentiality within the therapeutic relationship (APS, 2007). They included rapport, safety, a sense of respect, non-judgement, validation,

and empathy in their understanding of the therapeutic relationship, which was privileged over other influences on practice. Participants echoed the view expressed in Noble and Rizq (2020) that the therapeutic relationship has been incorporated into all models of psychotherapy and is considered a sound indicator of therapeutic outcomes:

> *we recognise with things in psychotherapy, the common factors, things like therapeutic alliance are in fact most powerful predictors of positive outcomes regardless of the sort of therapy that one does (interview 10)*

Participants also differentiated between the therapeutic relationship between a therapist and client and other types of relationships in society, as an explanation for why clients may choose to share dreams in therapy that they might not share elsewhere.

Some participants used dream sharing as clinical information about the current state of the therapeutic alliance, emphasising the value of validation. Consistent with using dream sharing to strengthen the therapeutic alliance as described by Eudell-Simmons and Hilsenroth (2005), participants privileged the therapeutic alliance over their professional opinion that several of their clients' dreams were not worth exploring. For example, one participant privileged the therapeutic alliance over her professional opinion that several shared dreams were not worth exploring:

> *I will pursue it [the shared dream] to build that therapeutic rapport. I definitely would never reject it. […] I'm very willing to, extremely willing to talk about it and use it as a - use it to build the therapeutic alliance (interview 3)*

Fourteen participants spoke about the connection between the therapeutic alliance and dream beliefs like that dreams can be revealing, meaningful, intimate, confronting, distressing or emotionally intense experiences:

> *talking about your dreams, I often think, it's a bit like undressing. You really are exposing one of the most vulnerable parts of your being to someone whom you really need to trust (interview 1)*

One participant explained that trust is important for clients sharing dreams by alluding to Freud's view of dreams:

> *I think people don't know what they [dreams] mean or if they mean anything and that they can be seen as kind of…well I guess, I think it was Freud who said 'the royal road to the unconscious' or something. Something along those lines you know, like they represent some deep, hidden desires or wants or needs that people have. And so it's a very private part of someone that they might not recognise themselves. And I think maybe because there's mysticism around the symbolism of dreams and what do they mean. […] I think they don't know what they're revealing and that's a very vulnerable place. (interview 7)*

This was evident in other participants' comments too:

> *you're showing some part of yourself that you don't understand to somebody else and that's a risky thing to do, so you need that kind of safe environment that you get with a good therapeutic alliance (interview 2)*

Many participants approached dream work in a manner that respected these types of dream beliefs, whether or not they held those beliefs themselves.

Participants also referred to shame, embarrassment or distress, taboo dreams and the lack of control dreamers have over their dreams as explanations for the importance of providing a safe space with no judgement. Some noted that when the specific content of dreams is inconsistent with the client's waking life values, such as engaging in sexual infidelity, it makes it risky to share those dreams.

> *Dreams can sometimes bring up things that a: we don't like, b: we're afraid of, we're ashamed of […] So therapeutic alliance is needed because I want them to feel safe in the fact that I can hold this thought with them and for them and not to break that trust, that this remains here, and it's a safe space and there's no judgement and that we can hold this together (interview 8)*

4.6.4 Sense of disquiet around dreams

The final superordinate theme focussed on the underlying *Sense of disquiet around dreams*. Despite many participants describing valuable and positive experiences of dream work, all of the participants spoke in a way that suggested there is a sense of disquiet associated with dreams for at least some psychologists or for the profession as a whole. For some it was a personal experience of discomfort around issues of competence, wanting to be good psychologists, the liminal nature of dream work or fears about the unknown or unprovable. A couple of participants explicitly mentioned experiencing imposter syndrome, for example:

> *not to bring out some imposter syndrome here but sometimes I wonder if you know, what I do is just laugh because I have no idea what I'm doing (interview 8)*

Being on the boundary of their practice, dreams force psychologists outside their comfort zone by removing the usual scripts, frameworks or models, and identities they are able to rely on when working with topics described in interview 4 as being more the '*meat and potatoes*' of contemporary, Australian psychological practice. Controversy can arise over whether the area of knowledge should belong within the boundary of professional practice for psychology and a number of ethical issues are raised, adding to the discomfort of those who do not feel confident or competent to work with dreams. Many participants spoke about how they received messages about questions of credibility or harm connected with dream work. This was mediated, for some participants, by clinical experience and their capacity for actionable knowledge.

4.6.4.1 Learning disquiet: dreams are taboo

Foucault asserted that the implicit, taken for granted assumptions of the ways that things are done, discourses or regimes of truth are considered normal, natural and true (Thomas, 2016). Norms transmission, or doxa within a profession is more powerfully achieved via

the hidden curricula than the explicit one in terms of identity formation (Goldie, 2012). To begin with, the absence of dreams in the curriculum was interpreted as a reflection of the profession's attitude towards dreams by one participant who explained her perception of the role of dreams in Australian psychology the following way:

> *given that we haven't had a lot of training in it [dreams], I'd probably say that it's [dreams/dream work] generally fairly irrelevant (interview 6)*

The process of learning the profession's position on something, or norms transmission, can also occur in part through interactions with or socialisation by supervisors, senior professionals and teachers (Goldie, 2012). In the absence of dream-related university or professional training in dreams, job contexts and practice experience were seen as means of norms transmission for some participants. The participants' comments showed that they quickly learned the profession's position that dreams are taboo, from the silence or the absence of dreams in peer supervision conversations or formal training:

> *I do three different forms of group professional supervision and I have done that for five years and dreams is not something that's ever come up <<chuckling>> so that kind of tells me something, that it's not 'popular' [mimed air quotes] (interview 12)*

Further support for this idea can be seen in the following excerpt where the participant is discussing the general attitude of Australian psychologists towards dreams based on their interactions with colleagues throughout their career. Both the previous and following excerpts are consistent with Hackett's (2021) study in which Irish psychotherapists spoke about not having been able to talk professionally about dreams.

> *I think a big one is just this idea that it's just not spoken about. […] I think that we all must be doing it to some degree, that clients are bringing up, if we're not asking, clients are bringing up these dreams in the room and we're doing something with them but we're not necessarily training specifically in that and we're not always bringing that into supervision or*

> *even into peer supervision environments to talk about it. So it's just like it's silenced. It's happening but it's not spoken about (interview 15)*

The argument by Hotho (2008) that there may be divergences between individuals and the profession as a whole when it comes to professional identities was reflected in many of the participants' comments. While they received messages about the collective identity of their profession, they did not necessarily comply with the profession's position on the role of dreams. Many '*admitted'* that they and other psychologists work with dreams but never discuss dream work with each other and while the profession does not see dreams as having a role in psychological practice, they personally believe otherwise.

4.6.4.2 Credibility discomfort: science versus woo-woo

The participants discussed living and working in a Western society that privileges the rational, scientific and measurable over the emotional or spiritual. Dreams' unscientific reputation was believed to elicit discomfort for psychology, which seeks credibility, associated with science, medicine and funding. Consistent with previous findings of Hill (1996a, 1996b), that there is a stigma associated with dreams due to some psychologists considering them unscientific, participants connected dreams with a range of negatively toned terms, such as *woo* or *pseudoscience*, that located dreams outside the realm of science. One participant when asked to clarify the risks of appearing '*left field*' to colleagues by introducing dreams into discussions explained:

> *you're challenging the norm […] you risk looking a little bit incompetent or that you're getting too much into territory of I don't know, a spiritual healer or you know, something non-allied health or non-evidence-based (interview 15)*

This perceived conflict between dreams and psychology's scientific identity was evident in one participant's explanation that dreams are not in the psychology university curriculum because they are seen as '*hocus-pocus*' and '*psychologists have fought for so long to be scientific-based, they don't want to go there*' (interview 16). She explained the importance

of being associated with Western medicine and the respect that science brings for the APS's success in lobbying the government for funding:

> *to have things recognised by government, they have to be measurable. […] we can recognise psychologists because they do focussed psychological strategies and scientifically proven strategies that can be measured and that have been shown to be true because there are not many governments are going to pay money for dream therapy (interview 16)*

This extended beyond psychology's perception of scientific credibility to general societal views about science. For example, one participant explained the need for trust and a strong therapeutic relationship for a client to share dreams '*because maybe talking about dreams could be slightly taboo?*' (interview 9). She went into more detail identifying tensions between her perception that society locates dreams within the bounds of psychology, yet there is also a perception that they lack credibility due to their unscientific nature:

> *Maybe people see it as kind of like a pseudoscience type thing? I'm not sure. But then on the other hand, I've talked already about how maybe clients assume that we're trained in it. So, it's a bit of a conflict there that I've brought up. Yeah, but, um… Maybe some people think it's kind of a bit more of an alternative medicine approach perhaps (interview 9)*

Another participant made sense of what she saw as psychology's attitude that dreams are not seen as relevant these days, by discussing societal changes in attitudes towards science and religion:

> *it's probably that move away in kind of like Australia being a secular society, […] we're trying to take psychology more into the scientific realm […] there'd be a lot of people who again prefer to focus on the here and now and what's happening and less of that kind of…not mythical, but that kind of more creative side […] Our dreams aren't always that logical and I think that our society prefers to work in logic […] we much more*

prefer like the logical and the problem solving and that sort of orientation doesn't really lend itself to dreams (interview 6)

4.6.4.3 Ethical disquiet: dreams are dangerous

Most ethical concerns were loosely tied back to the profession's ethical code (APS, 2007). The need to practice within one's competencies and not do harm were particularly emphasised, but several participants also spoke about respecting clients' cultural and religious beliefs, including beliefs about dreams.

One participant was concerned about ethical and reputational issues associated with dream work:

> *Interviewer: Where does that concern that it [dream work] might do damage come from do you think?*
>
> *Participant: Because I think there's a – I think I get it from the APS. I also think you get a lot of, there's a lot of 'we are psychologists, we are reputable' and you do have people, I have people who have gone to other therapists who have been charged so much money and have been damaged by pseudo-rubbish that they've been exposed to. So I think we feel that we have to be really careful about how we talk about it, if we talk about dreams. (interview 16)*

Another participant spoke about psychologists' concerns that anything outside what the research shows is the best treatment can lead to allegations of being unethical (interview 2). The lack of awareness of dream work models in widely used therapies like CBT or empirical support for dream work makes this particularly problematic for dream work.

Consistent with the argument in the literature about the hegemony of positivism in Australian psychology (Breen & Darlaston-Jones, 2010; Gough & Lyons, 2016; Keast, 2020), one participant observed that some psychologists have adopted a narrow interpretations of EBP that privileges quantitative epistemologies. He used this to explain the discomfort those psychologists experience in relation to dreams:

> *they're [dreams] murky and they're dangerous in the sense that […] as authorised psychologists, we're meant to be looking at the evidence-based therapies. Where are the evidence-based therapies? I mean how could you do research into the unconscious? (interview 1)*

Some participants were uncomfortable that dreams are not measurable and do not have a single, provable interpretation, an issue previously identified by Pesant and Zadra (2004). Participants worried that clients might make poor decisions based on a misinterpreted dream, that they might not be able to accurately assess waking life risk in response to a client's violent dreams, or that clients may lie about their dreams. Concerns around discerning the truth, or clients' capacity to differentiate between '*real'* (waking life) and '*not real*' (dreams), privileging a Western theory of mind lens for understanding dream experiences, were also raised when discussing contraindications for dream work:

> *you might have a situation where the people are starting to believe their experience as being real or their dreams as being real and I guess then depending on the content of those can have ramifications as well (interview 14)*

One participant who said '*I'm open to that stuff [dreams] and not bothered by it or scared by it*' (interview 11), offered an explanation for the discomfort some other psychologists' experience around dreams. Her explanation relates to the warning by Pesant and Zadra (2004), that clinicians need to be aware that the potential for mistaking dreams for real life events means clinicians need to be aware that dream material may give rise to false memories:

> *I think there's been a lot of stuff out there around false memories and all this kind of stuff and I think that sometimes that that can scare people off talking about dreams because they don't want to make something that's not a reality, a reality. Or perhaps they're actually scared that it is divulging something that's deeper perhaps. That they either don't feel comfortable dealing with as a therapist or again or it just might come down to ignorance like not knowing how to manage a dream or how to*

> *talk to someone about that. But yeah, I guess when I say the word scared, I'm probably referred more to people being scared about talking about the dream itself and making a thing of the dream when it might not need to be or vice versa (interview 11)*

A final ethical concern for some participants was contraindications for dream work. They identified contraindications that were consistent with those identified by therapists in previous studies such as psychosis (Hill et al., 2008) and an inability to differentiate between fantasy and reality (Carcione et al., 2021; Huermann et al., 2009).

4.6.4.4 Disquiet mediated by experience

Consistent with previous research (see for example, Lempen & Midgley, 2006), twelve participants from across different career stages offered clinical experience as an explanation for differences in discomfort levels around dream work between psychologists. Experience was also seen to mediate the influence of other factors on practice:

> *I'm just so mindful I guess of always being evidence-based because I guess I lean on that in lieu of experience (interview 7)*

This participant avoided discomfort by not exploring dream and emotional material to which she felt unprepared to respond. This can be seen in the comments below, taken from her discussion about this, along with her desire to address her lack of confidence and intolerance for uncertainty and taking risks at this early stage of her career:

> *I've never really gotten to explore what they [clients] might think or believe about dreams or why they might think it's relevant to the therapy […] [it] feels like a bit of a safer approach […] it's easier to do a cognitive, draw a cognitive model around that […] it might serve to keep it…keep things on that cognitive level instead of more emotional…I guess speculative, which I think is probably rich therapeutic material, but I've never felt comf-I will take any opportunity to encourage the detached side of me in therapy and that's something I'm constantly trying to*

overcome, is avoiding really emotional material or the kind of grey areas in a session, because I feel under prepared or unprepared (interview 7)

One participant described receiving no training on dreams at university and believed that practice-based evidence (Verling, 2014) was essential to his development as a psychologist who is able to work with clients' dreams. Here is his comparison of the two forms of learning:

While I think they were very, very good academics, I had the distinct impression that they had never met any human beings. And that did not serve me well […] I've learnt more in my thirty years of experience of clients, I've learnt more from them than I have from my lecturers (interview 1)

Several participants discussed the impact of life experience on comfort levels. A participant with over ten years of clinical experience discussed how being well read, exposed to all kinds of things and knowing the signs and symbols that people have in their lives influence psychologists' choices to work with dreams and regarding clinical experience, he added:

if my memory serves and the work I've done as supervision serves, early clinicians are keen to be very clear about their morals. […] they kind of stick to the manual and those kinds of things. […] there's a sense of wanting to be a good clinician and the way that someone is a good clinician is that they get results. So you know: I try to fix my clients. And sometimes that can drive us a little bit ahead of our clients. We want them to get better before they're ready to get better. It's when we get a little older, a little bit more long in the tooth, we're more able to, I think, and it's just from experience, […] we can sit with the clients more and that's ok. […] and also we're not surprised by something that comes out of left field. Because we've probably heard it somewhere or somewhere else before. […] So I think that having that comfort and not being surprised just tends to make life a little easier, makes me a little more relaxed. […] So sometimes it's ok to stop the manual and kind of take a break and breathe and spend some time with your client (interview 4)

Experience does not eliminate discomfort for everyone though. A participant with over ten years of clinical experience said if a client sought dream interpretation he would refer them to a psychodynamic psychotherapist '*as soon as possible*', adding:

> *I'd be outside of my comfort zone and I'd be outside of my competence zone as well (interview 10)*

4.6.4.5 Technician versus clinician

Beyond experience, some participants described psychologists who were good clinicians as experiencing less discomfort than those who were good technicians and followed the manual. Good clinicians responded to dreams with greater flexibility, creativity and complexity. Some responded to dream material just as they would any other clinical material. One described herself as embracing the concept that '*real life is messy*' (interview 2). This participant (quoted in the excerpt below) found ways to work with the research literature, in which her clients are often not represented. Rasmussen (2018) noted that this lack of representation of many clients is a problem with much of the research literature. This second participant demonstrates actionable knowledge in her implementation of many of the core competencies Australian psychologists are expected to have (Registration standard: General registration, 2016), including a deeper understanding of EBP as being more than the number of RCTs on a topic (Hamill & Wiener, 2018).

> *you look at the research evidence and you try and go with the therapy that the research evidence supports. But you have to be very ready to change the pace of it, to vary it, to use pieces of it rather than the whole programme, to look for the therapeutic opportunity in a session with the client to introduce a piece of that model of therapy rather than have a fixed agenda of we are going to do everything that they say we should do in session one we are going to do in today's session, because that just doesn't work in real life (interview 2)*

There were other examples of approaches to dream work that appeared to be ways that participants made sense of not experiencing greater levels of discomfort around dream

work. For instance, in response to questions about contraindications for dream work, one participant described the steps she might take, for example:

> *getting containment and regulation and some distress tolerance before going into difficult content (interview 15)*

She continued on to explain that this applied to all her work, not just in response to dream material. By approaching a particular dream with a particular client in the same way that she would any other clinical material introduced by the client and thereby applying a consistent approach across her practice, she is likely to experience less discomfort. The consistency would reduce any concerns stemming from a fear that dream work could cause harm for particular clients due to it being murky and dangerous in a way that it is seen as distinctly different to other clinical material. Approaching therapy as a clinician with higher levels of actionable knowledge also increased acceptance of discomfort for some participants. This was described by a participant with more than ten years of clinical experience, in his account of a response to an early career psychologist's recent question about when she will stop feeling like she is flying by the seat of her pants:

> *I actually sneakily suspect that all of us in psychology feel a little bit like we're imposters because we've had to find it our own way […] a good psychologist I don't think ever stops feeling that they're a bit flying by the seat of their pants. […] while it's not really a source of shame, it is a source of disquiet […] I kind of reject the whole idea that you can ever make psychology, or at least therapeutic work, safe, [and] predictable (interview 1)*

4.7 Discussion

4.7.1 Summary of findings

Four superordinate themes were identified in this study. The first three themes focussed on the participants' positioning of dreams as on the *boundary* of psychological practice, and the dynamic *influences of multiple, often conflicting factors*, on decision-making and

behaviours around dreams, including the *highly valued therapeutic relationship*, which can be seen as central to dream work and to psychotherapy in general. The final theme focussed on the underlying *sense of disquiet about dreams* in contemporary psychological practice within Australia. In relation to the two primary research questions, these findings demonstrated the diversity in psychologist experiences of dreams in psychological practice. Participants varied in the frequency of dream work, the way they use or do not use dreams in their work, and their feelings and opinions about dreams. Many of the participants valued the role dreams have played in their practice, but overall dreams were positioned as having an uncomfortable boundary role in contemporary Australian psychological practice at 'whole-profession' and public levels, despite the considerable variation at an individual level.

4.7.2 Complexity, and implications for training and practice

> *Researcher note: having completed an analysis of the data from an IPA perspective, I have implemented a triangulation strategy in this section of the discussion, and introduced tools like Stacey's Matrix, coming out of Complexity theory work (Zimmerman, 2001), to make sense of the findings through another lens*

Complexity theory views reality as a complex, open system in which the interrelated subsystems or variables interact via numerous, non-linear, recursive feedback loops (McMillan & Gordon, 2017; Sanger & Giddings, 2012; Woolcott et al., 2020). Complexity refers to the uncontrollable, unpredictable, messy, and confusing circumstances that professionals are inevitably confronted with and for which technical solutions do not provide an adequate response, but are often of the greatest importance to humanity (Schön, 1987). These complex problems are increasingly a part of everyday practice, presenting professionals with insufficient, ambiguous or contradictory data, including many stakeholders and interrelated variables, and potentially resulting in values conflicts (Cherry, 2005). This complexity that psychologists have to deal with means that simple

manuals and scripts don't always meet what is needed at any given time, particularly with boundary topics like dreams. Being on the boundary of the profession makes dreams an example of complex work for psychologists.

Complexity theory and tools such as Stacey's Matrix, from organisational leadership, provide a way of thinking about boundary topics and other manifestations of complexity in practice (Zimmerman, 2001). Stacey's Matrix has two dimensions – certainty and agreement. These can be seen below, in Figure 1, where the Stacey's Matrix graphic, as developed by Zimmerman (2001), has been adapted and is presented using the example of the current study.

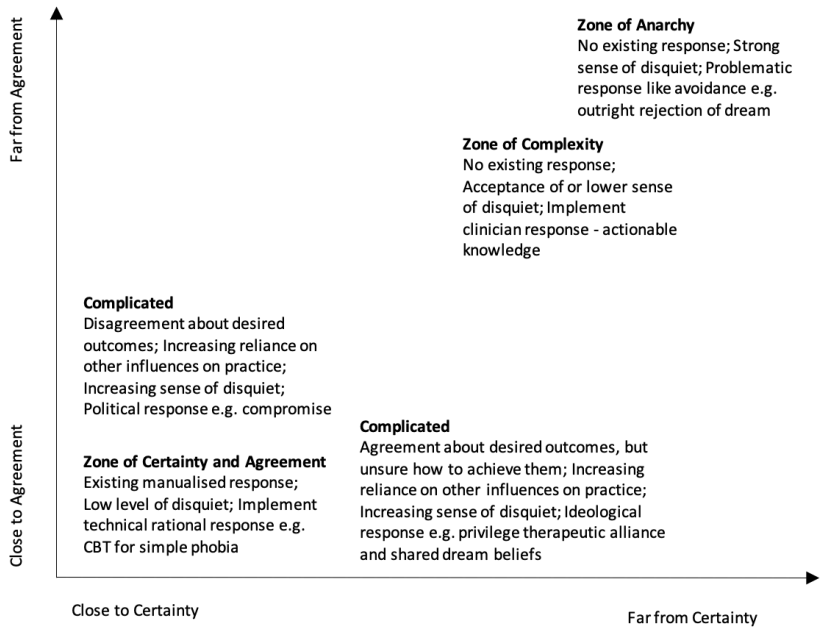

Figure 1

Current Findings Presented in an Adapted Form Following the Stacey's Agreement and Certainty Matrix*, developed by Zimmerman (2001)*

Technical solutions and manuals are useful when there is predictability with high levels of certainty and agreement. According to the Stacey Matrix, the lowest levels of certainty and agreement can lead to a zone of chaos or avoidance (Zimmerman, 2001), both of which can be problematic. External forces, such as the neoliberal privileging of CBT

(Rasmussen, 2018) to secure funding and the negative feedback loop created by the current policy settings claim to get clinicians to operate from an evidence base. Instead, it results in psychologists having to make it up or 'doing it on the fly' (interview 9) as the only evidence they are allowed to use does not cover the real, complex people and scenarios they work with in their daily practice. So instead of using evidence to take actionable knowledge, psychologists resort to rejecting particular areas of practice to the potential detriment of their clients and the profession, or they 'make it up' in an unconsidered way.

The participants agreed that there are single manualised epistemologies like CBT that have much positivist evidence supporting their use. However, doing the same thing in the same way will not be appropriate for every client, and existing responses will not always be appropriate for emerging, and future problems that psychologists will face. Sanger and Giddings (2012) describe social workers as having to deal with some of the most complex systems out there, often having to take biological, social, psychological, and macro factors into consideration as a part of their everyday practice. Psychologists also have to deal with these diverse and sometimes conflicting factors where there is little certainty and little agreement. The findings of this study illuminate the discomfort that may be evoked when participants were forced to privilege particular influences over others in their attempts to be good psychologists in areas of practice with little certainty or agreement.

Training that teaches psychologists to be technicians using manualised therapy, the rise of logical positivism (Gough & Lyons, 2016) with its claims of what counts as knowledge (including a narrowing definition of evidence), and the dominance of CBT approach (Rasmussen, 2018), do not provide everything that is needed to develop actionable knowledge. This is especially so for anything on the boundary of a profession or for engaging in EBP that incorporates the eight psychologist competencies. The need for more complex professional competencies for psychologists that reflect the complexity of real life practice has been recognised (von Treuer & Reynolds, 2017) and introduced into training and registration requirements, like the eight domains of competency model for

Australian psychologists (Registration standard: General registration, 2016). In professional practice these competencies may be interrelated and these competencies are not able to be acquired in a linear way (von Treuer & Reynolds, 2017).

Alongside this, contemporary conceptualisations of EBP have moved beyond counting RCTs in support of a particular therapy model for a particular diagnosis to requiring psychologists to apply a three-legged stool model of practice (Hamill & Wiener, 2018). Psychologists are expected to be able to assess and then integrate the best available research with their own clinical expertise with consideration of and respect towards the context, such as individual differences in ability, the client's cultural, language, gender, sexual, and religious identities, and other characteristics of the client and their preferences, to engage in an informed consent and feedback pattern to share decision-making with the client (Hamill & Wiener, 2018; von Treuer & Reynolds, 2017). This broader interpretation of EBP and competency-based model of practice combine to require psychologists to be competent in responding to complexity. In other words, it requires psychologists develop actionable knowledge and epistemic fluency in relation to examples of complexity like dreams.

The Stacey Matrix presents the inner edge of the zone of chaos (low levels of certainty and low levels of agreement) as the zone of complexity (see Figure 1). The zone of complexity provides opportunities for creativity and innovation (Zimmerman, 2001) and requires higher levels of judgement and negotiation. To be a good psychologist, clinicians must learn how to support diverse people to thrive. This points to the need for deeper forms of education for clinicians rather than teaching students to be good technicians who follow scripts and manuals. Practice requires the capacity to recognise what skills are needed when, and to be able to apply skills in the right combination at the right time. This idea can be referred to as actionable knowledge, an active and embodied readiness to sense what to do when and how (Markauskaite & Goodyear, 2017).

Interactions within a complex system are multiple, nonlinear and can have features like feedback loops and emergence, which is a term used to describe properties that emerge, which were unplanned (Woolcott et al., 2020). Linear training or policy intent is therefore inadequate in supporting psychologists to take action. Passive, teacher-centred training models are common in higher education setting, but knowledge has to be grounded in practice, with knowledge informing practice and practice informing knowledge. Grounded and actionable forms of learning (e.g. Markauskaite & Goodyear, 2017) that connect to the messiness of world and 'real life', assist students to develop the skills and knowledge they need for actionable knowledge. It enables psychologists to respond professionally and ethically to any material introduced into therapy (including dreams) and support their clients to thrive.

Actionable knowledge requires epistemic fluency, which is the capacity to understand, switch between, and combine different kinds of knowledge and different ways of knowing about the world. According to Heatherington et al. (2012), learning multiple theoretical perspectives helps students develop creativity, intellectual flexibility, and the capacity to develop new interventions for a changing world and changing issues that clients are seeking support around. As Breen and Darlaston-Jones (2010) argue, epistemic pluralism provides a way forward for dealing with the complexities of modern social issues in a multicultural society like Australia.

Epistemic fluency, critical, intersectional reflexivity, and the capacity to respond creatively to the liminal experience of complexity may support psychologists to cope with discomfort that they will experience, particularly early in their careers, in implementing a broad definition of EBP and embracing uncertainty. These pathways forward may also better meet the needs of multicultural Australian society. Aboriginal and Torres Strait Islander peoples have identified the epistemological and ontological shortcomings of Australian psychology with the hegemony and colonisation of Western psychology in the curriculum, and in the lack of diversity within the Australian psychologist workforce (Breen & Darlaston-

Jones, 2010; Cameron & Robinson, 2014; Dudgeon, 2017; O'Connor et al., 2015). There is a need for a socially accountable approach to psychology as a cultural practice in itself, open to a range of approaches and committed to engaging with the politics of therapy and acknowledging that psychology exists and occurs in a broader historic-cultural context (Riggs, 2004). One specific dream-related example can be seen in comments about how dreams and nightmares are interpreted through a filter of personal and cultural values and traditions, which means that ignoring cultural meanings can hamper therapeutic outcomes (Schubert & Punamäki, 2016).

Psychologists need to consider the ramifications of policies on indirectly related aspects of psychological training and practice. For instance, it has been suggested that the two tiered Medicare funding model has contributed to a reduction in course and training diversity for Australian psychologists (Di Mattia & Grant, 2016; Keast, 2020), due to the financial rewards associated with a clinical psychology qualification over other postgraduate areas of study such as counselling psychology or health psychology (Keast, 2020). A critical mass of expertise is required to ensure diversity within psychology in the future and quick action is needed to avoid that expertise being lost to time. Furthermore, the current narrow scope of the psychology curriculum, connected with its ideological position of psychology being a hard science and claims of being neutral or value-free, risks unintentionally reinforcing power structures that cause or maintain inequality (Cullen et al., 2020). Contextualisation of the curriculum and critical reflexivity, as advocated by Cullen et al. (2020) and (Darlaston-Jones et al., 2014), could better equip psychologists to feel more confident and competent around working ethically with their clients' dreams within the context of a culturally and socio-politically diverse world, and improve client experiences of dream work and of therapy in general, even without explicit instruction in dream content.

As well as broader policy and educational solutions, more specific strategies could be of assistance in the shorter term. For example, a study looking at the marginalisation of

dreams in psychiatric training recommended that a dream course within the mainstream curriculum may help to address the gap in psychiatrist training and the marginalisation of dreams that may be reinforced by an individual with a niche interest in dreams running a course outside the mainstream curriculum (Goodwyn & Reis, 2020). Workshops accredited through the current continuing professional development system, for existing psychologists, could also assist in addressing the competence and confidence gaps some of the participants reported experiencing around dream work.

4.7.3 Implications for research

One participant (interview 10) described the current state of psychological practice and research as a self-reinforcing cycle of what gets funding is what already has support. This does not enable any broadening to include diverse voices, methodologies, theoretical orientations, topics, epistemologies and ontologies. Psychology needs to expand what is studied. A broadening of research methodologies is necessary to include more qualitative and mixed methods approaches that can deal with the complexities of real-world modern social issues and human experience (Gough & Lyons, 2016). Including the client voice in research into psychological practice is another important step. Many participant comments included assumptions and interpretations about the client experience through the lens of the psychologist, rather than the clients' interpretations of their motivations, beliefs, and experiences. Clients' experience of their therapist(s) is an important factor in therapy (Amos et al., 2019) and the client voice along with practice-based evidence are central to researching what works for whom and to shaping good policy (McLeod, 2001).

The current data comes from a larger study that has also interviewed clients about the same research questions. That second study was an attempt to address the problem identified by Crook-Lyon and Hill (2004) of there being too few studies focussing on the client's perspective of sharing dreams in psychotherapy. The inclusion of the client voice in research aligns well with work in Australia in both the critical psychology space, and the

work focussing on increasing inclusivity of Aboriginal and Torres Strait Islander peoples' voices, that emphasise the importance of diversity in methodologies, and in conceptualisations (see for example, Breen & Darlaston-Jones, 2010; Dudgeon et al., 2017; Dune et al., 2021).

> *Researcher note: In recognising the relevance of this growing body of work to the inclusion of the client voice, I also acknowledge that this research project has approached the research aims, method selection, data collection, and analysis from privileged white, Western conceptualisations of research, psychology, clients, and dream work, with the significant impact and limitations that has on the research processes and outputs*

Returning to this current study, the findings also revealed that few participants were aware of the existing body of dream and dream work research or recent theoretical developments in the area. This points to a need for better dissemination of and communication about existing dream research and dream work guidelines within the psychologist population, potentially through the curriculum or professional development opportunities.

4.7.4 Strengths and limitations

The value of the smaller sample size IPA approach to research is that it can produce deep, rich data rather than being representative (Noble & Rizq, 2020). The data collected provides evidence that the experiences and understandings described by the participants do exist within contemporary Australian psychological practice, however, there may be other salient points about dreams and psychological practice that were missed. While the psychologist population is not representative of the diversity of the wider Australian population (Cameron & Robinson, 2014), the small sample size meant that even all parts of the Australian psychologist community were not represented in this study. It is also likely that findings may differ across time and place with the current data representing a snapshot of a specific sociocultural epoch. Furthermore, despite the range of opinions and

experiences expressed in the current data, it is likely that the sample overrepresented a subset of the psychologist community who were more interested in and engaged with dreams.

4.8 Conclusion

The participants in this study described the experience of clients sharing dreams as potentially exposing, revealing, and vulnerable. Echoing this, the data revealed much about the vulnerabilities of the participants' experiences with the complexities, challenges, and privileges of psychological practice. The findings showed the diverse ways Australian psychologists think about and work with dreams, and believe the role of dreams is and should be, within contemporary psychological practice. As a boundary topic, dreams are an example of complexity, something that psychologists are likely to be confronted with throughout their professional lives. Despite the value and enjoyment of dream work for many participants, dreams were seen as a taboo and associated with an underlying sense of disquiet for some individual psychologists and for the profession as a whole. The introduction of dreams in psychological practice raises questions about what being a good psychologist entails and it requires clinicians to privilege some influences on their practice over others. For example, some participants spoke about privileging the therapeutic alliance over other influences. The therapeutic relationship was seen to be of value to both dream work and psychological practice in general.

The participants presented psychologists as professionals seeking to do their job well. They cared deeply about their work and found it challenging to balance credibility and the comfort of reductionist, technical, rational manuals, that are valued in the wider secular, neoliberal society in which they operate, with the therapeutic relationship, ethical guidelines, client factors, and personal factors, that they also consider core to their work and identity.

Things are changing at an increasing rate and psychologists often have to engage with clients and situations for which they don't have an existing script or specific training. This study captures the experience and sense-making of the participants around how training within a narrow set of epistemologies combined with a desire to promote a particular scientific identity and its associated narrow definition of evidence-based practice, leaves psychologists ill-equipped to engage confidently and competently with dreams, and other examples of complexity in their clinical practice. Psychologists need to be able to take actionable knowledge when working collaboratively and respectfully with clients to respond competently to the complex and ever-changing psychological needs of society. This requires a degree of epistemic fluency, which is captured in the concepts of EBP and the current Registration Standard core competencies (*Registration standard: General registration*, 2016) for psychologists (Hamill & Wiener, 2018; von Treuer & Reynolds, 2017). Further development of grounded, actionable, and contextualised forms of learning in higher education settings along with greater diversity in the curriculum and the psychologist community, will assist psychologists to develop an actionable knowledge approach to the complexity of their professional practice, such as when dream material is introduced into therapy.

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Chapter 5. Study two

5.1 Introduction to Chapter 5

This chapter reports the findings of the second study in this research project, an interpretative phenomenological analysis of how clients understand their lived experience of dream sharing in psychotherapeutic settings and the role of dreams in contemporary Australian psychological practice. A short version of the findings, focussing just on the aspects of the findings directly related to therapy, can also be found in Appendix K, published in the journal Dreaming (see Appendix I for copyright permissions).

Leonard, L., & Dawson, D. (2019). Client experiences and understandings of dreams in contemporary Australian psychological practice: An IPA study. *Dreaming*. Advance online publication. https://doi.org/10.1037/drm0000228

An extensive coverage of the methodological issues and details about the methods, including a summary of profile data about the participants (see Table 2.3) can be found in Chapter 2. Continuing the reflexivity process discussed in previous chapters, you can see the influence of my earlier readings into particular topics and theoretical frameworks within my analysis in this chapter. In particular, this chapter shows the influence of my readings into intersectional frameworks for understanding privilege and harm, as well as my earlier reading of *The Gift*. The former I discuss in more detail both in this chapter and in Chapter 6. The latter I will recapitulate below.

In his work on the exchange of gifts, Mauss (1970) described there being specific expectations in exchanges, such as social interactions, on the part of the giver and receiver. This has previously been applied to dream sharing, in passing by Vann and

Alperstein (2000) and Wagner-Pacifici and Bershady (1993), and then expanded upon in detail by us in Leonard and Dawson (2019). We argued that dream sharing can be conceptualised as a social interaction in the form of an offered gift, or exchange in which a risk-benefit evaluation occurs, and potentially used both as a way to test and to increase intimacy in a relationship, including a therapeutic relationship. This application of the concept of dream sharing as a gift exchange can serve as a reminder to psychologists of the underlying expectations on the dreamer and listener and the performative nature of therapy.

5.2 Summary of findings from study two

Five adult client participants completed semi-structured interviews via video call as a part of an Interpretative Phenomenological Analysis (IPA) study interested in the following two questions:

1. How do clients understand their lived experience of dream sharing in psychotherapeutic settings?
2. How do clients make sense of the role of dreams in Australian psychology?

As shown in Table 5.1, the two final superordinate themes identified in this study have been characterised as *Dream sharing experiences* and *Dream sharing rules*, both of which are explained in more detail later in the chapter. Both superordinate themes included data from all five transcripts, as did all the six subthemes within *Dream sharing rules* theme, exceeding the criterion of being present in three or more transcripts to be considered a subtheme. While the data associated with the first superordinate theme could be organised into various clusters relating to different types or aspects of experience, these were not sufficiently reported to constitute formal subthemes.

Following the summary of the themes in Table 5.1, the findings from this study are described and explicitly linked to relevant pre-existing research as part of the triangulation

strategies used in this project (see Chapter 2 for more detail on triangulation). In this way, the traditional 'discussion' section of the study is included within the *Findings*. Other sections of a traditional discussion section are then presented after the findings, such as strengths and limitations of the study, and its implications for research, training, and practice.

Table 5.1

Summary of Themes

Superordinate Themes	Subthemes
Dream sharing experiences	No subthemes. Instead, clusters of relevant data focussed around: - Feelings of relief - Feeling pressured - Vulnerability, shame, embarrassment and a fear of judgement; and validation - Frustration; and the influence of time constraints and stage of therapy on experience
Dream sharing rules	With whom do we share our dreams What to share outside therapy and why What to share in therapy and why What not to share outside therapy and why What not to share in therapy and why The influence of the psychologist

5.3 First research question and superordinate theme: dream sharing experiences

Directly addressing the first research question for the study, the first superordinate theme of *Dream sharing experiences* encapsulates participants' descriptions of what it was like for them to share dreams in therapy, what they felt, and what thoughts ran through their minds during those experiences. The participants' experiences were diverse and they

varied in emotional tone, varied from one experience of therapy to the next, and were influenced by the stage of therapy.

5.3.1 Relief

The first type of experience described is exemplified in the relief experienced by the second participant:

> *I felt relieved that I could talk to her about something that is quite personal (because I do believe that dreams are very personal) […] there's always that comfort that I keep bringing dreams to her and we can keep working through whatever it is (interview 2)*

5.3.2 Pressure

The second cluster of dream sharing experiences focuses on the pressures and difficulties experienced when articulating a dream experience. Some felt past therapists they had seen had pressured them to recall more details from their dreams. The second participant felt stressed by one of her early therapy experiences with a social worker in USA. The social worker was part of a dream group with other therapists and would often ask this participant if she had had any interesting dreams lately. She described it as feeling like:

> *it was more about the dream and less about me (interview 2)*

She elaborated:

> *she [the social worker] wanted to extract information from me that I couldn't recall or that I couldn't quite make sense of and I found that a bit stressful. So, I would try to recall as much as I could about a dream and I don't tend to write them down, so it was really just my memory. So you know, 'oh describe to me what you're wearing and what you're seeing and who's there,' and she would*

> *try and make connections about maybe the people who were involved and how that might have related to the people in my life, the people in my past. And I think that just got a bit, it got complicated for me and I felt like, you know, that there was a whole lot more going on that I needed to be worried about […] I felt like I could and probably should talk to her about dreams because she had interest in them and because she was part of this dream circle and they like to interpret things' (interview 2)*

By conveying an expectation that the client would provide data about her dreams, the therapist could be seen to be controlling the dream narrative. This is consistent with Foucault's examination of power, described by Eivergard et al. (2021) as the struggles of different discourses, such as the medical perspective, to maintain dominance over the patient's perspective. Pylypa (1998) examined Foucault's concepts of individual and societal self-regulation in relation to the perpetuation of the medical profession's power over defining reality and controlling scientific knowledge, and also pointed to the limitations of Foucault's work around the potential for free will, resistance and change. The concepts of free will, resistance and change could also be presented as being consistent with the second participant's description of her decision to end therapy (for various reasons) with that therapist and her capacity to articulately describe her experiences with multiple therapists, and her preferences for particular ways of engaging (or not) with different therapists around dreams.

The fourth participant reduced this pressure by writing her dreams down but was then concerned about her psychologist being able to read her writing, however she described her choice to write her dreams down for her therapist in the following way:

> *I found it really cathartic. And again I didn't have to worry about remembering things or jumbling up my words (interview 4)*

She noted that she had initially felt awkward bringing up her dreams thinking it was unrelated to her psychologist's agenda, but it led to a positive impact on therapy enabling the focus to shift to include the important underlying issues. For some participants, pressure also came from the challenge of translating a dream experience into a verbal narrative. For example, one participant compared her experience at the end of the interview, when asked if she wished to include any further thoughts or experiences, with her experience of sharing a dream:

> *I'm kind of feeling like I do when I try to describe a dream, which feels kind of like a slippery kind of thing where it's hard to grasp exactly what the most important things are to mention or you know, I'm sure that there are lots of things that I've forgotten to mention about it (interview 5)*

5.3.3 Vulnerability and validation

Consistent with previous research (Boyd, 2005; Dombeck, 1991; Schredl, Fröhlich, et al., 2015; Schredl, Kim, et al., 2015), the third cluster of dream sharing experiences suggests that dreams can be intimate and personal experiences, which can make sharing them a vulnerable experience. Shame, embarrassment, and a fear of judgement were common concerns, providing a further explanation around why clients may feel vulnerable about sharing dreams in therapy. The second participant attributed the connection between vulnerability and dreams to dreams occurring during sleep, outside the dreamer's conscious control, '*it can be scary and it can be humiliating and it can be traumatising and so it's this big, naked thing to talk about with somebody*'. She continued to make sense of her experience in the following way:

> *It's taking a huge risk in sharing something that is quite murky, like we don't really know what this means. We don't know why we're having this dream. It's*

affected us in some way, so maybe it's really, really funny or maybe it's really traumatic (interview 2)

The first participant emphasised the importance of validation for dream sharing, explaining:

I think from a client position, for someone to acknowledge what you just said and that you've had the guts to bring it up, because it wasn't easy to say, it's never easy to open up about that sort of stuff (interview 1)

She said that the acknowledgement, normalisation, and validation from her psychologist helped her feel that she was not weird, crazy or a failure, and that she could use the strategies she had been taught to manage her feelings. She believed that this helped settle the intensity of her feelings and helped her to understand why she felt the way she did and that her symptoms were not her fault helped.

5.3.4 Frustration, time constraints, and stage of therapy

The final cluster of experiences involved frustration and the influence of time constraints and the stage of therapy on the dream sharing experience. Like clients in previous research (Crook-Lyon & Hill, 2004), the third participant discussed how the time constraints of therapy affected her dream sharing in therapy. She described how the time limits of therapy make her feel rushed and prevent them delving as deeply into any single dream as she would like:

It's just a little frustrating because they're so detailed and there are so many and it's so overwhelming and there's very little time (interview 3)

For others, experiences of frustration varied according to the stage of therapy. This applied to other aspects of the dream sharing experience in therapy with three of the participants describing how their changing expectations of therapy coloured their experiences and

feelings about their therapists' responses to their dreams. This is discussed further in *dream sharing rules* section of the chapter.

5.4 Second research question: the role of dreams

Data from both superordinate themes are relevant to the second research question, examining clients' understanding of the role of dreams in Australian psychological practice. The participants all expressed the opinion that dreams have at least some relevance to therapy, although dreams are not always the sole, or even a major focus, of therapy. They described multiple ways in which they and their psychologists have used dreams in psychological practice, and emphasised that dream sharing often reflects trust and the desire to engage deeply with psychologists, as sharing a dream can be a very risky and vulnerable experience. Participants' comments about dream sharing included assumptions about social rules for different kinds of relationships, the value and meanings of dreams, and expectations of therapy and the therapeutic relationship.

5.5 Second superordinate theme: dream sharing rules

The term *rules* was chosen in the name for the second superordinate theme, to capture the individually, socially, and culturally informed influences on which aspects of a dream the participants choose to share (or not share), and with whom, when, and why. The term *rules* is not referring to clients setting rules for how a particular model of dream work should be implemented. Instead, it refers to how the participants spoke about the unspoken or tacit *rules* and underlying assumptions, which they believe everyone has around sharing dreams. This theme reveals how the participants' expectations about the role of dreams in contemporary Australian psychological practice, have been shaped prior to, and during, their experiences of therapy. These *rules* were also often offered as explanations for some of the participants' experiences around dream sharing in therapy.

5.5.1 Dream sharing rules - with whom do we share our dreams?

The participants reported sharing at least some dreams with multiple people or groups. These included psychologists, doctors, psychiatrists, partners, friends, other relatives, colleagues, acquaintances, other dreamers, and people on social media. For example, the first participant experienced post-traumatic nightmares and discussed them with her husband, father (who is a psychiatrist), and in a post on Facebook about her mental health story, explaining: '*dreams played a big role and so I did put it in there*' (interview 1).

Every participant struggled to identify any professions, unrelated to psychotherapy, that they associated with dream sharing. The first three participants were unable to think of any other non-health related professionals, the fifth participant thought some may share their dreams with someone like a hairdresser, psychic or clairvoyant and the fourth participant suggested an artist commissioned to create an artwork based on a dream. The second participant tentatively suggested a hypnotist.

5.5.2 Dream sharing rules - what to share outside therapy and why

Overall the findings aligned with previous literature around there being some degree of a hierarchical pattern of intimacy associated with dream sharing with participants sharing dreams more often with those they feel closer to; and opportunity playing a role, such as the availability of a partner with whom to share (Curci & Rimé, 2008; Graf et al., 2021; Olsen et al., 2013; Schredl, Fröhlich, et al., 2015; Vann & Alperstein, 2000). This can be seen in the fourth participant's comment:

> *I guess against the current social standards, there's a time and a place for it [sharing dreams] and I guess it isn't small talk and getting to know someone. It's people you have intimate relationships with like family, friends and your therapist (interview 4)*

However, the level of intimacy associated with dream sharing in the current data appeared to be mediated by the purpose of dream sharing and the nature of a particular dream. For instance, the second participant shared some entertaining or weird dreams with friends but explained she would only share '*the juicy, scary, vulnerable stuff*' with a small group of friends or her partner she would trust enough with dreams '*of that sort of importance*' (interview 2).

Consistent with the literature (Carcione et al., 2021; Duffey et al., 2004; Graf et al., 2021; Szmigielska & Holda, 2007), the participants share their dreams with others for many reasons. These included entertainment purposes, to create and maintain cultural connections or increase emotional intimacy in a relationship, to understand a dream's meaning, because the listener featured in the dream and the dream is therefore seen as relevant to them (the third, fourth and fifth participants), for emotional relief, in anticipation of receiving support from the listener, and for therapeutic reasons. The third participant was more open to sharing dreams with a broader selection of people than the others. She explained that the listener's personal dreaming experience was important for her in deciding who she shared her dreams with, so they could understand her experience. An example of this is when she spoke about her sister-in-law, someone with whom she explained that she shares dreams due to her being a dreamer:

> *she dreamt more than anyone I'd met. So we could share our dreams with each other because we understood (interview 3)*

Personal dream beliefs also influenced the third participant's decision about who gets to hear her dreams. She shares her '*prophetic dreams that are biblical, which a certain group of people are interested in hearing and the certain people I have recurring dreams of*' (interview 3). Her belief that her dreams are valuable and that she is supposed to do something with them, perhaps sharing them with people who appear in them to stop them recurring, motivates her to continue sharing them with those for whom she thinks they are

relevant. She also made sense of her dream sharing behaviours by referencing the influence of her religious beliefs on her dream beliefs. Previous research on sharing psychic dreams suggests that they are not often told to therapists or casual acquaintances due to concerns that sharing them in the wrong context could damage the dreamer's reputation with the risk that the listener will judge them as superstitious or weird (Dombeck, 1994b).

5.5.3 Dream sharing rules - what to share in therapy and why

In making sense of what they shared in therapy and why, the participants identified their underlying assumptions about issues like psychologist expertise and credibility, dream relevance, the therapeutic relationship, and the influence of the psychologist, which is discussed as a separate subtheme. Previous research suggests that often it is clients who introduce dreams into therapy, although clients will generally engage in dream work if their therapists initiate it (Schredl et al., 2000). Some have suggested that this makes exploration of the timing and manner of dream sharing important for therapists as it may provide insights into the client's goals or motivations for sharing dreams, such as using a dreams to change the topic in therapy, offering a dream as a gift, or believing dreams are meaningless or negative (Pesant & Zadra, 2004). The current data provide support for the relevance of questioning why a client chooses to share a particular dream rather than another and at this particular moment in therapy, as raised by Ermann (1999).

5.5.3.1 Credibility

Credibility and the expertise of psychologists were important to several of the participants. The second participant believed that her first therapist's expert training gave her the expertise to better interpret her dreams than the '*really woo-woo websites*' of dream meanings:

having some sort of psychological training, she [my therapist] would be able to sort of like filter through the bullshit (interview 2)

The third participant connected credibility with a scientific or clinical understandings of dreams, her therapist's personal experience of dreaming, and being widely and deeply read about psychological dream theory. She described difficulties finding books on dreams, only locating one that she was satisfied with:

It's the only book I found that I can take seriously that isn't some new age, overly new age kind of take on what dreaming is about (interview 3)

There was also a perception that there is a lack of evidence for dream work:

it seems like such a field lacking in evidence that other medical and allied health professions probably wouldn't delve into dreams or if somebody brought up a dream they wouldn't know how to respond because how do you get training in that you know (interview 2)

The latter is reminiscent of a participant's comment in a study by Boyd (2005), that more research was needed before dream work was used as a stand-alone technique. These comments reflect the value that the participants place on scientific credibility, contrasting with some of their comments about psychologists having expertise and training in dreams.

5.5.3.2 Relevant dreams

When it came to choosing which dreams to share in therapy, all but the fourth participant mentioned recurring dreams as warranting the attention of their psychologists. In keeping with the existing literature (Curci & Rimé, 2008), all the participants also believed emotionally intense dreams that had an continuing impact on them after waking were relevant to share in therapy.

5.5.3.3 Use of dreams

The participants' goals for sharing dreams included using dreams to tell the therapist something or to facilitate insight or self-awareness, using dreams as a source of clinical information such as identifying issues important to the client or assessing change, or to facilitate therapeutic processes such as increasing the client's engagement in therapy or contributing to the development of a safe, trusting relationship. All of these align with previous studies (Boyd, 2005; Eudell-Simmons & Hilsenroth, 2005; Pesant & Zadra, 2004; Skrzypińska & Szmigielska, 2018). For example, dream sharing has previously been identified as a way to facilitate self-disclosure, which in turn increases intimacy in a relationship, and is therefore relevant to therapy (Carcione et al., 2021; Duffey et al., 2004; Eudell-Simmons & Hilsenroth, 2005). The safety and trust aspects of the therapeutic relationship have also been found to be necessary for pivotal moments of awareness and insight to occur in therapy as they enable clients to take emotional risks, such as making themselves vulnerable (Giorgi, 2011). The participants' descriptions of sharing intimate dream experiences entailing vulnerability and risk, make these characteristics of the therapeutic alliance highly relevant to dream sharing in therapy both in terms of facilitating dream sharing and as an outcome of dream sharing.

The fifth participant described the use of what Boothe (2001) labelled as naïve self-distancing when she explained how dream sharing in therapy could be used as a way to talk about difficult issues:

> *you kind of don't have the same responsibility for stuff that happens in dreams. So I think it may be an interesting, you know, a different way to talk about difficult issues that puts you a little bit at arm's length from what's gone on […] 'it wasn't under your control, it happened in your dream.' […] it's a little bit just less, I guess, charged emotionally, if it's from a dream […] It enables difficult things to be discussed maybe more because of that (interview 5)*

Linking this back to previous research, Stefanakis (1995) provided examples of how linguistic resources, such as dream agency and meaningfulness, can be used flexibly in dream sharing to achieve various social goals. For example, the dream can be constructed in a way that allows it to be used to validate or justify a particular action or goal. Alternatively, dreamer passivity and dream meaninglessness can be used to distance the dreamer from the dream allowing face-saving, blame avoidance and reduced responsibility for the dream narrative. This naïve self-distancing concept, as described by Boothe (2001), is mentioned above in relation to the participant's comments. The flexible application of these types of linguistic resources enables seemingly contradictory positions or beliefs about dreams (dreams are meaningful, dreams are meaningless, the dreamer is passive, and the dreamer has agency) to be applied as appropriate in a given context (Stefanakis, 1995). This social constructionist approach sees dream sharing research as contributing to the understanding of social life and social interactions more broadly (Stefanakis, 1995; Vann & Alperstein, 2000).

The fourth participant also used her dreams as '*a transportation device*' (interview 4), to guide therapy towards a particular topic of conversation, or discuss anything emotionally relevant to therapy, which she had trouble talking about directly with her first psychologist:

> *This was my first therapist and I had a hard time verbally bringing up things. It was very uncomfortable, a bit scary so I would go home, write things down when they were fresh and new and sometimes dreams would be in there. And then I would give those letters to my therapist and then we would debrief in the session (interview 4)*

She explained her experience: '*I wasn't at the point where I could bring things up without feeling ashamed or feeling weak*' (interview 4). This fits well with proposed use of dream sharing to discuss personal problems as useful for clients seeking professional help for whom this is perceived as shameful within their culture (Tien et al., 2006).

5.5.3.4 Importance of the therapeutic relationship and safety

Most of the participants alluded to the way that safety from judgement or rejection were key to them be willing to share dreams in therapy. They attributed this to the revealing nature of dreams and their view of therapy as an appropriate place to expose more of one's self or one's emotions. The association between intimacy and dream sharing could be seen in participants' comments about the importance of trust and a safe place being necessary to share dreams in therapy and in the first participant finding that taking her husband as a support for the first few sessions really helped her cope until she felt '*more comfortable and not scared*' (interview 1). The fifth participant saw her dreams as an indication of the state of the therapeutic relationship as well as providing other relevant clinical information for her psychologist. She said:

> *for me, it's a no-brainer for therapists to be open to discussing dreams if their client wants to because I just think it's part of your mental life as much as thoughts or feelings or reactions to things are in your waking life. (interview 5)*

Two participants spoke about deciding whether to share dreams about their therapist, especially dreams about abandonment or rejection. This supports the conclusions drawn from a study of trainee-therapists' and clients' dreams of each other, which found that therapists could use dreams to understand their clients better, especially around attachment difficulties (Hill et al., 2013). Other ways the participants spoke about their psychologists using dreams included as a diagnostic tool and to assist the client to '*sit with it and process whatever's happening*' (interview 2).

5.5.3.5 Influence of dream beliefs

The meanings ascribed to dreams and subsequent implications for dreamers vary across time and culture (Wagner-Pacifici & Bershady, 1993). The current data supported previous suggestions that to understand dream sharing it is important to consider the social and

cultural context in which it occurs (den Boer, 2012; Dombeck, 1994a; Ijams & Miller, 2000; Stefanakis, 1995; Tedlock, 1991; Vann & Alperstein, 2000; Wax, 2004). The participants often made sense of their dream sharing choices in therapy through their dream beliefs. An example of this was the second participant explaining that she shared dreams in therapy because of her belief that dreams are meaningful, revealing, symbolic, a message from the unconscious, or:

> *a gentle reminder that something's not quite in balance and therefore I need to pay more attention (interview 2)*

She identified the sources of her dreams beliefs, or at least influences on them:

> *Probably, a fair amount from pop culture <<laugh>> movies and tv and seeing like what other people with dreams have and dream sequences and so much. I went to art school, there's a lot of symbolism in there and so trying to apply those things (interview 2)*

She also noted that reading Jung or articles about dreaming, and academic and personal interests in consciousness and the unconscious influenced her views. Another participant cited personal interest in her unconscious mind and the influence of her lived experience on her dream beliefs:

> *I think I've been really self-absorbed <<laughs>> and just being interested in stuff that goes on in my head, unconscious stuff, how your unconscious mind works. And I suppose for that you have to have a belief that that sort of thing is real and kind of chimes with your own experience of your own mental life (interview 5)*

The third participant also alluded to her own experience as an influence on her dream beliefs, along with her religious beliefs:

Just really my own experience. Really when it comes down to it. You know, I mean they are trying to tell me something and also a lot of them allude to my biblical beliefs as well, as in what's to occur as far as biblical prophecy as well (interview 3)

Several participants noted that their dream beliefs had changed over time due to their personal dream experiences and messages they received from positive therapeutic experiences differing from the broader societal views they had encountered in their upbringings, that dreams are meaningless or of no value.

5.5.4 Dream sharing rules - what not to share outside therapy and why

Dream recall is essential to dream sharing as you cannot share what you have forgotten (Schredl, Kim, et al., 2015; Schredl & Schawinski, 2010). Of those that are remembered, literature suggested that the types of dreams that are not shared include dreams inconsistent with the dreamer's waking life values, many sexual dreams, such as sexual infidelity dreams (Ijams & Miller, 2000), dreams in which the listener was endangered or dreams that portrayed the dreamer in a negative light (Vann & Alperstein, 2000). Basically, self-censorship is believed to be contingent on the dreamer's judgement about safety and risk, with Wagner-Pacifici and Bershady (1993) assuming that the more disturbing a dream, the fewer groups with whom it will be shared.

Other studies found a number of reasons for not sharing some dreams with others, including a desire to protect the self, such as avoid humiliation or loss of respect, to protect the listener's feelings, and to protect the relationship between the dreamer and the listener (Ijams & Miller, 2000; Vann & Alperstein, 2000). Stefanakis (1995) gives an example of how miscalculating these factors can end badly, with a dreamer's colleagues being distressed by the shared dream about their violent death when the dreamer had intended

it as a meaningless, amusing anecdote. These reasons were present in various forms in the current data.

Firstly, the current data supports previous studies in finding that there are taboo dreams with strong social and cultural norms around which dreams are deemed inappropriate to share with which particular people (Ijams & Miller, 2000; Schredl & Schawinski, 2010; Szmigielska & Holda, 2007; Vann & Alperstein, 2000). In relation to learning the rules of what to not share, with whom and why, the first two participants identified their upbringings and exposure to popular culture as sources of their dream beliefs. For example, the first participant, whose beliefs have changed to seeing dreams as '*your brain trying to tell something sometimes*' (interview 1) following her second psychologist's response to her dreams, spoke about influences on her dream beliefs throughout her earlier life:

> *But it's almost like tv, like they, dreams are just seen as something crazy or like you're in love and that's why you dream about the person that you want to spend time with. But I don't know where I got it from, it's just something I grew up believing was that dreams were just, you know. And like they'd talk about how your brain when you sleep, and you have the R.E.M. sleep and that's when you dream and it's your brain trying to process everything (interview 1)*

The participants spoke about not sharing dreams that are irrelevant or uninteresting to the listener. For example:

> *one would want to very carefully choose which ones [which dreams to share], like if they are to do with her personally and she might be interested in hearing them. Otherwise it's just bombarding somebody trying to share your dreams all the time <<chuckles>> (interview 3)*

The participants wished to avoid rejection due to breaking social norms or the cultural connections between nightmares and mental health:

> *I definitely would not mention dreams that were disturbing or I might mention that I have a lot of nightmares to friends and that, you know, I wake up a lot and whatever. But more like that's a symptom because they know that I have a mental health issue. […] So, I think the decision is just on basically a fear that if I mention too many of these dreams to people in my everyday life…it's that fear of rejection again, they're not going to want to hang out with me if all I talk about, or if I talk about dreams on an regular basis. I don't think that's something that people generally want to hear about (interview 5)*

Some were concerned about lay misinterpretations of dreams or conflicting dream beliefs and the second participant also chose not to share some dreams with her partner to avoid his concern and judgement. The first participant avoided sharing some dreams with others because of the intense feelings or the impact caused by thinking and talking about her nightmares.

Dreams were seen to be devalued in Australian society with the fourth participant interpreting the silence around dreams in the media and the absence of dreams as a topic of conversation as there being a taboo around sharing some dreams. She differentiated between sharing dreams outside and in therapy by noting that it is not necessarily socially appropriate to expose so much of yourself or how you are feeling outside therapy as it may be seen as weird:

> *it's [dreams] not something that you ever see in media as a topic of conversation. If you haven't brought it up to someone before there's quite a high chance that they might take it as a weird thing to bring up or something too intense or like too much or stuff like that (interview 4)*

This is consistent with previous research which found that social rules for dream sharing may also include awareness of when enough is enough regarding what to withhold when

sharing a dream, or even just recognising appropriate time limits or gauging the level of interest the listener has in hearing a particular dream (Hilbert, 2010). Dream sharing has been positioned as a social interaction, or performance, with social goals and culturally informed rules of social interaction that apply to it, just as they do with interactions about other topics or experiences (Dombeck, 1991; Stefanakis, 1995; Tedlock, 1991). The negotiation of social rules determine what can be shared with whom in relation to dreams, with rules around the appropriate levels of self-disclosure and what is considered to be taboo in relation to dream sharing varying between different relationships, different types of relationships, and different cultures (Ijams & Miller, 2000; Vann & Alperstein, 2000).

5.5.5 Dream sharing rules - what not to share in therapy and why

The participants identified shame, embarrassment, unimportant or what they considered to be irrelevant dreams, time constraints, therapist expertise, and stage of therapy and its connection with levels of safety and trust, as the major reasons for choosing not to share particular dreams with their therapists. They also differentiated between trivial dreams and meaningful dreams through their use of terms like ‘just’ to indicate the lesser value of this category of dreams that they chose not to share. This may suggest that the Western privileging of waking reality over dream experiences (Stefanakis, 1995) is present in some of Australian society.

5.5.5.1 Knowledge about dreams and therapy

While all the participants saw therapy as a relevant place to share dreams, prior to seeing her second psychologist, the first participant and her friends had not been aware that dream sharing in therapy existed. She searched online and assumed that dream work in therapy was rare as even the website of the psychologist with whom she shared dreams mentioned CBT, but not dreams. This may well speak to the marginalisation of dreams in contemporary psychological practice (Leonard & Dawson, 2018).

5.5.5.2 Cultural and individual dream beliefs

Participants provided several potential explanations for the rarity of dream work in Australian psychological practice, including the cultural devaluing of dreams. The fourth participant believed the general attitude towards dreams in Australia is that '*dreams are considered of low value to the average Australian because they are seen as feminine*':

> *They're probably seen as not practical, artsy-fartsy [sic], esoteric or new wave, or like dumb and spiritual. But I don't know if it's Australia in particular or it's just like a very capitalist mindset, like everything that you do in your life must be productive or must earn money or generate money and stuff like that. So, maybe a general Western perspective or just like a late-stage capitalism perspective (interview 4)*

She interpreted the silence around dreams in the media and the absence of dreams as a topic of conversation as there being a taboo around sharing some dreams.

5.5.5.3 Stage of therapy and taboo topics

The stage of therapy influenced the participants' choices to not share certain dreams in therapy both in relation to fears about rejection and abandonment and the need to have established trust and a strong therapeutic alliance. The fourth participant chose not to share dreams about abandonment when her therapist terminated therapy in her first therapy experience because she felt embarrassed, ashamed and weak at that stage of her therapy journey. Her description of what this felt like is below:

> *It was very awkward. I was embarrassed and ashamed for having those dreams in the first place (interview 4)*

She continued on to explain that she felt '*like I was closed off, not just about the dreams but also everything else*' (interview 4). The stage of therapy also influenced the fifth participant's decision to not share dreams featuring her psychologist:

> *for the first couple of years of therapy with my current psychologist, I was probably embarrassed to mention stuff where she was in the dream. It was sort of, not because it was sexual but because I thought she would perceive it as sexual. And so I didn't want to mention it because I was embarrassed. Um…but now I don't care <<laughs>> (interview 5)*

The second participant identified some taboo dream topics for sharing in therapy but believed that this would be mediated by the client in question, the stage of therapy, and the therapeutic relationship. Below is an excerpt with her discussing what she thinks may or may not be appropriate to share with her therapist:

> *Maybe things that would cause so much shame. Like if I were to dream about you know, going on a murdering spree. Then again, I would find that very compelling <<laughs>> I'd want to know why am I going on this murdering spree? <<laughs>> I think it depends. It depends on the client, it depends on the therapist. I have a bit of a rapport with mine now. I certainly wouldn't go to her with murdering dreams in the first few months <<smiles>>. But, if I was murdering a whole bunch of people then yeah, I'd be like, what am I doing? <<laughs>> What's happening, what does my brain want me to know? <<laughs>>. I think suicide, I would definitely talk to her about that because that has been a problem in the past, so that would be sort of a red flag that we could discuss. Um…sex stuff. Um…I kind of mostly talk about that with my partner. So even the embarrassing stuff because again, we just have a laugh about it. (interview 2)*

Finally, the third participant explained that her choice to not share some of her many dreams in therapy was mainly due to time constraints.

5.5.6 Dream sharing rules - the influence of the psychologist

The data show that clients do not arrive at therapy with a complete set of explicit shared rules around dream sharing. As with other social interactions, both people involved in the interaction can influence what occurs. The explanations that participants' offered for their experiences and choices around dream sharing in therapy appear to be in keeping with the social constructionist approach to understanding dream sharing in therapy (Stefanakis, 1995). This approach understands dream sharing as a culturally imbued social interaction or exchange, or cultural practice, which can only be understood in context, and in which the intentions or goals of clients when sharing dreams, are important considerations for therapists. The fourth participant provided an example of how even the *unspoken* can influence clients:

> *I had different therapists who I wouldn't share dreams with because I felt maybe it wouldn't fit their style or it wouldn't fit the way that we were conducting sessions with each other (interview 4)*

As this excerpt shows, psychologists can have a profound impact on clients' dream sharing without dreams ever being mentioned. This is consistent with previous research in which clients' reasons for not sharing dreams in therapy included reasons like the perception that their therapist was not interested in dreams (Crook-Lyon & Hill, 2004). Even the smallest of behaviours, such as writing something on a notepad can act as a cue to clients about what the psychologist sees as important (second participant).

The influence of the psychologist's style, theoretical orientation, relationship with the client, and their response to a client sharing a dream on the client's perception of the relevance of dreams to therapy, their future dream sharing behaviours, and their dream beliefs, were

all evident in the interview with the first participant. She described a negative experience of dream sharing with her first psychologist, whose disinterest in her dreams led her to believe dreams were irrelevant to therapy. It was only when she saw another psychologist who talked about her dreams that she changed her mind:

> *I didn't really understand the role of dreams at that point [with her first psychologist]. So I kind of just like 'oh my gosh, she's not focussing on it then it mustn't be important in this situation,' and it wasn't until I saw the therapist who did talk about the dreams that I went 'oh, like, yeah, it actually does play a role' (interview 1)*

This different response to her dreams from her second psychologist played '*a massive role in that it helped me to then tell my story without any fear*' (interview 1). This fits with previous findings that psychologists mentioning dreams in therapy can act as encouragement for clients to share dreams (Crook-Lyon & Hill, 2004). The first participant's experience also points to the potential ramifications of divergent dream beliefs, which can been seen in an analysis of a CBT-oriented dream sharing interaction by Alder (2016). Alder notes that interactions convey more than the just the spoken words. She describes how the client in the analysis took a risk in sharing personal issues (a dream) with their therapist, making themself vulnerable. The therapist's response to (or rejection of) the client's dream beliefs or a shared dream, can in turn upgrade or downgrade the value of the shared dream as well as impact the therapeutic relationship (Alder, 2016).

5.5.6.1 Training and theoretical orientation

Therapists were seen to frame, understand and respond to dreams in different ways because of their training, theoretical models of therapy and goals. To illustrate this point, the fifth participant said her nightmares are seen as an undesirable symptom for her

psychiatrist to address through medication adjustments, so she rarely shares dream content with him. In contrast she shares recurring, disturbing dreams that affect her the following day with her psychologist, and dreams that may reflect their relationship, noting that she tells her psychologist everything and dreams are just a part of what might help their work together.

The participants' discussions about the influence of theoretical orientation on dream sharing in therapy aligned with previous findings about dreams and theoretical orientation (see Alder, 2016; Freeman & White, 2002; Montangero, 2009; Schredl et al., 2000). When asked about her psychologists not initiating dream work, the fourth participant attributed it to many Australian psychologists being trained in CBT, which she had not heard of being a dream-focussed type of therapy. The second, fourth and fifth participants differentiated between the more a rigid adherence to 'manualised' and skills-focussed models of therapy, such as CBT or DBT and more client-led, flexible approaches that allow space for dream sharing:

> *I think a lot of therapists are CBT-focussed…I'm not really sure how that relates to dreams. But it seems a little bit rigid and not as open to exploration (interview 4)*

The therapeutic relationship and trust were also seen as essential for dream sharing in therapy. The second participant described her experience of one CBT-oriented therapist she saw and how it influenced her dream sharing choices:

> *There was no room and there was no real trust. […] So it was just very clinical. It wasn't really therapeutic <<short laugh>> It was just going through the motions [...] I didn't feel like talking to him about a dream would have gotten anywhere. Nor did I feel comfortable bringing it up. So it was more like him*

leading the sessions. It was more, just, retraining my brain and dreams just didn't seem to factor in. It wasn't a comfortable space (interview 2)

5.5.6.2 Rejecting dreams

When asked about the possibility of psychologists rejecting shared dreams or refusing to work with clients' dreams, four participants said they would not work with a psychologist who did not work with dreams, particularly in long term therapy. This was attributed to the connection between emotions and dreams, the role dreams play in the participants' lives and identify, and the relevance of dreams to therapy. The fourth participant said:

I would probably feel like I couldn't share as much as I wanted to about myself with them. So even if it wasn't dreams-related, I would probably hold back on other things too (interview 4)

In response to being asked about a therapist not working with dreams, one participant said:

I would just find it weird that they would say one aspect of your experience, you can't talk about here. I would just find that really weird and think what are they scared of or like isn't that just part of life or you know? To me it just wouldn't make sense to exclude one […] I would not welcome censorship on what I could say and what I couldn't say (interview 5)

The third participant's response to the question was:

it's such a huge part of my life if that therapist doesn't understand or doesn't care to understand about that, we would have no connection whatsoever. I would think even generally, a therapist should have some kind of interest or knowledge or…I can't understand anyone who would say something like that.

I can't even fathom any therapist who would think like that. I don't think they should be a therapist (interview 3)

The participants' advice for psychologists focussed on respecting the vulnerability of clients and recognising the impact that their behaviour and responses can have on a client. They advised against rejecting dreams. Instead, they recommended that psychologists approach dreams with an open mind and provide a safe space without pressure for clients to share dreams, irrespective of their own theoretical orientation and goals, as clients are probably bringing up a dream because they wish to explore it or are seeking validation from the psychologist. This is consistent with the idea we explored in Leonard and Dawson (2019), where we proposed that when dream sharing is seen as a gift or exchange, inappropriate psychologist responses could impact the therapeutic relationship, the credibility of the therapist's expertise and even potentially the credibility of the broader psychology profession. The fifth participant advised:

just take people seriously and don't give them the feeling that they can't bring up that stuff (interview 5)

5.5.7 Strengths and limitations

Most participants explicitly noted that they were interested in self-reflection and their comments showed evidence of some relevant reading. This contributed to the collection of high quality data with participants providing rich descriptions of their experiences alongside insights and reflections they made connecting these with their knowledge of themselves, therapy, theoretical orientation, dreams, and psychology.

IPA research delves deeply into a specific experience to gather rich, relevant data and is not designed for broad generalisations. Samples are therefore small and may not represent all relevant experiences around a topic like dream sharing. To begin with, sampling factors are likely to have contributed to the findings of many dream sharing

studies due to the opportunity for various sharing scenarios (Curci & Rimé, 2008; Graf et al., 2021; Olsen et al., 2013; Schredl, 2009; Schredl, Fröhlich, et al., 2015; Schredl, Kim, et al., 2015; Vann & Alperstein, 2000). Opportunity could also explain why therapists were located towards the bottom of the hierarchy of people with whom dreams are shared in the study by Olsen et al. (2013), despite the intimacy of the therapeutic relationship.

In the current study, sampling factors, such as the recruitment of people wishing to talk about their experiences of sharing dreams in therapy for the current study, and people with high levels of dream recall, may account for why all participants had shared dreams in therapy and the importance given to the therapeutic relationship. Similarly, opportunity and sampling influences could account for the first two participants discussing how they share many of their dreams with their partners, while the fifth participant explained that she might mention her dreams to her partner if they heard her yelling in the night, but did not do so because she did not have a partner.

All five participants in the study identified as female and while previous research has found that volunteers for dream interpretation sessions are more often female (Hill et al., 1997), people who identify as other genders also share dreams in therapy. Similarly, while dream sharing occurs in therapy around the world, the interviews focussed only on the contemporary Australian psychological therapy experience, delving deeply into the specifics of that particular context. The small number of participants in this study and the focus on a specific time and place context, means that the data may have missed some important aspects of dream sharing experiences and perceptions present in the wider, very demographically diverse Australian population or international populations.

5.5.8 Implications for research, psychologist training, and practice

As previously mentioned in relations to the limitations of this study, future research using larger samples, and in different cultural contexts, could determine whether any salient points around clients' experiences and perspectives around dream sharing in therapy, may

have been missed in this study. Participants in the current study also perceived a difference between their own and the broader Australian society's dream beliefs. Further research could determine whether this is a universal experience or specific to particular subgroups in society. Such research could yield data that could be used for the normalisation of client experiences, which has been identified as an important factor in clients' experience of a therapist in general (Amos et al., 2019). Such data could also assist psychologists in adopting a culturally sensitive approaches to dreams, as advocated by Schubert and Punamäki (2016).

The findings of this study point to the importance of the therapeutic relationship for dream sharing to occur, and the risk for ruptures in it as a result of inappropriate cues or responses from a psychologist. The therapeutic alliance is most at risk under conditions with low levels of cultural competence and high levels of racial and ethnic blindness, and a one size all model is an inadequate solution (Dune et al., 2018). Consideration of a dreamer's and listener's cultural and social conceptualisations of dreams can assist in avoiding misunderstandings and unintended outcomes from dream sharing. Improving cultural diversity in university staffing, and the recruitment of psychologists to better reflect the diversity of the society in which psychologists practice, are essential for ethical and competent psychological practice in general (Cameron & Robinson, 2014; O'Connor et al., 2015), as is training and practice that assists psychologists to actively avoid instances of cultural incompetence or avoidance of the potential for cultural differences to impact therapy (Chang & Berk, 2009).

For such changes to be successful in a sustainable and substantial way, a range of strategies, or starting points have been promoted by a growing number of people (see for example Bogle et al., 2021; Cullen et al., 2020; Darlaston-Jones et al., 2014; Dudgeon et al., 2017; Dune et al., 2018; Krusz et al., 2020; O'Connor et al., 2015). Their recommendations include increasing epistemological diversity and flexibility/adaptability in the curriculum, increasing pedagogical diversity in teaching practices, ongoing

engagement in critical, intersectional reflexivity, recognition of within group diversity as well as diversity between groups, and contextualisation of the curriculum. Contextualisation of the curriculum would also require a broadening of the ideological position of psychology as a hard science, which narrows its scope and risks unintentionally reinforcing power structures that cause or maintain inequality (Cullen et al., 2020). Such changes could better equip psychologists to feel more confident and competent around working ethically with their clients' dreams within the context of a culturally diverse world and improve client experiences of dream work and of therapy in general, even without explicit instruction in dream content.

Those types of changes and processes, such as critical reflexivity, would also support psychologists to cope with their inevitable experiences of uncertainty, and to develop strategies to increase awareness of their own feelings and how to respond when confronted with situations in which their clients' cultural or other values and beliefs clash with their own (Ahn et al., 2021). This could be particularly beneficial in responding to clients' shared dreams. The impact of psychologist responses on clients' experience of dream sharing, their dream beliefs, future in-therapy behaviours, and decisions around working with a particular psychologist, shows that psychologists' responses to dreams are important for that dream and for the impact on therapy more broadly.

The current study provides further support for the value of including the client voice in psychological practice research and practice guidelines for psychologists. Such research may not just contribute to clinical practice for psychologists and better outcomes for clients, but could also provide another form of validation and normalisation for clients in relation to their dream beliefs and dream sharing practices. The role of individual, social and cultural factors in relation to dream sharing in therapy also support collaboration and the exchange of ideas between different disciplines, as Ijams and Miller (2000) advocate.

Finally, the way that participants explained their experiences and perceptions, suggests that sharing a dream is a contextualised narrative of an experience, imbued with personal, social, and cultural meanings, emotions, rules, and expectations. The findings support the need to consider performative and social/cultural practice conceptualisations of the introduction of dream material in therapy, rather than limiting approaches to dream work to a decontextualised application of a particular model of therapy. A performative or social exchange (gift) view of dream sharing comes from a position that understands there are multiple, cultural, social and individual influences on clients' choices to share particular dreams (or not) in particular contexts and that there is a need to consider these when engaging in therapy with a client, irrespective of the psychologist's theoretical orientation. The impact of psychologist responses on clients' experience of dream sharing, their dream beliefs, future in-therapy behaviours, and decisions around working with a particular psychologist, shows that psychologists' responses to dreams are important for not just the dream that is shared, but also for psychological practice more broadly. Awareness of the impact that these unspoken elements of exchanges around dreams can have on therapy, could help ensure that these elements are not misinterpreted or missed altogether.

5.6 Conclusion

In his work on the exchange of gifts, Mauss (1970) described there being specific expectations in exchanges, such as social interactions, on the part of the giver and receiver. This has previously been applied to dream sharing, in passing by Vann and Alperstein (2000) and Wagner-Pacifici and Bershady (1993) and then expanded upon in detail by us in Leonard and Dawson (2019). We argued that dream sharing can be conceptualised as a social interaction in the form of an offered gift, or exchange in which a risk-benefit evaluation occurs, and potentially used both as a way to test and to increase intimacy in a relationship, including a therapeutic relationship. This application of the concept of dream sharing as a gift exchange can serve as a reminder to psychologists of

the underlying expectations on the dreamer and listener and the performative nature of therapy.

IPA's emphasis on context has enabled the application of a social/cultural practice framework as an explanatory model for the participants' accounts of their experiences and understandings around the use of dreams in Australian psychological practice. This framework sees exchanges and interactions that occur during therapy, as existing within a broader cultural context of beliefs, rules and expectations. The data shows that dream sharing is one such exchange, or cultural practice, in which intimate, personal, and subjective experiences are selected by clients for various reasons to be shared (or not shared) with their therapists. Cues from the psychologist can influence client choices to share dreams, the client's experience of dream sharing in therapy, and the client's future dream- and therapy-related beliefs, expectations, and behaviours.

From the client's perspective, the ways that dreams are used in therapy and the role that dreams play in contemporary Australian psychological, may vary considerably between each experience of therapy, and from one client to the next. The participants emphasised that dream sharing can be a risky and vulnerable experience. It can both increase the intimacy of the therapeutic relationship and act as a barometer of an already strong therapeutic relationship. Openness to clients sharing their dreams, and the creation of a safe space, and personalised, culturally sensitive responses to shared dreams, can assist in preventing damage to the therapeutic alliance, and the client's future choices about, and experiences of, therapy. Consideration of context, inclusion of the client voice, and greater diversity in psychological practice research have the potential to further improve the knowledge base, practice guidelines, training for psychologists, and client outcomes. Further research into dream beliefs and practices may also provide data for psychologists to use when validating and normalising client experiences, helping to increase therapist confidence in responding to shared dreams.

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Chapter 6. Conclusion

6.1 Introduction to final chapter and chapter overview

This final chapter of the thesis provides a summary of the PhD research project. It draws together the findings and recommendations from both studies, including an evaluation of the project and its contribution to knowledge, before concluding with a final engagement in the reflexive process underlying and informing this project.

6.2 Justification for the research

The following four subsections, from 1.2.1 to 1.2.4, step through the core argument justifying this research project, along with the gap in the literature identified in section 1.2.5.

6.2.1 Dreams have been marginalised in contemporary Australian psychologist training and practice

Most psychologists, particularly those trained in CBT, receive limited formal training on how to work with dreams (Freeman & White, 2002; Skrzypińska & Szmigielska, 2018). Indeed, dreams seem to have been marginalised in contemporary psychological training and practice, due to a range of historico-cultural reasons, such as psychology seeking to align itself with an outdated, narrow, natural sciences identity (Leonard & Dawson, 2018). As argued in Chapter 3, while such alignments successfully helped psychologists to access government funding and credibility in an increasingly neoliberal policy context, it may also increase the risk of the profession losing relevance in relation to the world of psychologists' clients.

6.2.2 Some within wider society see dreams as relevant to psychology

Dreaming is a universal human experience (Schredl & Bulkeley, 2019; Schredl & Schawinski, 2010; Vann & Alperstein, 2000). Some dreams are seen as intimate and personal experiences, which can result in people feeling quite vulnerable when sharing them (Schredl, Fröhlich, et al., 2015; Schredl, Kim, et al., 2015). The psychologising of dreams (Nell, 2014), and the nature of therapy with its emphasis on the therapeutic alliance and creation of a safe, nonjudgmental space, mean that many people see therapy as an appropriate place to share dreams.

6.2.3 Dream sharing can be understood as a social interaction or exchange, which comes with rules and expectations

Sharing dreams can be understood as a 'gift' or an interaction or exchange between people. There are individual and cultural expectations around exchanges and interactions in our society (Mauss, 1970), including both what occurs in therapy, and what occurs when dreams are shared. This creates potential for conflicts or gaps between client and psychologist expectations in relation to dream sharing in therapy.

Mismatches may occur even at the most rudimentary level like whether clients and psychologists are both expecting dream material to be introduced into therapy, let alone differences in expectations around the level of expertise psychologists have in dream work and how they might respond to shared dreams. For example, studies show that while therapists will generally experience clients introducing dreams into therapy at least occasionally, many report feeling they lack the confidence and competence to respond appropriately (Crook & Hill, 2003; Freeman & White, 2002; Keller et al., 1995; Pesant & Zadra, 2004; Schredl et al., 2000). These findings suggest that therapists are not expecting to work with dreams while their clients clearly are.

6.2.4 There is potential for negative consequences due to mismatches in expectations between clients and psychologists

The possible consequences of the mismatches and expectations not being met (outlined in the previous section - 6.2.3) include damage to the therapeutic alliance, negative impacts on therapy, and the risk of psychologists losing credibility in the eyes of their client, with clients also beginning to question their expertise in other areas of practice in which they expected them to be experts (Leonard & Dawson, 2019). Such situations may also lead to vulnerable clients seeking dream and psychological expertise in other places that may not provide the safety, evidence-based practice, and ethical standards associated with regulated psychological practice.

6.2.5 Gap in the research literature and justification for this research

While there are many papers and theories around dreams more generally, there is limited research that focusses on the lived dream work experiences of therapists (Hackett, 2020, 2021; Leonard & Dawson, 2018), and very few studies that include the client voice (Crook-Lyon & Hill, 2004).

Due to the potential consequences of mismatched expectations, outlined above, it is important to address this gap in the literature and understand the experiences and sense-making around dream sharing and the roles of dreams in psychological practice from both the client's and the psychologist's perspectives.

6.3 Summary of the research aims and objectives

The aims of this research were to identify psychologists' and clients' understanding of the role of dreams in contemporary Australian psychological practice and of their lived experiences of the introduction and use of dream material in therapy.

The objective of this research project was to undertake an interpretative phenomenological analysis of transcriptions from semi-structured interviews with Australian psychologists and adult clients (current and former) of Australian psychologists about psychologists' and clients' perceptions of their experiences around the introduction of dream material in therapy and the role of dreams in contemporary clinical practice.

6.4 Summary of the methodology and methods

This research took an interpretative phenomenological analytic (IPA) approach and the analysis of the de-identified interview transcripts was completed making use of Dedoose qualitive data analysis software for the initial data coding process. IPA research is interested in collecting rich, quality accounts of participants' lived experience, to delve deeply into a poorly understood, novel or complex topic, rather than focussing on quantity and generalisability (Smith et al., 2009). For this reason sample sizes are generally small and need to be highly relevant. Following approval from the Central Queensland University Human Research Ethics Committee, a purposeful, snowballing approach to recruitment resulted in sixteen psychologists and five clients completing semi-structured interviews that focussed on two general questions:

1. Please tell me about some of your experiences of dreams being brought up in therapy?
2. What do you think the role of dreams is in Australian psychology?

The double hermeneutic nature of IPA research recognises that researchers interpret and seek to understand a participant's interpretation of their lived experience through the lens of their own values and knowledge, and existing theory and research (Smith et al., 2009). In turn, readers of this research are understood to interpret the write up of the research through the lens of their own lived experience, values, and knowledge. For these reasons, much attention has been given to providing contextualisation throughout the thesis. This includes several narrative literature reviews and chapter introductions that explicitly

discuss the theoretical and research influences on the researcher throughout the research process. Some relevant ontological, epistemological, and personal value assumptions, have been explicitly discussed in this thesis, along with a summary of the researcher's background for readers to use in their interpretation of the thesis.

IPA approaches to research are interested in convergences and divergences within the data (Smith et al., 2009). To enable a deep analysis of the data that gave voice to the many participants and their divergent experiences and understandings, the data from the two studies (psychologist interviews and client interviews) were analysed separately. The themes reflected the researcher's attempt to capture an interpretation of the participants' interpretation of their experiences, at this point in time and place. In keeping with IPA principles, it is understood that the interpretation presented in this thesis is not the only possible interpretation possible, and that were the interviews or the analysis completed at a different time, it would be likely that the findings or output from this research would be different (Smith et al., 2009). The themes balance the need to give voice to both convergences and divergences within and between the data, and encompass as much of the available data as possible. These findings are summarised below, along with a discussion that draws together the convergences and divergences between the two studies.

As a final note regarding the data analysis, to qualify as a superordinate theme, the theme had to be present in all of the transcripts (sixteen for the psychologist study and five for the client study). To qualify as a subtheme, the subtheme needed to be present in at least half of the transcripts.

6.5 Summary of the psychologist (study one) findings

The first study, reported in Chapter 4, focussed on the psychologists' experiences around dreams in contemporary psychological practice, and the need for psychological training, research, and the profession's identity to adapt to the complex needs of the diverse and

rapidly changing society in which psychological practice occurs. Complexity theory was used as a framework for making sense of the findings. Complexity theory conceptualises reality as a complex, open system in which the interrelated subsystems interact through multiple, non-linear, recursive feedback loops (McMillan & Gordon, 2017; Sanger & Giddings, 2012; Woolcott et al., 2020). Complexity, in this sense, refers to the uncontrollable, unpredictable, messy, and confusing circumstances, that professionals must face, and that are important to humanity, but that cannot be resolved with mere technical solutions (Schön, 1987).

The four superordinate themes identified in the first study are below:

1. *Dreams have boundary characteristics,* in the context of psychological practice
2. Psychologist must negotiate *Multiple influences on practice*, on a daily basis, and in their dealings with dreams
3. The *Importance of the therapeutic relationship* is evident for both dream sharing and therapy in general
4. There is an underlying *Sense of disquiet around dreams* within contemporary Australian psychology

The *Dreams have boundary characteristics* theme focussed on the contradictions and the diversity around perceptions of both dreams and psychology, that position dreams as an example of complexity in professional psychological practice. The subthemes for this first theme included the diversity in the incidence of dream work, the absence of training, competence, and confidence around dream work, and the diversity in views amongst the general public's and psychologists' around whether dreams do or should belong within psychological practice. The final characteristic of dreams that pointed to them being a boundary topic for psychologists was the absence of a widely agreed upon script for responding to dreams. This was evident in the lack of resources, and the lack of professional-level knowledge about dream theories and models of dream work within

various theoretical approaches to therapy, resulting in diverse and idiosyncratic responses to dreams among the participants.

The second theme in the psychologist study revealed the participants' experiences and perceptions of their everyday juggling of *Multiple influences on practice.* The absence of a pre-existing script to respond to dreams meant that the participants were forced to privilege particular influences on their practice over others, when making decisions about dreams and dream work. Subthemes pointed to some of the major influences on dream work including a psychologist's theoretical orientation(s), theoretical trends within the field of psychology over time and place, the participants' jobs, which have restrictions on what they are allowed to do with whom, and the need for psychologists to earn money. Psychologist and client dream beliefs, psychologist assumptions about clients, psychologist position on the influence of clients, and governance and governmentality influences, were also identified as major contributors to psychologists' decisions around dreams and dream work.

The third theme in the psychologist study was one of the most pervasive influences on dream work and psychological practice in general. This theme was the *Importance of the therapeutic alliance*. This relationship was seen as special and different to other types of relationships, and both necessary and valuable to therapy and therapeutic outcomes. The therapeutic alliance was seen to be important for dream sharing. This could be explained, at least in part, by the belief that some dreams may be seen as meaningful and revealing, frightening, distressing, confusing, intimate, personal, shameful, or embarrassing. Sharing dreams was also seen by some, to strengthen the therapeutic relationship.

While dream work was valued by many of the participants, many alluded to a *Sense of disquiet* in trying to reconcile dream work with being a good psychologist. This final theme of the psychologist study was expressed through discussions about the topics covered in the subthemes. These included credibility, imposter syndrome, the lack of a script for

dream work, and low confidence levels around dream work. Participants discussed how they, and other psychologists, learnt the message that dreams are taboo in psychology. This was often through the silencing of discussions about dreams, their absence in the curriculum and cultural devaluing of dreams in which they are associated with the irrational, non-scientific, not-credible and fringe, woo-woo, or spiritual sectors of society that are perceived as inferior, and with which it is considered professionally embarrassing to be associated. Participants also alluded to the desire to be good and ethical psychologists. They discussed the mediating influences of clinical experience, practice knowledge, and transitioning from a technician who follows a manualised script, to a clinician who engages in a more broadly defined manifestation of evidence-based practice (EBP), on levels of discomfort, or levels of acceptance of discomfort. This was particularly so in relation to ideas about dreams and dream work connected with Western theories of mind, and discomfort around dreams not being objective, verifiable events that have a single, 'correct' interpretation.

The discussion of the findings in Chapter 4, particularly around complexity, identified the value of epistemic fluency, actionable knowledge, and diversity in training and research. Improvements in these aspects of psychologist training, and ongoing engagement in critical, intersectional reflexivity, would enable students to better develop the expected core competencies for psychologists (Registration standard: General registration, 2016). It would also support students to further develop the capacity to implement a broader interpretation of evidence-based practice (Hamill & Wiener, 2018), to address current and future social issues, and client needs.

Recommendations have been made for a number of strategies for achieving sustainable and substantive changes in these aspects of psychology. These include contextualisation of the curriculum alongside a broadening of psychology's identity as a hard science; increased epistemological, methodological, and pedagogical diversity in the psychology curriculum, research, and teaching; a greater recognition of within-group as well as

between-group diversity, greater inclusivity of diverse voices, and increased diversity in university staff and the psychologist community. Implementing these recommendations would help to ensure that psychology can move beyond just a superficial decolonisation of the curriculum that would see the continued (unquestioned) dominance of white and neoliberal conceptualisations and positions (see for example Bogle et al., 2021; Cullen et al., 2020; Darlaston-Jones et al., 2014; Dudgeon et al., 2021; Dune et al., 2018; Krusz et al., 2020; LaMarre et al., 2019; Rasmussen, 2018). This could indirectly result in increased seeking out of, and acceptance of, new knowledges and types of knowledges about topics like dreams that have been sidelined by a field fearful of compromising its scientific credentials and financial successes in a neoliberal context.

6.6 Summary of the client (study two) findings

In the second study, the first superordinate theme focussed on the *Dream sharing experiences* of the client participants, and the second superordinate theme focussed on the *Dream sharing rules* that the client participants had identified.

Dream sharing *experiences* were diverse and feelings associated with them ranged from positively-toned to negatively-toned, even within the sample of five participants. They included feeling a sense of relief, safety, nonjudgement, validation, and vulnerability; feeling frightened, pressured, stressed, frustrated, or embarrassed; and struggling to articulate the nonverbal, often nonlinear dream experience.

Dream sharing *rules*, or underlying assumptions, focussed on which dreams should or should not be shared with whom, when, and why. The intimacy of the dream and dream sharing experiences were presented as influences on who dreams are shared with, and which dreams are shared. For example, entertaining dreams that feature the listener were seen as acceptable for sharing socially at work, with friends, or with family. On the other hand, dreams that are seen as meaningful, intimate, frightening, or embarrassing, were seen as relevant, and appropriate, to share in therapy. Avoidance of social rejection and

judgement were strong influences on both participants' choices to not share dreams both outside of therapy, and their fears about sharing them in therapy. This made sense of the level of importance given to the therapeutic alliance. The stage of therapy, also potentially related to the therapeutic alliance, was also seen to influence client decision-making and experiences around dream sharing and dream work.

One of the most significant influences on clients' dream sharing in therapy was the psychologist. This occurred through factors that were absent as much as those that were present. For example, some participants described the lack of 'space' as having a negative impact on their dream sharing. A lack of space was experienced when a psychologist insisted on strictly adhering to a manualised agenda or where there was a perception that a psychologist has a particular, negative attitude towards dreams. Negative attitudes could be conveyed via explicit statements about dreams, particular responses to shared dreams or attitudes on other matters being generalised to dreams. Other ways in which a lack of space could manifest included a lack of safety or sufficient therapeutic relationship. A psychologist was seen to not only affect the participants' choices around sharing dreams with that particular psychologist, but also influenced participants' future perceptions of the role of dreams in therapy.

The participants also perceived the theoretical orientation of their therapist(s) as being a key factor influencing dream sharing in therapy. Theoretical orientation was seen to shape expectations around how a particular therapist might engage with a dream. Examples included viewing a dream as a symptom, focussing on strategies to reduce or change the dream or nightmare experience, using dream material as clinical information or as a way to strengthen the therapeutic alliance, or using the dream content to explore and understand its relevance to waking life matters for the client.

Finally, the participants tended to perceive any rejection of shared dreams, or refusal to engage in dream work, as '*really weird*' (fifth client interview). They attributed this to their

views that dreams are relevant to therapy, part of the human experience, or that therapy is a safe place to discuss emotional, vulnerable experiences that are relevant to their psychological health. Many of them noted that they would not see a psychologist for long term therapy if that psychologist did not work with dreams, due to the importance they placed on this aspect of professional practice. One participant also spoke about dream work requiring psychologists, rather than just clients, to be willing to feel vulnerable, due to the unpredictable nature of dreams and dream work.

6.7 Convergences and divergences between the two studies

In both studies, the participants alluded to Australian society devaluing dreams by associating them with concepts and constructs such as non-scientific, woo-woo, spiritual, and 'not real'. Credibility was seen to be associated with scientific evidence, despite many individual participants expressing personal opinions that were inconsistent with this view that they perceived to be the dominant view of dreams within Australian society. The divergences between the views that some participants held, and the views that they perceived others, the profession of psychology, or broader Australian society to hold, go some way to making sense of the sense of disquiet that many experienced around dreams and dream work. This was exacerbated by the perceived silence and taboo around dreams both in lay and professional communities.

There was a general consensus across both studies, that dreams are not all the same, and that not all dreams should be shared in therapy. A number of the psychologist participants differentiated between dreams and nightmares, some implying that nightmares had more relevance to psychological practice and possibly more credibility as they were deemed to be a symptom related to a DSM diagnosis. This may point to a perception that the medical model, which focuses on pathology, remains dominant in Australian psychology, as opposed to 'positive psychology' paradigms, which may be more open to seeing 'non-pathological' dream experiences as relevant to therapy. Future

research examining this interpretation of the implications of some psychologists differentiating between nightmares and dreams would be valuable in determining the veracity of potential interpretations. Some participants in both groups also differentiated between what they believed the dreamer saw as meaningless or entertaining dreams (irrelevant to therapy), and those that held emotional or psychological significance for the dreamer (that some believed to be relevant to therapy).

Whatever the views of an individual psychologist or client, there was an acceptance that there are a diverse range of dream beliefs and practices in Australian society, and that these should be respected by psychologists, whether dream work occurred or not. Clients' expectations of therapy and dream work were thought to have been influenced by pop culture, Australian cultural expectations, and individual expectations, personal experiences, and knowledge, about both therapy and dreams.

Both groups of participants identified multiple influences on psychologists' behaviours around dreams in therapy. Psychologist participants emphasised the influence of some factors on their practice (including dream work) more than the client participants did. These included the need for income, funding, policy settings and performance indicators, professional credibility, and the profession of psychology's scientific identity. Both groups of participants identified theoretical orientation, psychologist training, individual psychologist and client factors, and the importance of the therapeutic alliance, as influences on dream work. Due to the potential vulnerability people experience when sharing dreams that are believed to be intimate, personal, meaningful and revealing, both groups assumed that there was a need for validation from the psychologist in response to dream sharing. The client voice was particularly valuable in verifying the truth of this assumption about vulnerability, and the need for validation and safety around dream sharing in therapy.

The influence of the psychologist on dream work was more deeply and widely recognised by the client participants in the second study. This was particularly so in relation to nonverbal cues. Such cues included actions like note taking, and even behaviours preceding clients' decisions to share dreams, such as the need for space rather than strict adherence to a manualised script, or factors like time constraints, and expectations about interest, attitudes, and likely goals and responses to dreams related to theoretical orientation.

The outcome of psychologist influence on dream sharing could well be a self-perpetuating cycle (presented in Figure 2). This cycle would see psychologists lacking the confidence and training to feel they can initiate dream work, acting as a cue for clients to not share dreams, which in turn leads to psychologists interpreting the lack of clients sharing dreams as client disinterest in sharing dreams, which in turn, results in psychologists perceiving no need to address their lack of confidence and training around engaging in dream work. Such a cycle could further marginalise dreams in psychological practice.

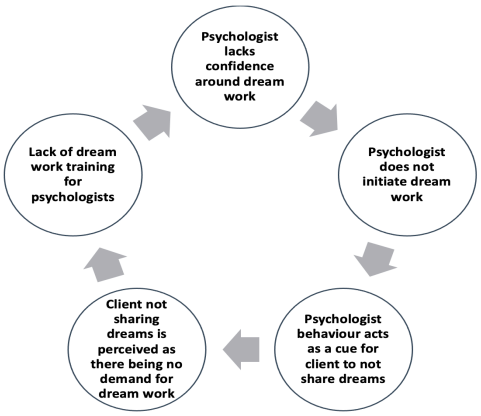

Figure 2
Potential Psychologist Role in Marginalisation of Dreams in Therapy

The client participants also noted that psychologist responses to dreams, including a perception that they are not interested in dreams, influence the clients' own views of their dreams, the relevance of dreams to therapy, and their perception of both that particular

psychologist, and therapy in general. Many of the client participants also stated that they would not see a psychologist who would not engage in dream work. Put another way, negative psychologist influences on dream sharing could potentially lead clients to question their perception that therapy with a psychologist is an appropriate place to take their immediate and important concerns and interests, such as their personal, subjective experiences and questions. This might potentially reduce the perceived value and relevance of psychological practice to these clients. This possibility is presented below in Figure 3. Given the potential impact of rejecting or prohibiting the sharing of a dream on the therapeutic alliance, not to mention the client's perception of dreams, the therapist, and therapy, these findings suggest that psychologists cannot afford to ignore the influence of their attitudes and behaviours around dreams.

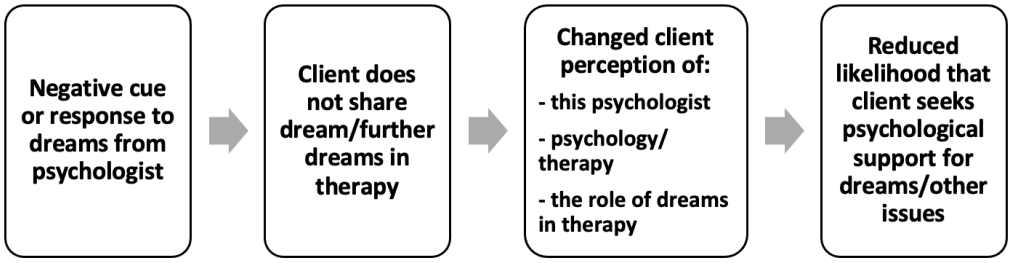

Figure 3
Potential Consequences of Negative Psychologist Cue/Response to Dreams

All participants recognised that there is not a 'one size fits all', 'correct' response to a shared dream. Respect for clients' cultural and personal dream beliefs can be extended to advocacy for culturally-informed and epistemologically diverse training, and approaches to practice, and the implementation of strategies to increase diversity in the Australian psychologist community. Increasing the capacity of psychologists around actionable knowledge in the face of the complexity that they inevitably must engage with as practitioners in contemporary society will better equip psychologists to meet the diverse needs of their clients. Such an approach, including engagement in critical, intersectional reflexivity, could assist psychologists to accept and manage any feelings of disquiet or

discomfort. It would also assist therapists, and those working in the related field of psychological research, to adapt and remain relevant, in a rapidly changing world where attachment to out-dated understandings of science and credibility do not serve the profession well, nor the clients whom they wish to support to thrive.

6.8 Strengths and limitations

In terms of self-evaluating the quality of this project, consideration was given to the guidelines for IPA research, outlined by Smith (2011), and Smith et al. (2009), who outlines Yardley's principles, as one potential approach to evaluating the quality of IPA research. These principles include sensitivity to context, commitment and rigour (or how thorough a study is), transparency and coherence, and impact and importance. These principles were examined, as relevant to this project, in Chapter 2, including discussion about the completion of an informal audit, and an examination of ethical issues associated with this project. Sensitivity to context, in particular, is a primary focus of this thesis, with references to various subtypes of it present in each chapter, as transparency assists the reader to more readily identify and consider the research outputs in light of them.

The small sample sizes of IPA studies allow a focus on producing deep, rich data from a fairly homogenous sample, valuing theoretical transferability rather than focussing on producing generalisable results (Noble & Rizq, 2020). This has meant that much rich data about many salient aspects of experience and sense-making have been revealed through the research. Triangulation through the application of multiple theoretical lenses as explanatory tools to assist in making sense of the research findings, and comparisons between the data and the pre-existing research literature, were used to improve the trustworthiness of the data.

The diversity present in the data, points to the possibility that other salient points of discussion may be present in the wider client and psychologist populations, which were not identified within the current sample due to the sampling bias inherent in small sample

sizes. Furthermore, the data from these studies demonstrate the influence of context and participant characteristics on research findings. For example, multiple participants referred to the influence of theoretical trends, and wider political and professional issues, on their experiences and understanding of dreams in psychological practice. Consistent with IPA principles relating to context, suggesting that research at a different time or with different participants could produce different or additional data about the topic, the findings presented here are only one of many possibilities.

6.9 Implications and recommendations for research, training, and practice

The implications of this research along with recommendations across six major areas of research, training, and practice, are discussed below.

6.9.1 Dream work would benefit from psychology increasing diversity and inclusivity in research, training, and practice approaches, and in researcher, trainer, and practitioner communities

One of the psychologist participants (tenth psychologist interview) spoke about the self-reinforcing nature of psychological research and practice, in which what already has support is what gets funding. This idea also points towards potential underlying issues like assertions of publication bias around the likelihood that positive research findings are more likely to be published in a timely manner than null findings, and the implications of such biases for ensuring that the transparent, efficient, self-correcting processes of research occur (see Ioannidis et al., 2014 or Rasmussen, 2018). The influence of context, sample characteristics, and the researcher, on the findings of this project's two studies, all build on this point. They point to the need to increase diversity and inclusivity within researcher and practitioner communities, topics of interest, methodologies, theoretical lenses, epistemologies, ontologies, and participant populations, when researching areas of complexity in psychological practice, like working with dream material. A broadening of research methodologies is necessary to include more qualitative and mixed methods

approaches that can deal with the complexities of real-world modern social issues and human experience (Gough & Lyons, 2016). Further to this, this research project provides an example of the value of including the client voice in dream research. It also shows the value of considering the wider historico-cultural and political/policy context in which psychological practice and research take place. These aspects of this research project have enabled the production of a richer, fuller and deeper understanding of the activity systems being examined.

6.9.2 Dream researchers could expand the ways they effectively disseminate research findings and theoretical development across the psychology community and within the psychology curriculum

The lack of research and theoretical knowledge around dreams among the psychologist participants points to there being room for more effective dissemination of existing dream research findings and theoretical developments. Directly targeting spaces inhabited by psychologists is one potential approach. For example, in addition to targeting research-oriented publications, dream researchers could also contribute clinician-focussed articles or summaries to various nations' local clinician- or professional association-oriented journals, magazines, and newsletters. While psychology curriculums could include explicit instruction on dream theories and various theoretical models for working with dreams there are, as many participants identified, time limitations within training programmes. Such content could therefore be included in professional development opportunities, for those interested in the specifics of working with dreams. Perhaps, a more effective approach within the higher education setting would be to develop a curriculum which prepares psychologists for the reality that, like many other professionals in the contemporary world, they will inevitably work with and within complex (nonlinear, interactive, and unpredictable) systems.

6.9.3 Dream work would benefit from higher education psychologist training that focusses more on producing clinicians, not simply technicians, by incorporating forms of learning with knowledge that is grounded in practice and in which epistemic fluency and actionable knowledge are valued

As argued in detail in Chapter 4 of the thesis, training of a linear nature does not address the complexity inherent in contemporary psychological practice, including examples of practice like dream work for which many psychologists feel they do not receive sufficient, specific training. Including actionable forms of learning with knowledge that is grounded in practice and creating cycles in which knowledge and practice inform one another (e.g. Markauskaite & Goodyear, 2017), can better equip psychology students to develop the skills like epistemic fluency and actionable knowledge, needed for working in the messiness and complexity of the real world in which they will work as psychologists. As Heatherington et al. (2012) explain, learning multiple theoretical perspectives can assist students to cultivate creativity, intellectual flexibility, and the capacity to develop new interventions for responding to a dynamic world and emergent issues for which clients of the future will seek psychological support.

Epistemological pluralism is a pathway towards tackling the complexities of the emerging and future social issues of multicultural societies like Australia (Breen & Darlaston-Jones, 2010). Such changes could support psychologists in developing the skills to access existing research and theoretical developments on topics, like dreams, with which they are unfamiliar. Secondly, these changes could provide frameworks or approaches for responding to the introduction of unfamiliar material during therapy. Thirdly, they could also assist psychologists in either reducing or accepting levels of discomfort around taboo topics, like dreams, that have been silenced or marginalised in psychology, during a particular era. However, a critical mass of expertise is required to ensure diversity within psychology in the future. Quick action is needed to avoid existing expertise being lost to time, as Australia continues to experience reductions in theoretical pluralism, particularly

non-CBT-focussed options, in advanced clinical psychology training (Heatherington et al., 2012), and reductions in 'professional area of practice' diversity with the privileging of postgraduate clinical psychology university courses over other forms of psychology (Breen & Darlaston-Jones, 2010; Di Mattia & Grant, 2016, Keast, 2020).

6.9.4 As demonstrated through the example of diverse conceptualisations of dream sharing in therapy, psychologist training needs to promote critical-analytic and reflexive practice for future resilience for the profession and for the benefit of their clients and communities

This research demonstrates the performative and social practice aspects of therapy, particularly in relation to the sharing of dreams in therapy. Conceptualising dream sharing as a gift or social exchange, positions the psychologist so that they assume that a client's decisions around whether they should share a particular dreams in a particular context is occurring within a broader cultural context of beliefs, rules, and expectations. Reflexive practices can support psychologists in identifying these (in relation to themselves and their clients), and in recognising the cues they are giving clients, whether spoken aloud or not. These cues may be influencing their clients choices not just about dream sharing, but about therapy and their psychologist's expertise in all areas they are believed to be an expert. This leads to the importance of adaptability for psychologists and psychological practice, as a *social field*. Adaptability enables psychologists to maintain relevance during times of change. Rigid adherence to a manualised script or an identity that is aligned with an outdated and narrow understanding of the natural sciences may have served psychology adequately in the past, but these approaches are inadequate for dealing with the complexities of the present or the future, do not foster resilience or adaptability.

Furthermore, fostering practices in educators and students that encourage engagement in reflexivity and contextual, critical-analytic thinking would benefit professionals working in areas of complexity and address what Morawski (2005) identified as a lack of explicit

reflexivity present in much quantitative, 'experimental'/'scientific' research in psychology. Reflexivity also needs to extend beyond the individualistic perspective to consider intersectionality and the psycho-political, through the lens of a human rights framework (Gemignani & Hernández-Albújar, 2019; Llorens, 2020). This project points to an opportunity for psychologists to broaden their approach to advocacy and lobbying, and to embrace their expertise and creativity, rather than apologetic compliance with non-expert, neoliberal definitions of what constitutes good practice, or valid content, for therapy.

I have compiled a list of reflexive practice prompts emerging from these studies' findings. While not an exhaustive list, they may act as a starting point for a reflexive practice process in relation to dreams in therapy. They are presented in Appendix L.

6.9.5 Psychologists need to recognise the potential for vulnerability (for both the psychologist and the client) in dream sharing situations

Both studies pointed to the value of the therapeutic alliance, the special connection and characteristics of trust, safety, and nonjudgement, that are important not just for dream sharing, but for therapy in general. The client participants and some of the psychologist participants recognised the vulnerability that clients may experience when sharing a dream in therapy. Consideration of this vulnerability, whether a psychologist is interested in dream work or not, is of paramount importance in protecting the wellbeing of the client, and the reputation of therapy as a safe place for people to be willing to be vulnerable and engage fully in the process of therapy. When it comes to dreams, this research found that risk and vulnerability do not just apply to the clients, dreams invoke a sense of disquiet for many psychologists, and the profession a whole. As the fifth client participant noted, dream sharing can be unpredictable and requires a willingness on the part of the psychologist to be vulnerable too. Courage, it would seem, is a core part of dream sharing and therapy for both clients and psychologists, or the development of a clinician approach to practice,

which can support psychologists to cope with uncomfortable feelings, like a sense of disquiet.

This discussion of vulnerability, discomfort, and courage connects back to the value of the types of higher education learning approaches discussed earlier in the third recommendation, which better equip students for facing the discomfort of uncertainty and complexity in their future complex work environments. Castell et al. (2018) discuss these ideas of safety and discomfort in relation to decolonial approaches to the psychology curriculum. While recognising the restrictions associated the privileging of dominant educational practices over Indigenous epistemes within the Australian university system, the authors provide a potential pathway forward through conscious tolerance of discomfort and contextualised critical reflexivity (Castell et al., 2018). Engaging in reflexive practice along with a willingness to grow and to be curious, increases the profession's, clients' and individuals' adaptability and resilience when taken to a contextualised level beyond the individual.

The sense of disquiet emanating from the tension between the silencing of dreams in Australian psychology and the valuing of dream work by some psychologists and clients could also be abated through openness and discussion to address social norming around dream work. This potential approach arises from comments made by several participants at the end of their interviews. They expressed interest in what other participants had said. When asked why they were interested in their colleagues' interviews, one participant responded:

> *Because psychologists always want to know everything. They want to compare. They want to find out if they're doing a good job. Are they normal? Are they a good psychologist? (third psychologist interview)*

Many of the other psychologist and client participants shared this interest in numerous aspects of the human experience, including dreams. This curiosity, along with the psychologist participants' desire to perform their job competently and ethically, to build

strong therapeutic relationships with their clients, and to be 'good psychologists', bodes well for psychologists' willingness to confront the sense of disquiet around dreams.

6.9.6 Research is needed to address gaps in the recording of cultural moments and seek to maintain accurate data about Australians' dream beliefs and practices

Finally, many participants made comments about Australian dream beliefs, or Australians' attitudes towards dreams, often differentiating between such attitudes and their own. Future research into contemporary Australian dream beliefs and practices could determine the accuracy of these assumptions, and provide a record of this type of cultural belief and practice. Beyond the intrinsic value of such a historic and cultural record, this information would be valuable for psychologists as a source of information about the types of beliefs and practices that their clients may be bringing with them into the therapy room, the sources of those beliefs and practices, and what influences them, providing a starting point for discussion and how to approach dreams/dream work with a particular client.

Such research could also more deeply investigate data identified in the current research, such as:

- The degree of influence of Western theory of mind models on Australians' conceptualisation of dreams, particularly around any differentiation between 'not real' dreams and 'real' waking life, and the implications of perceiving dreams as fundamentally different material to waking life material in therapy.
- The impact on clients and on therapy of psychologists perceiving dream work as dangerous or as a process that has a 'correct' answer or single 'interpretation'.
- How common the differentiation between subtypes of dreams, such as dreams and nightmares, or meaningful and meaningless dreams, is among psychologists; and the implications of this for clients and for conceptualisations of therapy around what is seen as relevant to therapy (e.g. only 'pathological' or 'symptomatic' material).

6.10 Contribution to knowledge

This research gave voice to the client and psychologist experiences and understandings of dreams within contemporary Australian psychological practice. In doing so, the two studies have filled a gap in the research literature, increasing our knowledge about psychologists' and clients' understandings of their experiences of dream work in therapy and of the role of dreams in contemporary psychological practice in Australia. The project both highlighted, and contributed to addressing, the relative absence of the client voice in psychological research, and the need for further progress towards diversity within psychological research.

This thesis contributes to the expanding corpus of literature in which the application of socio-cultural theories is used to understand professional practice, and specifically in the case of this thesis, the practice of Australian psychologists.

The findings of this project can be used to inform higher education and professional development training for psychologists. This is so not just in relation to dreams specifically, but also more generally in relation to supporting psychologists to develop epistemic fluency, actionable knowledge, and confidence in responding to the inevitable complexity of current and future problems that their clients and the world face. This research also provides further evidence of the continued value of the therapeutic alliance to both psychologists and clients.

Finally, the current research provided further support for the social constructionist approach to understanding dream sharing in therapy (Stefanakis, 1995). This approach conceptualises dream sharing as a social interaction or exchange, promoting the view that dream sharing is purposeful, even performative, and can only be understood in context.

6.11 Revisiting reflexivity

There is a possibility that the very process of qualitative research may transform the phenomenon being researched, wherein engaging in an interview can change meaning and change people (Finlay, 2002). This idea is also mentioned by Smith et al. (2009) in their discussion of pre-reflective through to deliberate and controlled reflective states (p189-194). These ideas about reflexivity and the potentially transformational nature of engaging in an interview were evident in a number of the interviews. For example, in the excerpts below, the participants identified that they had never before thought about the point they were discussing and that their engagement in the interview process was leading them to reflect on it now:

> *you said the second question's going to be what role does it [dreams] play. I never - I've got my answer now, but I've never actually thought about it (third psychologist interview)*
>
> *I haven't really thought about this before (ninth psychologist interview)*
>
> *I've never thought of this before, but it's something that's happened and now I'm thinking – that's interesting…I am thinking why […] (sixteenth psychologist interview)*

In response to her comment questioning whether focussing on dreams is a worthy way to spend time in therapy, one participant was asked about what constitutes valid material for therapy, or what is or is not relevant to therapy. Part of her answer was:

> *I guess I would have said before we started this discussion, whatever the client brings into the room, but I've kind of already contradicted myself by saying I'd shy [laughing] away from dreams (seventh psychologist interview)*

At the end of their interview, another participant commented:

> *I hadn't given much thought to dreams so it's [the interview] kind of opened my mind a little bit […] to start thinking about things a bit differently and things I haven't thought of (thirteenth psychologist interview)*

This again points to the impact of the interview process on this person's thinking about a particular issue. It is possible that the process of bringing the participants' attention to the

topic of dreams in therapy, whatever their experience and sense-making thereof was, may well change their future experiences of dreams in therapy and their interpretations thereof, if only through increasing the saliency of the phenomenon for them. This may or may not in turn lead to further reflexivity around the topic or changed behaviour, but for those who are newly conscious of the topic, it certainly changes their relationship to the topic as they can no longer be unaware of it.

6.11.1 Personal reflexivity

The findings of this research in relation to the influence of the psychologist on client beliefs and behaviours about dreams and about therapy in general, demonstrate the importance of self-awareness and reflexivity for psychologists. Reflexive practice moves beyond 'naval gazing' or a solely internal journey, requiring the person to engage with the external world again, to evaluate multiple perspectives within a particular context, and to take action. Finlay (2002) describes it as a more immediate, ongoing, changing and subjective self-awareness than reflection, which only requires someone to think about something. This process requires awareness of my impact on the research and related fields of practice as well as its impact on me.

For me, this has included recognition that my reading into various theoretical frameworks and the critical psychology space have significantly impacted my interpretation and contextualisation of the data collected in these two studies. It also included my decision to publish during my doctoral studies. I saw each journal paper about dreams or non-quantitative approaches to psychological research as a contribution to the diversity within the research literature. I hope that any contribution towards diversity will give permission or reassurance to those who feel they need an example to follow in order to choose a path of methodological or topic diversity in their research. I certainly found such examples reassuring, inspirational, and useful, throughout my doctoral studies. It has also forced me to consider the implications of my post-doctoral studies choices and of my choices about

what else I will do with the findings of this research. When any personal insight is achieved, any avoidance of reflexivity becomes an active decision to support the status quo, which may not always be the best course of action. This also often brings a certain degree of discomfort.

When I began this PhD, I was expecting to find a few novel points about dreams and to learn a formula for a new type of research method. I ended with insights into a range of new frameworks or lenses, which gave me tools and languages for making better sense of my own experiences in my past career as a psychologist and in my conversations about dreams with psychologists and others in the community. What I love most about learning, and what I also find to be the most challenging aspect of learning, is that new insights bring new responsibilities and far more questions than answers. Reflexivity is certainly not a linear, once off process that takes you to a 'correct' and final place of insight. However, being aware that there are questions to ask and being able to begin to articulate those questions gives me hope and excitement alongside the discomfort.

I have found myself in the position of my participants - valuing safety at a time of vulnerability. I have found comfort in the safety in the writings of people within the critical psychology and dream research communities, with whom I feel I share many values and I hope to continue to learn from their knowledge, skills, and examples! Simultaneously, while identifying the beginning edges of my ignorance I have experienced a sense of disquiet in the challenges that opening one's eyes inevitably brings. I acknowledge the great cost to many of the people who have entered the space of challenging the enduring dominance of mono-cultural psychology, both in the critical psychology space and in the dream research and practice spaces. I value and greatly admire their courage and tenacity in their continuing efforts to chip away at the monolith to sculpt something greater. They show those of us who are privileged enough to remain ignorant, that there are pathways forward. That is, if we are willing to accept the sense of disquiet, the uncertainty, and the responsibility for engaging in what Smith et al. (2021) describe as a developmental and

recursive process of cultural responsiveness rather than seeking to identify or arrive at a place of adequacy or perfection, associated with linear understandings of cultural competence as a static collection of information.

6.11.2 Final comment - dreams are an example of complexity within psychological practice

'*Real life is messy!*' (second psychologist interview). No matter how much training psychologists receive they will inevitably face people, situations, and topics that do not fall neatly into the descriptions and categories they learnt about during their training. They will be confronted with people and situations that were not described in the textbooks and research papers they read, and for which there is not always a 'manualised' script that provides an appropriate, technical response. As a topic that falls on the boundary of their profession, dreams are an example of this type of complex work for psychologists

Addressing the silencing and marginalisation of dream material in contemporary Australian clinical psychological practice, often artificially differentiated from all other (waking life) material with which psychologists work, could resolve the complex feelings of guilt and disquiet that go with dream work. Simultaneously this would enable psychologists to access some of the advantages uniquely associated with dream work, such as clients using dreams as a way to raise topics that are particularly sensitive or difficult to talk about. Some of the pathways forward include directly targeting clinicians in the dissemination of dream research outputs, promoting engagement in critical reflexivity, and promoting forms of learning in which knowledge is grounded in practice and in which epistemic fluency and actionable knowledge are valued. These strategies in turn provide pathways forward for other examples of boundary topics, other experiences of vulnerability and disquiet for clients and psychologists, and generally for the complexity that psychologists will inevitably face in their everyday professional practice.

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Appendices

Appendix A: Ethics approval

From: ethics@cqu.edu.au
Date: 12 June 2019 at 16:11:42 ACST
To: linda.leonard@cqumail.com, drew.dawson@cqu.edu.au, s.blunden@cqu.edu.au
Cc: ethics@cqu.edu.au
Subject: Human Ethics Application outcome - 0000021573

Application reference: 0000021573
Title: Psychologist and client understandings of the use of dream material in psychotherapeutic settings

This project has now been approved by the Human Research Ethics Committee, either at a full committee meeting, or via the low risk review process.

The period of human ethics approval will be from 11/06/2019 to 30/11/2022.

The standard conditions of approval for this research project are that:

(a) you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;

(b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. (A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)

(c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

(d) you provide the Human Research Ethics Committee with a written Annual Report on each anniversary date of approval (for projects of greater than 12 months) and Final Report by no later than one (1) month after the approval expiry date;

(e) you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project

(f) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

(g) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the National Statement on Ethical Conduct in Human Research may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee wishes to support researchers in achieving positive research outcomes. If you require an approval letter on university letterhead, please do not hesitate to contact the ethics officers, Sue Evans or Suzanne Harten or myself.

Yours sincerely,

Ms Susan Evans
Senior Ethics Officer
on behalf of the Chair, Human Research Ethics Committee
Research Division - Central Queensland University

Appendix B: Recruitment advertisements

Phase One of Data Collection

Recruitment Advertisement

What do you think about dreams being a part of therapy?

CQUniversity is seeking volunteers to participate in a study. We're looking for psychologists to interview about their thoughts on the role of dreams in psychological practice in Australia and their experiences of dreams/dream material being introduced into therapy (by clients or by the therapist). We're looking for participants who reflect a range of opinions. For more information, please email Linda Leonard at: l.leonard@cqu.edu.au

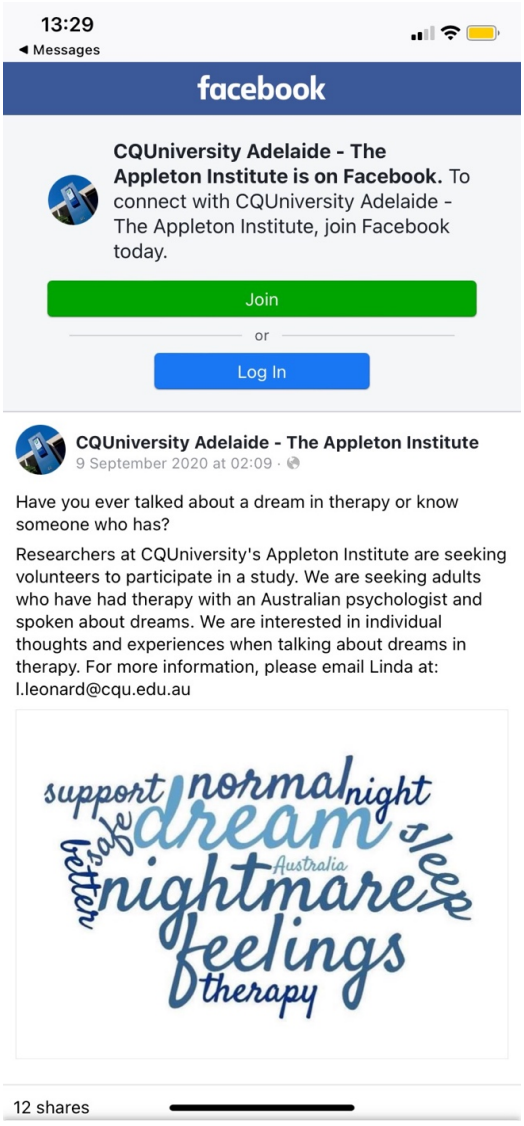
Phase Two of Data Collection

Recruitment Advertisement

Have you ever talked about a dream in therapy?

CQUniversity is seeking volunteers to participate in a study. We're looking for adults to interview who have had therapy with a psychologist in Australia. We're interested in your thoughts and experiences of talking about dreams in therapy. We're looking for people who reflect a range of opinions and experiences. For more information, please email Linda Leonard at: l.leonard@cqu.edu.au

A screen shot of Appleton Institute (at Central Queensland University) Facebook recruitment advertisement for client participants is below.



Appendix C: Information sheet for psychologist participants

CQUniversity
Participant Information Sheet

Psychologist and client understandings of the use of dream material in psychotherapeutic settings

Australian psychologists both past and present are invited to participate in a research study. Participation is voluntary. Before agreeing to participate in this study, it is important that you read and understand the explanation of the study and procedures. This information sheet describes the purposes, procedures, benefits and risks associated with the study. If you choose to participate, you have the right to withdraw from the study at any time.

What is the study about?
The aim of this research is to identify psychologists' and clients' perceptions of the role of dreams in contemporary clinical practice and their experiences of the introduction and use of dream material in therapy. The findings of this research project will contribute to the future development of clinical guidelines for psychologists on how to respond to the introduction of dream material in therapy.

Who can participate?
Anyone who is, or has been, a psychologist in Australia and has internet access to be able to complete the video call interview.

What will happen?
A suitable time and date for your interview will be arranged. You will be emailed a link for a video call that you click on at the time of your interview. This will take you into a Zoom video call with the researcher. You will be asked some questions about your experiences of dream material being introduced into therapy and the role of dreams in Australian psychological practice.

Benefits and risks of participation
All participants will be offered a gift card to the value of $100 for any inconvenience associated with your participation in this study. It is recommended that participants seek independent financial advice as to whether this incentive offered should be considered as assessable income under the Australian Taxation Office ruling. It is expected that the interview may take up to an hour and completion of the consent form and profile information may take up to five minutes.

The results of this study will contribute to the development of future clinical guidelines for psychologists, around responding to the introduction of dream material in clinical practice.

Anonymity, publication of results and feedback
Your interview recording and the de-identified transcript of your interview will be stored securely by CQUniversity, in accordance with the Data Storage Management Plan

developed for this study and relevant ethical guidelines. Your data will be destroyed seven years after the completion of the study in accordance with relevant legislation, research guidelines and CQUniversity policy. Only de-identified data will be published or made public. This means that your name and any other identifying data will be changed when your interview is transcribed, to ensure your anonymity. The results of this study will be used in a PhD thesis, publications such as academic journals, and at conferences.

During the informed consent process, you will be asked for your preferred contact details. If you consent, these will be used by the researcher to contact you should any further information be required during the transcription of your interview, to clarify what you have said. They will also be used to forward you a gift card for your time. Finally, your contact details will be used to send you a summary of the overall results upon completion of the study. Your name will be recorded next to the value of your gift card and stored securely by CQUniversity. This will be stored separately to your interview data so your data will not be identifiable via any record of you receiving a gift card.

Consent
You will be asked to provide written consent via email and you will also be asked to confirm via verbal consent at the start of the Zoom video call.

Right to Withdraw
If at any point you do not wish to continue participating in the study, you are free to stop. You will be asked whether you consent to have the interview recording that has been completed up to that point, used in the study or destroyed.

Who do I contact if I have a question about the study?
If you have a question about participating in the study, your interview time or how to access the Zoom session for your interview, please contact Linda Leonard directly on l.leonard@cqu.edu.au

Concerns/Complaints
Please contact CQUniversity's Office of Research (Tel: 07 4923 2603; E-mail: ethics@cqu.edu.au; Mailing address: Building 32, CQUniversity, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

This project has been approved by the CQUniversity Human Research Ethics Committee, approval number 0000021573.

Contact Details

Linda Leonard (researcher; RHD student)	l.leonard@cqu.edu.au
Drew Dawson (principal supervisor)	drew.dawson@cqu.edu.au
Sarah Blunden (supervisor)	s.blunden@cqu.edu.au
CQUniversity's Research Division	ethics@cqu.edu.au (Tel +61 7 4923 2603)

Appendix D: Information sheet for client participants

CQUniversity
Participant Information Sheet

Psychologist and client understandings of the use of dream material in psychotherapeutic settings

Any adults who have talked about or mentioned a dream they have had to their psychologist during therapy in Australia, are invited to participate in a research study. Participation is voluntary. Before agreeing to participate in this study, it is important that you read and understand the explanation of the study and procedures. This information sheet describes the purposes, procedures, benefits and risks associated with the study. If you choose to participate, you have the right to withdraw from the study at any time.

What is the study about?
The aim of this research is to identify psychologists' and clients' perceptions of the role of dreams in contemporary clinical practice and their experiences of the introduction and use of dream material in therapy. The findings of this research project will contribute to the future development of clinical guidelines for psychologists on how to respond to the introduction of dream material in therapy.

Who can participate?
This study is seeking adults who have had therapy with a psychologist in Australia and have talked about, been asked about, or have mentioned a dream during therapy. To be able to participate you will need internet access to be able to complete the video call interview. To be eligible to participate you will also need to pass a quick screening question about how much distress you are likely to experience thinking and talking about your dreams and therapy experiences.

What will happen?
A suitable time and date for your interview will be arranged. You will be emailed a link for a video call that you click on at the time of your interview. This will take you into a Zoom video call with the researcher. You will be asked some questions about your experiences of dream material being introduced into therapy and the role of dreams in Australian psychological practice.

Benefits and risks of participation
All participants will be offered a gift card to the value of $20 for any inconvenience associated with your participation in this study. It is recommended that participants seek independent financial advice as to whether this incentive offered should be considered as assessable income under the Australian Taxation Office ruling. It is expected that the interview may take up to an hour and completion of the consent form and profile information may take up to five minutes.

For those who are eligible to participate, there is still some risk that you may find thinking about and discussing your dreams and therapy experiences a little distressing.

If you do choose to participate you are able to take breaks as you need to throughout the interview process and you are able to withdraw from the study at any time if you wish to. Details for lifeline, a telephone and online support service, are provided below for anyone requiring further support.

Lifeline:	24 hour support (phone, online chat and online support resources)
Online support	https://www.lifeline.org.au
Telephone support	13 11 14

The results of this study will contribute to the development of future clinical guidelines for psychologists around responding to the introduction of dream material in clinical practice.

Anonymity, publication of results and feedback
Your interview recording and the de-identified transcript of your interview will be stored securely by CQUniversity, in accordance with the Data Storage Management Plan developed for this study and relevant ethical guidelines. Your data will be destroyed seven years after the completion of the study in accordance with relevant legislation, research guidelines and CQUniversity policy. Only de-identified data will be published or made public. This means that your name and any other identifying data will be changed when your interview is transcribed, to ensure your anonymity. The results of this study will be used in a PhD thesis, publications such as academic journals, and at conferences.

During the informed consent process, you will be asked for your preferred contact details. If you consent, these will be used by the researcher to contact you should any further information be required during the transcription of your interview, to clarify what you have said. They will also be used to forward you a gift card for your time. Finally, your contact details will also be used to send you a summary of the overall results upon completion of the study. Your name will be recorded next to the value of your gift card and stored securely by CQUniversity. This will be stored separately to your interview data so your data will not be identifiable via any record of you receiving a gift card.

Consent
You will be asked to provide written consent via email and you will also be asked to confirm via verbal consent at the start of the Zoom video call.

Right to Withdraw
If at any point you do not wish to continue participating in the study, you are free to stop. You will be asked whether you consent to have the interview recording that has been completed up to that point, used in the study or destroyed.

Who do I contact if I have a question about the study?
If you have a question about participating in the study, your interview time or how to access the Zoom session for your interview, please contact Linda Leonard directly on l.leonard@cqu.edu.au

Concerns/Complaints
Please contact CQUniversity's Office of Research (Tel: 07 4923 2603; E-mail: ethics@cqu.edu.au; Mailing address: Building 32, CQUniversity, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

This project has been approved by the CQUniversity Human Research Ethics Committee, approval number 0000021573.

Contact Details

Linda Leonard (researcher; RHD student)	l.leonard@cqu.edu.au
Drew Dawson (principal supervisor)	drew.dawson@cqu.edu.au
Sarah Blunden (supervisor)	s.blunden@cqu.edu.au
CQUniversity's Research Division	ethics@cqu.edu.au (Tel +61 7 4923 2603)

Appendix E: Consent form

Consent Form

Project Title: Psychologist and client understandings of the use of dream material in psychotherapeutic settings (CQUHREC clearance number: 0000021573)

Researcher's name and contact:	Linda Leonard	l.leonard@cqu.edu.au
Supervisors' names and contacts:	Drew Dawson	drew.dawson@cqu.edu.au
	Sarah Blunden	s.blunden@cqu.edu.au

I consent to participation in this research project and agree that:

1. I have read the information sheet, and I understand the nature and purpose of the research project and my involvement in it. I have had any questions I had about the project answered to my satisfaction by the Information Sheet and any further verbal explanation provided.
2. I understand the potential benefits and risks associated with participating in this study.
3. I understand the research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet. I understand that while information gained during the study may be published, I will not be identified or identifiable.
4. I am aware that a Plain English statement of results will be sent to me via email or post using the contact details I have provided.
5. I understand that my interview recording will be stored securely by CQUniversity for seven years and then destroyed.
6. I understand that I have the right to withdraw from the project at any time without penalty. I understand that I can withdraw from the study at any stage and that this will not negatively affect my relationship with the researcher or CQUniversity now or in the future.
7. I understand the statement concerning compensation for taking part in the study, which is contained in the information sheet.
8. I confirm that I am over 18 years of age.
9. I agree that I am providing informed consent to participate in this project.

Preferred email/postal address contact for a Plain English statement of the results	
Preferred postal address contact for the gift card to be sent	
Preferred email/phone number contact for the researcher to contact me to clarify my comments during the transcription process	
Name and Date	
Signature	

Appendix F: Screener, profile and interview questions for participants

Screener Questions

Are you 18 or older?

Do you have internet access and a computer/device with a camera and microphone that you can use for video calls?

Are you happy to talk about your views on the role of dreams in therapy?

Are you happy to talk about your experiences of sharing dreams in therapy?

If anything we talk about is distressing or might be, are you able to let me know so we can decide whether to continue or not and how best to help you deal with any feelings that may have arisen as a result of my questions?

Profile Information

Profile information requested from psychologist participants in the study

Gender:

Cultural and Religious Identity:

Clinical experience: <5 years 5-10 years >10 years

Primary location of practice:

Capital city Regional city Rural city or town Remote

Which theoretical perspectives do you most often use in your clinical practice e.g. CBT, narrative therapy etc.?

How often do you personally recall or remember your dreams?

Daily > 1/week weekly Rarely Never

Profile information requested from client participants in the study

Gender:

Cultural and Religious Identity:

Where I live: Capital city Regional city Rural city or town Remote

How often do you personally recall or remember your dreams?

Daily > 1/week weekly Rarely Never

Therapy experience (how many therapists I have seen): 1 2 > 2

In one or two words e.g. depression, trauma, grief, what were the main issues I sought therapy about?

If you know, which types of therapies did your psychologist(s) use or what was their theoretical orientation?

Interview Questions

Participants were asked two questions:

1. Please tell me about some of your experiences of dreams being brought up in therapy?
2. In Australia, what do you think the role of dreams is in psychology?

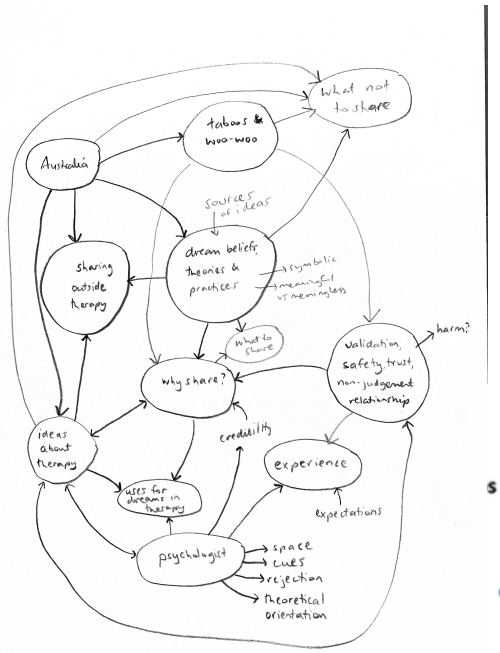
Further prompt and probe questions were used to elicit further details as appropriate throughout the interviews. These included questions such as “you mentioned …X…, what did you mean by that?”, “Can you tell me more about that please?”, “thinking about the last time …X…, what happened first?/what happened next”, “what went through your mind when that happened?”, “can you give me an example of that?”

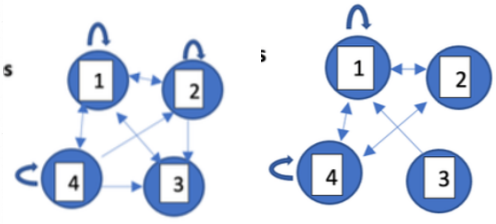
Appendix G: Research data management plan

[This appendix has been removed prior to publication]

Appendix H: Examples from analysis process and reflection memos

Below left: an early iteration exploring some potential code clusters, emerging themes and their relationships, during the data analysis process for the second (client) study. **Below right:** as part of my analysis process for the first study, I worked through each interview looking for any directional relationship patterns among the final themes across the participants. The themes are numbered: 1- Boundary characteristics, 2 – Multiple influences on practice, 3 – Importance of the therapeutic relationship, 4 – disquiet around dreams. These two example show the ways that these two participants used a theme or subtheme to explain or account for another theme or subtheme. For example, an arrow going out from 1 and back into 1 might indicate that a participant explained the absence of dreams in therapy as a result of the absence of training/university coverage of dreams. Another example is that an arrow from 3 into 1 might indicate that a participant explained that a strong therapeutic relationship with high levels of safety and trust are needed for a client to be willing to share dreams (presence of dreams in psychology). These rough diagrams quickly provided visual confirmation for my sense that there were no simple, consistent directional patterns of relationship among the themes across the whole group.





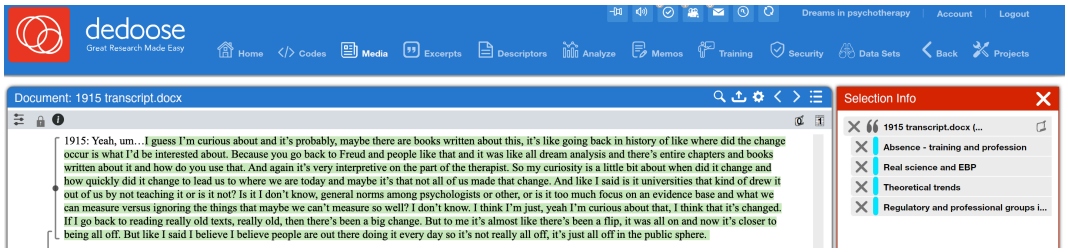
Extracts from two of my personal reflection memos at the start of the each study:

First extract: A psychologist I met at uni [university] this morning asked me about my PhD research. She questioned my topic choice, explaining that she was concerned because dreams are not relevant, nor a 'proper' topic for psychological research. She told me that she felt she needed to caution me about the impact that my choice to research something like dreams would have on my reputation and credibility if I want an academic career. Another psychologist asked about my research later this afternoon and immediately shared a dream from childhood and asked me what I thought it meant. These have been two of the most common responses I've received when asked about my research…

Second extract: My health issues resulting in a change of career have meant that during the PhD process I've also been going through a lot of identity work myself. I'm shifting from identifying as a psychologist to a student researcher, which requires a shift from clinical interviewing to research interviewing. My earlier reflection memos show I was approaching my practice interviewees from both a fellow insider psychologist perspective and an outsider perspective, at a time when I was no longer going to be a psychologist. When I spoke about my research or talked with practice interviewees, I kept moving between saying I, our, we and us, then psychology, psychologists, you, they or them. I felt it would be very easy to slip into the role of colleagues chatting. Now I have revisited my practice client interviews in preparation for my second study and I notice aspects of my old psychologist identity and response patterns from that role automatically emerging. I'll have to be more mindful of adhering to a research interview style, not 'doing therapy'. As with the first study, I will go back through each interview to see where these feelings come up, and note how I reacted and what I said so I can more consciously choose how to respond in the future. I will also go through a couple of interviews in detail with my supervisors with a focus on this, before examining them just as data for my project. I'm aware of my different reactions to my two groups of participants and how this may impact each participant in various ways, as well as how it may affect the data I collect and how I interpret it.

Example of multiple codes being applied to an excerpt in Dedoose

Below is a screenshot from Dedoose. It shows an example of a single excerpt within a transcript from the first study, which has had multiple codes attached to it. The codes applied are listed on the right hand side under the red bar entitled Selection Info.



Appendix I: Evidence of copyright permissions for inclusion of published journal papers in thesis

[This appendix has been removed prior to publication]

Appendix J: Dreams in ancient Greece

Additional information about the cult of Asklepios (discussed in Chapter 3, part A).

The story of Asklepios

There are many versions of the story of Asklepios, son of the mortal woman Koronis and the god Apollo and how he became the god of medicine (Jayne, 1962). In one version, Asklepios was raised by the centaur Chiron (a famous healer) who taught him the art of medicine (King, 2003). Other versions of the story have Asklepios being abandoned as a baby and fed by a nearby shepherd's dog and goat, which could account for the association between Asklepios and these two animals (Blaśkiewicz, 2014). Asklepios's expertise culminated in him having the ability to bring the dead back to life, which resulted in Zeus killing him with a thunderbolt as punishment for breaking the laws of nature (King, 2003; Tick, 2005). Such a manner of death guaranteed greatness and Asklepios was placed among the stars as the constellation known as the Serpent Holder (Kanellou, 2004). The Egyptians also associated this constellation with one of their gods of medicine (Meier, 2012). Over time Asklepios shifted from being seen as a great physician to being a hero and then later he was referred to as the god of medicine.

Asklepieia

Asklepieia (sanctuaries connected with the cult of Asklepios) were used by people coming to worship, by visitors who came to use the facilities at some of the more extensive sanctuaries, and by many people seeking healing through incubation. Asklepieia are often portrayed as being akin to contemporary spa/health resorts. Cilliers and Retief (2013) suggest that this may be due to Vitruvius, a Roman architect from the first century BCE, recommending that healthy sites with natural water springs being chosen for setting up shrines to Asklepios and Plutarch echoing this advice a couple of centuries later. They argue though that the archaeological evidence shows that asklepieia were established in

a range of locations, varying considerably in their degree of resemblance to contemporary health resort environments. Remains of asklepieia have been found at Kos, Athens, Corinth, Piraeus and Pergamon and other places. One of the earliest is thought to have been the asklepieion at Epidauros that had been established by the sixth century BCE (King, 2003). The hundreds of asklepieia subsequently built throughout the Greco-Roman world were an indication of how popular and how influential the cult became by the first few centuries of the Common Era (Barbera, 2015; Flannery-Dailey, 2000).

Incubation: definition and origins

Incubation provided another domain in the ancient world of sleep and dream medicine, in which a role for experts could be created. Enkoimesis was the Greek word used to described incubation, or sleeping in a temple (Askitopoulou et al., 2002). Incubation involves intentional engagement in a ritual act and sleeping in a sacred place with the explicit objective of receiving a divine dream (Harrisson, 2014; von Ehrenheim, 2011).

Many agree that the location and the time period influenced the development and expression of particular incubation rituals (Cilliers & Retief, 2013; Hemingway, 2009). For example, historio-cultural influences on incubation rituals can be traced across the later development of incubation practices in Egypt during the Ptolemaic period (Lang, 2013) with Egyptian features that were not present in earlier Greek examples (von Ehrenheim, 2011). Even within Classical Greece, there were local variations in incubation and healing rituals and it is likely that regular worshippers may well have engaged in some of the same practices as the incubants at some asklepieia (von Ehrenheim, 2011). The flexibility this created in how the cult could adapt to new surroundings and be easily assimilated into local customs may well have contributed to its portability and widespread popularity, accounting for the widespread acceptance of the cult's expertise in sleep medicine.

It has even been argued that particular cultural conditions within societies such as Classical Greece enabled or even encouraged incubation rituals to develop. These include

features such as the widespread acceptance of the existence of divine dreams, the focalisation of deities within a particular topography like a temple, the history of hero healers or more generally a belief that gods can be consulted to solve problems or answer questions (Hemingway, 2009). The approachability of Asklepios is a little unusual in the context of Greek religion as encounters with deities often resulted in death or blindness, the opposite of the intimate and healing encounters people experienced with Asklepios (Csepregi, 2007). His shift from mortal, to hero, to god is important as it positioned Asklepios as a balance between mortal and god, at once allowing him to be both compassionate and approachable while not being overwhelmed by emotion (Tick, 2001). This balance may well have contributed to making Asklepios and his cult accessible to the general population.

Finally, the concept of reciprocity in Greek religion was not only a cultural condition conducive to the development of incubation but it can also account for some of the practices associated with incubation (Hemingway, 2009). The Greeks understood that favours met favours, and therefore accepted that some form of payment and acknowledgement would follow healings through incubation, to ensure continued good relationships with the gods. The dedications found in Asklepieia reflected patterns of mutual exchange and assurance of a good relationship and hope of receiving favours at the time of incubation and in the future (Hemingway, 2009).

In addition to the willingness to adapt to local customs and the fertility of the cultural context in which the cult of Asklepios arose, the democratisation of dreams may also have contributed to quick rise in popularity and expansion of incubation and the cult of Asklepios across the Greek world (von Ehrenheim, 2011). Many cultures either restrict particular types of (important/significant for society) dreams to a small, privileged group within society, such as leaders or kings, or at least the reception and credibility of such dreams vary according to the dreamer's status (Hemingway, 2009). During the Archaic and early Classical times in Greece the elites had been able to seek oracular and other dream

contact with the gods. During the Classical period this began to spread and change from more purely oracular techniques to incubation rituals for the general population (von Ehrenheim, 2011).

The democratisation of dreams in Greece, perhaps aided by the rise of incubation in the hero cults (more accessible to everyday people) meant that by the end of the fifth century BCE, anyone in society could directly access Asklepios and healing dreams (von Ehrenheim, 2011). While the democratisation of dreams enabled practices such as incubation to become accessible to everyday Greeks, it did not necessarily mean there was a corresponding change in the reception, significance, and credibility accorded to dreams of lower status people. The rejection of the societal significance of everyday people's dreams can be seen in both the suspicion raised in relation to the possible manipulation of dream reports by some Classical period Athenian politicians and in the focus of Asklepion incubation practices on very personal and individual matters of healing rather than matters of societal significance (Hemingway, 2009).

The role of the Asklepios expert

Just like the preparatory, incubation, and thanksgiving practices, the role of the Asklepios expert varied from place to place and over time. Evidence suggests that earlier healings, such as those listed in the inscriptions at Epidauros, were more commonly attributed to direct healings during sleep by meeting Asklepios or his representative in a dream, possibly including an occasional quick surgical procedure (Csepregi, 2007). In such examples, dreams were used not just as diagnostic tools as Hippocratic physicians used them, but also as the means of treating the incubant (Petridou, 2016) with the dream being the medicine or cure itself. Direct healing meant no dream, religious or medical expert was needed as an intermediary during the healing. However, priest-healers still ensured a role for themselves as intermediaries between the incubant and the god, especially as guides for ritual practices (Jackson, 1999). The expert (priests) still had a critical role in providing

the place for healing (the asklepieion), the atmosphere and rituals that were necessary for healing.

Later, during the Roman period, it was more common for the incubant to receive instructions for a remedy in a dream, which they were to follow to be healed (Barbera, 2015; Tick, 2005). These later prescription cures, seen in examples such as the inscription of Iulius Appellas (second century CE), were still considered to be miraculous cures just like the more direct healing dreams (Csepregi, 2007). The change to incubants receiving instructions for healing in dreams opened up a role for temple experts to assist with the interpretation of these instructions at some Asklepieia. They may have begun to offer some opinions on treatments as well as continuing their earlier role as ritual guides, and administrative, financial, organisational and logistical managers (Lang, 2013). Finally, in some Asklepieia it is thought that there were some medical experts who may have performed interventions or treatments, whether directly as part of the Asklepieion or as invited experts.

While many explanations have been offered as explanations for asklepieian healings, the challenge of identifying the exact mechanisms for healings does not negate the important psychological benefits and psychological healing that incubants appeared to experience (Jackson, 1999). Whatever the mechanics of cures at asklepieia during a particular era, the evidence we have provides insights into the ancient Greeks' beliefs and attitudes towards life, death, health, illness and medicine and what they believed was possible, likely and credible (Blaśkiewicz, 2014). At every stage of the incubation ritual, the authority and the perception of the priests' power as divine was of paramount importance to the success of the process and the cult (Hamilton, 1906). It began with the priests' role in preparing the incubants' minds for receiving a dream, claiming to have received a dream on behalf of the incubant and ensuring incubants left with an appropriate remedy from their dream or the proxies' dreams if they had not been spontaneously healed (Hamilton, 1906). Over time, the experts shifted what had been a more spontaneous experience towards a

more curated experience. Their control over incubants' environment and ritual practices led to more industrialised and controlled processes that ensured their privileged place as sleep medicine experts.

Through the use of expert knowledge, be it surgical, pharmacological, or related to autosuggestion, the placebo effect or cultural knowledge, these experts were able to shape their practices and ensure their place as dream, sleep, medical and religious experts in their society. This shows that the medical experts of the time carefully managed the meaning making of the experience, helped to induce particular experience and most importantly they managed the cultural designations of meaning that people gave to those experiences.

Relevance

An important part of the ancient Greek medical legacy is the enduring cultural acceptance of there being a role for a medical expert in the area of sleep and dreams. There has been strong growth in sleep and dream research during the past century and increasing recognition of the important role for medical and psychological experts in sleep medicine. As Palagini and Rosenlicht (2011) note, recent developments in sleep and dream research methodology and technology provide exciting and promising avenues of inquiry that could lead to a deeper understanding of these phenomenon and their relationship with psychological health. The time is ripe for health-related practitioners and researchers to occupy the space created for them as experts in sleep, dreams and healing.

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Appendix K: Published paper

The paper presented here in Appendix K is from: Leonard, L., & Dawson, D. (2022). Client experiences and understandings of dreams in contemporary Australian psychological practice: An IPA study. *Dreaming*. Advance online publication. https://doi.org/10.1037/drm0000228 An expanded version of the findings presented in this paper appears in the fifth chapter of this thesis (see Appendix I for copyright permissions). Paper begins on next page.

Client Experiences and Understandings of Dreams in Contemporary Australian Psychological Practice: An IPA Study

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Identifying and understanding the beliefs, experiences, and expectations of clients around dreams in psychological practice can assist psychologists to avoid or minimize unintended, negative consequences of mismatches in expectations between the client and the psychologist. In this study, 5 adult Australian clients undertook semistructured interviews in which they explained their experiences and perceptions of dreams in psychological practice. An interpretative phenomenological analysis approach was used, and the themes emerging from the analysis clustered around participants' experiences (with emotions ranging from feeling pressured, frustrated, or vulnerable, to feeling relief or validation), and their underlying assumptions or rules, around what to share (or not share) with whom, and when. The participants' explanations for their experiences and opinions reflected their underlying individual and sociocultural understandings of both psychotherapy and dreams, with references made to dream beliefs, the stage of therapy, and psychologist cues. The findings highlight the value of approaching therapy (and dream sharing in therapy) from a social/cultural practice framework. This framework understands interactions or exchanges between psychologists and clients as being influenced by a range of cultural assumptions, which both parties bring into the therapy room with them.

Keywords: clients, cultural practice, dreams, interpretative phenomenological analysis (IPA), psychotherapy

Everyone dreams, making it unsurprising that most people will share some of their dream experiences with others (Schredl & Bulkeley, 2019; Schredl & Schawinski, 2010; Vann & Alperstein, 2000). Psychotherapy is often seen as an appropriate

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setting for sharing dreams[1] (Boothe, 2001; Boyd, 2005; Crook & Hill, 2003; Dombeck, 1991; Huermann, Crook-Lyon, et al., 2009).

Most often it is clients who introduce dreams into therapy, although clients will also usually engage in client-initiated dream work (Schredl et al., 2000). Understanding clients' expectations around dreams in therapy could provide valuable information for the therapist when deciding how to address clients sharing dreams. Some researchers have suggested that therapists examine the timing and manner of dream sharing, as it may provide insights about the client's goals or motivations for sharing dreams, such as using dreams to change the topic in therapy or offering a dream as a gift (Pesant & Zadra, 2004). Conversely, examining why clients choose to not share dreams in therapy might also provide relevant data for therapists. Wagner-Pacifici and Bershady (1993) believed that such self-censorship is subject to the dreamer's judgment about safety and risk, with dreamers choosing to share a dream with fewer groups or people, the more disturbing it is. They see dream sharing as a strategy to test and forge solidarity, in which dreams are offered as a gift in the form of an intimate revelation that comes with expectations around how the receiver will respond. We explored this idea further and proposed that when dream sharing is seen as a gift or exchange, inappropriate psychologist responses could negatively impact the therapeutic relationship, the credibility of the therapist's expertise, and even potentially the credibility of the broader psychology profession (Leonard & Dawson, 2019).

Dream Sharing and the Therapeutic Relationship

Sharing dreams has also been identified as a way to facilitate self-disclosure, which in turn increases intimacy in a relationship, demonstrating the potential importance of dream sharing to therapy (Carcione et al., 2021; Duffey et al., 2004; Eudell-Simmons & Hilsenroth, 2005). There is little doubt that the therapeutic alliance is important for therapy (Flückiger et al., 2020; Wampold, 2015). For example, the safety and trust aspects of the therapeutic relationship are necessary for pivotal moments of awareness and insight to occur in therapy, as they support clients to take emotional risks (Giorgi, 2011). One study found that the therapeutic relationship seemed important for clients to be willing to explore and understand their dreams (Hill et al., 2013). Achieving the required safety requires more than a generic, manualized script. Giorgi (2011) emphasized that safety must be personalized for the individual client with consideration to their history, social, religious, ethnic, and interpersonal relationship backgrounds. This points to the need to consider sociocultural context in research interested in either the therapeutic relationship or dream sharing.

The Contemporary Australian Context

Australia is demographically diverse. The Australian Bureau of Statistics (ABS) reported that 30 percent of the resident population are born outside of Australia (ABS, 2021a), and 3.2 percent of the population identify as being of

[1]For the purpose of this article, the term *dream sharing* simply refers to clients telling their therapists about their dream(s).

Aboriginal and/or Torres Strait Islander origin (ABS, 2021b). This diversity makes it likely that the client population in Australia will be bringing a range of histories, social, religious, ethnic and interpersonal relationship backgrounds to therapy, and to dream sharing. Another potential influence on dream work in Australian psychology is that many psychological services and programs in Australia have conditions around which topics and types of therapies are approved and funded, and how many sessions are allowed. For example, in around 2006, the Australian government funded the Better Access program, which provides rebates for eligible people to access eligible, short-term, evidence-based, mental health services with registered providers, via Medicare, Australia's universal health insurance scheme (Australian Government, 2022). Only a limited range of *focused psychological strategies* and *psychological therapy services* are approved for various providers, such as cognitive behavior therapy (CBT), interpersonal therapy (IPT), or narrative therapy, which is able to be included when working with Aboriginal and Torres Strait Islander peoples clients (The Royal Australian College of General Practitioners, 2019).

Rationale for the Current Study

At least some clients share some dreams in therapy, and it is generally the clients who initiate dream sharing (Schredl et al., 2000). To minimize or avoid the potential ramifications for therapy resulting from psychologists responding inappropriately to shared dreams, it is important to understand clients' expectations around psychologists' response, and their expectations around psychologists' expertise in using dreams in a clinical setting. The client experience of a therapist is an important factor in therapy (Amos et al., 2019), increasing the imperative to include the client voice in this area of research. Furthermore, the presence of the client voice in psychological practice research is consistent with primary health policy initiatives that seek to include the user in all aspects of their care (Boyd, 2005), and of benefit to psychological research and effective therapy in multiple other ways too (Elliott, 2008). Despite this, Crook-Lyon and Hill (2004) reported that relatively few studies focus on the client's perspective on dream sharing in therapy (with a couple of notable exceptions outside the Australian context, e.g., Boyd, 2005; Hill et al., 2013).

This study is interested in *clients' perceptions* about the role of dreams in psychological practice. This is because *how* clients makes sense of, or understand, the role of dreams may influence their expectations about the relevance of dreams to therapy or their psychologist's expertise and interest in dreams. Rather than focusing on a session-by-session analysis of client experiences within a particular model of dream work or dream interpretation, this study is interested in a broader understanding of experiences and perceptions around the use of dreams in psychological practice.

A decision was made to not include definitions of terms like *dream* and *dream work* for the participants in this study, as narrow definitions may deter participants from sharing potentially relevant data that they may mistakenly assume falls outside the scope of the study. This decision also underscores the openness of the researchers to discovering new or unexpected data. This definitional decision follows the example of previous studies, like the broad definition approach adopted by Boyd (2008), which did not limit dream work in therapy to any one particular model of

dream interpretation and could include all client-initiated or therapist-initiated dream-related interactions. Dream work may, therefore, include sharing a dream narrative, using nightmares as a part of the diagnostic process, interpretative/analytic activities, and more.

Aims

This study addresses a gap in the literature regarding the client's perspective on dreams in contemporary Australian psychological practice and gives voice to the client experience and sense-making on this topic.

The central research questions are as follows:

1. How do clients understand their lived experience of dream sharing in psychotherapeutic settings?
2. How do clients make sense of the role of dreams in Australian psychology?

Method

Methodology

Interpretative Phenomenological Analysis and Underlying Assumptions

An interpretative phenomenological analysis (IPA) approach was selected for this study. IPA emphasizes the production of knowledge about the quality and texture of a person's experience as well as its meaning within a specific cultural and social context (Willig, 2013). Drawing on traditions including phenomenology, hermeneutics, and idiography, IPA has become one of the more commonly used qualitative methodologies in psychology (Smith, 2011).

Rather than assuming an objective truth about a phenomenon can be discovered, IPA is committed to examining how people perceive or subjectively experience the world (Willig, 2013). Consistent with this commitment, the current study takes a critical realist ontological position, and a social constructionist epistemological stance. That is, it assumes that meaningful reality is created or constructed through the interaction between a person and the world. This means for ensuring quality, IPA makes use of a range of strategies commonly used in qualitative research, such as personal and epistemological reflexivity, transparency, and triangulation. Reflexivity involves the explicit examination of how the researcher and underlying ontological and epistemological assumptions of IPA influence the research process (Willig, 2013). Transparency has been addressed through the provision of details about the primary researcher and influences on the research, for the reader to use to evaluate and interpret the article. This study also uses triangulation strategies—linking findings back to preexisting literature and the use of multiple theoretical lenses to interpret the data (Leavy, 2017).

Due to the interpretative and cocreated nature of the IPA processes, it is understood that the themes reported in the findings for an IPA study reflect the influences on and of the researcher and the participants, and therefore reflect only one of many possible interpretations of the data. IPA researchers are expected to

interpret their participants' accounts of experiences in the context of other accounts, the researchers' personal experiences and values, and the researcher's knowledge of existing research and theory (Smith et al., 2009). This is referred to as a *double hermeneutic*. Rather than seeing research as empirically generalizable, IPA focuses on theoretical transferability, assuming that a rich, transparent, and contextualized analysis of the participants' accounts enables the reader, in turn, to make links between an analysis in an IPA study, their own experiences, and the wider literature on the topic (Smith et al., 2009). In this way, readers' interpretation of this article can be seen as creating a triple hermeneutic.

Researcher Roles and Influences

Linda Leonard was lead researcher for this study. She conducted the interviews, transcribed them, and completed the data analysis. Drew Dawson provided initial interviewer training and engaged in the reflexivity process with Linda Leonard around prestudy assumptions, and potential influences of her personal and professional histories and background reading, on her interviewing, and analytic processes. The following information about Linda Leonard's background is provided for transparency, to assist readers to identify influences on the research processes.

> Prior to this doctoral project, I worked as a clinical psychologist for over a decade, in both urban and regional settings in Australia. I come from a privileged, white background and my training focused on CBT and Western understandings of psychological practice. My views that humans are complex and diverse beings capable of some degree of change, influenced me throughout my previous career in psychology, and during this project. Multiple approaches and frameworks have been valued and synthesized for the work in this project, consistent with my approach during my previous career as a psychologist. I received no formal training on dreams at university, but regularly had clients introduce dreams into therapy. Those clients told me that they believed the dreams they shared were relevant and important to therapy, and described them as emotionally intense experiences. Clients varied in their beliefs about dreams and their meanings, and their expectations around how I would respond.

The following information is provided about Drew Dawson's background:

> I am a professor of psychology, a senior, full-time researcher, and I have been the director of a research institute specializing in sleep research for thirty years. I have engaged in lab-based quantitative, qualitative, and mixed methods approaches to research, and I have a broad interest in dreams, ranging from socio-cultural to the neuro-scientific. I come from a privileged, white background.

Locating This Study

This article focuses on the findings from a study within a larger doctoral project, interested in the experiences and sense-making around dreams in Australian psychological practice from both psychologist and client perspectives. In keeping with the IPA guidelines for homogeneous sampling, psychologists for the other study were recruited independently to the client participants in this study, and the analysis was completed separately.

Participants

Following approval by the Central Queensland University Human Research Ethics Committee, participants were recruited via a purposeful, snowballing method. Purposeful approaches to sampling assumes that selecting the most relevant participants for a study produces better, richer data (Leavy, 2017; McIntosh & Morse,

2015). In this case, adult psychologist clients in Australia, who had shared dreams in therapy, were recruited. Profile data for the participants is presented in Table 1.

Procedure

Semistructured interviews with the participants were conducted via video call, using *Zoom*. This enabled participants who otherwise would not have been able to, due to distance or restrictions in place for COVID-19, to participate. The interviews took between half an hour and an hour and were conducted and recorded by Linda Leonard. They focused on two primary questions:

1. Please tell me about some of your experiences of dreams being brought up in therapy?
2. What do you think the role of dreams is, in Australian psychology?

These questions were occasionally modified as appropriate for the situation to ensure the flow of the interview was not compromised.

Data Analysis

The guidelines outlined by Smith et al. (2009) and Smith (2011) for quality IPA formed the basis for how the study was designed and conducted. Analysis in IPA research is an iterative process. It moves through several levels of interpretation of increasing depth on the way to developing a final set of themes. The final themes need to make sense of both the data as a whole (convergences, or similarities across the data), and individual differences in how the themes manifest (divergences, or differences within or across the data).

To qualify as a final subtheme (a theme that focuses on an element or facet of the superordinate theme to which it belongs), any potential themes have to be present in at least fifty percent of the transcripts. To qualify as a final superordinate theme (a broader or higher level theme capturing a recurring pattern across the dataset), any potential themes have to be present in all the interview transcripts. The final superordinate themes were examined to ensure that, together, they incorporated (or made sense of) the majority of the available data, and were representative of the participants' reported experiences and sense-making. This process contributed to the trustworthiness and rigor of the final superordinate themes and subsequent theorization of the analysis. *Dedoose* (http://www.dedoose.com) qualitative data analysis software was used in the coding process of the transcribed interview data.

Findings

As shown in Table 2, the two final superordinate themes identified in this study have been characterized as *Dream sharing experiences* and *Dream sharing rules*, both of which are explained in more detail later in this section of the article. Both superordinate themes included data from all five transcripts, as did all the six subthemes within *Dream sharing rules* theme, exceeding the criterion of being present in three or more transcripts to be considered a subtheme. Although the data associated with the first superordinate theme could be organized into various clusters relating to

Table 1
Participant Profile Data

Number assigned to interview transcript	First participant	Second participant	Third participant	Fourth participant	Fifth participant
Gender	Female	Female	Female	Female	Female
Cultural identity	Australian	Australian American	White, European Australian, Eastern European background	Vietnamese	Anglo-Saxon, Caucasian
Religious identity	Mormon	Atheist	Jesus Christ and King James bible, no formal church or denomination affiliation	Buddhist	None
Location	Regional city	Capital city	Capital city	Capital city	Capital city
Dream recall	Most days	At least once a week	Every day	Twice a week	Every day
Number of therapists seen	>2	>2	1	>2	>2
Presenting issues	Anxiety, PTSD	Depression, anxiety, trauma, grief	Depression	Self-harm, ADHD	Depression, anxiety, obsessive compulsive disorder
Theoretical orientation of therapist(s)	CBT, EMDR	CBT (past), ACT (current)	Psychoanalysis—Jungian, not Freudian	Mostly CBT	Psychodynamic, integrative, CBT, RODBT, internal family systems theory mentioned during interview

Note. PTSD = posttraumatic stress disorder; ADHD = attention deficit hyperactivity disorder; CBT = cognitive behavior therapy; EMDR = eye movement desensitization and reprocessing; ACT = acceptance commitment therapy; RODBT = radically open dialectical behavior therapy.

Table 2
Summary of Themes

Superordinate themes	Subthemes
Dream sharing experiences	No subthemes. Instead, clusters of relevant data focused around: -Feelings of relief -Feeling pressured -Vulnerability, shame, embarrassment and a fear of judgment; and validation -Frustration; and the influence of time constraints and stage of therapy on experience
Dream sharing rules	With whom do we share our dreams What to share outside therapy and why What to share in therapy and why What not to share outside therapy and why What not to share in therapy and why The influence of the psychologist

different types or aspects of experience, these were not sufficiently reported to constitute formal subthemes. The participants' comments about dream sharing outside of therapy are reflected in the analysis, and included in Table 2 with the other subthemes. However, this article focuses only on the subthemes directly related to sharing dreams in therapy. Following Table 2, the "in-therapy" findings from this study are described and explicitly linked back to relevant preexisting research as part of the triangulation strategies used in this project. This is followed by a discussion of the limitations of the study, and implications for research and practice.

First Research Question and Superordinate Theme—Dream Sharing Experiences

Directly addressing the first research question for the study, the first superordinate theme of *Dream sharing experiences* encapsulates participants' descriptions of what it was like for them to share dreams in therapy, what they felt, and what thoughts ran through their minds during those experiences. The participants' experiences were diverse, and they varied in emotional tone, varied from one experience of therapy to the next, and were influenced by the stage of therapy.

Relief

The first type of emotional experience described is exemplified in the relief experienced by the second participant:

> I felt relieved that I could talk to her about something that is quite personal (because I do believe that dreams are very personal) [. . .] there's always that comfort that I keep bringing dreams to her and we can keep working through whatever it is. (Interview 2)

Pressure

The second cluster of dream sharing experiences focuses on the pressures and difficulties experienced around articulating a dream experience. Some felt past therapists they had seen had pressured them to recall more details from their dreams, rather than allowing them to control how they revealed their dream narrative both pace- and content-wise. The second participant felt stressed by this and described it seeming like:

> It was more about the dream and less about me. (Interview 2)

The fourth participant reduced the pressure she felt by writing down her dreams, but then experienced concern about the legibility of her writing. She described her choice to write her dreams down for her therapist in the following way:

> I found it really cathartic. And again I didn't have to worry about remembering things or jumbling up my words. (Interview 4)

She described initially feeling awkward bringing up her dreams, thinking it was unrelated to her psychologist's agenda, but believed it had a positive impact on therapy, enabling the focus to shift to include the important underlying issues, identified via the dreams.

For some, pressure came from the challenge of translating a dream experience into a verbal narrative. For example, one participant compared her experience at the end of the interview, when asked if she wished to include any further thoughts or experiences, with her experience of sharing a dream:

> I'm kind of feeling like I do when I try to describe a dream, which feels kind of like a slippery kind of thing where it's hard to grasp exactly what the most important things are to mention or you know, I'm sure that there are lots of things that I've forgotten to mention about it. (Interview 5)

Vulnerability and Validation

Consistent with previous research (Boyd, 2005; Dombeck, 1991; Schredl, Fröhlich, et al., 2015; Schredl, Kim, et al., 2015), the third cluster of dream sharing experiences suggests that dreams can be intimate and personal experiences, which can make sharing them a vulnerable experience. Shame, embarrassment and a fear of judgment were common concerns, providing further sense-making around why clients may feel vulnerable about sharing dreams in therapy. The second participant attributed the connection between vulnerability and dreams to dreams occurring during sleep, outside the dreamer's conscious control, "it can be scary and it can be humiliating and it can be traumatizing and so it's this big, naked thing to talk about with somebody." She continued to make sense of her and other clients' experience of sharing dreams in the following way:

> It's taking a huge risk in sharing something that is quite murky, like we don't really know what this means. We don't know why we're having this dream. It's affected us in some way, so maybe it's really, really funny or maybe it's really traumatic. (Interview 2)

The first participant emphasized the importance of validation for dream sharing, explaining,

> I think from a client position, for someone to acknowledge what you just said and that you've had the guts to bring it up, because it wasn't easy to say, it's never easy to open up about that sort of stuff. (Interview 1)

She said that the acknowledgment, normalization, and validation from her psychologist helped her feel that she was not weird, crazy, or a failure, and that she could use the strategies she had been taught to manage her feelings. She believed that this helped settle the intensity of her feelings and helped her to understand why she felt the way she did and that her symptoms were not her fault helped.

Frustration, Time Constraints, and Stage of Therapy

The final cluster of experiences were frustration, and the influences of time constraints and stage of therapy on the dream sharing experience. The time constraints of therapy made the third participant feel rushed and prevented her from delving deeply into any single dream as much as she would like:

> It's just a little frustrating because they're so detailed and there are so many and it's so overwhelming and there's very little time. (Interview 3)

For others, experiences of frustration varied according to the stage of therapy. This applied to other aspects of the dream sharing experience in therapy with three of the participants describing how their changing expectations of therapy colored their experiences and feelings about their therapists' responses to their dreams.

Second Research Question—the Role of Dreams

Data from both superordinate themes are relevant to the second research question, examining clients' understanding of the role of dreams in Australian psychological practice. The participants all expressed the opinion that dreams have at least some relevance to therapy, although dreams are not always the sole, or even a major focus, of therapy. They described multiple ways in which they and their psychologists have used dreams in psychological practice, and emphasized that dream sharing often reflects trust and the desire to engage deeply with psychologists, as sharing a dream can be a very risky and vulnerable experience. Participants' comments about dream sharing included assumptions about social rules for different kinds of relationships, the value and meanings of dreams, and expectations of therapy and the therapeutic relationship.

Second Superordinate Theme—Dream Sharing Rules

The term *rules* was chosen in the name for the second superordinate theme, to capture the individually, socially, and culturally informed influences on which aspects of a dream the participants choose to share (or not share), and with whom, when, and why. The term *rules* is not referring to clients setting rules for how a particular model of dream work should be implemented. Instead, it refers to how the participants spoke about the unspoken or tacit *rules* and underlying assumptions, which they believe everyone has around sharing dreams. This theme reveals how the participants' expectations about the role of dreams in contemporary Australian psychological practice, have been shaped prior to, and during, their experiences of therapy. These *rules* were also often offered as explanations for some of the participants' experiences around dream sharing in therapy.

Dream Sharing Rules—What to Share in Therapy and Why

In making sense of what they shared in therapy and why, the participants identified their underlying assumptions about issues like psychologist expertise and credibility, dream relevance, the therapeutic relationship, and the influence of the psychologist, which is discussed as a separate subtheme. Their comments provide support for the relevance of questioning why a client chooses to share a particular

dream rather than another and at this particular moment in therapy, as raised by Ermann (1999).

Credibility

Credibility and the expertise of psychologists were important to several of the participants. The second participant believed that her first therapist's expert training gave her the expertise to better interpret her dreams than the "really woo-woo websites" of dream meanings:

> Having some sort of psychological training, she [my therapist] would be able to sort of like filter through the bullshit. (Interview 2)

The third participant connected credibility with a scientific or clinical understandings of dreams, her therapist's personal experience of dreaming, and being widely and deeply read about psychological dream theory. She described difficulties finding books on dreams, only locating one that she was satisfied with:

> It's the only book I found that I can take seriously that isn't some new age, overly new age kind of take on what dreaming is about. (Interview 3)

There was also a perception that there is a lack of evidence for dream work:

> It seems like such a field lacking in evidence that other medical and allied health professions probably wouldn't delve into dreams or if somebody brought up a dream they wouldn't know how to respond because how do you get training in that you know. (Interview 2)

The latter is reminiscent of a participant's comment in a study by Boyd (2005), that more research was needed before dream work was used as a stand-alone technique. These comments reflect the value that the participants place on scientific credibility, contrasting with some of their comments about psychologists having expertise and training in dreams.

Relevant Dreams

When it came to choosing which dreams to share in therapy, all but the fourth participant mentioned recurring dreams as warranting the attention of their psychologists. Consistent with the existing literature (Curci & Rimé, 2008), all the participants also believed emotionally intense dreams that had an continuing impact on them after waking, were relevant to share in therapy.

Uses of Dreams

The participants' goals for sharing dreams included using dreams to tell the therapist something or to facilitate insight or self-awareness, using dreams as a source of clinical information such as identifying issues important to the client or assessing change, or to facilitate therapeutic processes such as increasing the client's engagement in therapy or contributing to the development of a safe, trusting relationship. All of these are consistent with previous studies (Boyd, 2005; Eudell-Simmons & Hilsenroth, 2005; Pesant & Zadra, 2004; Skrzypińska & Szmigielska, 2018).

The fifth participant described the use of what Boothe (2001) labeled as naïve self-distancing, when she explained how dream sharing in therapy could be used as a way to talk about difficult issues:

> You kind of don't have the same responsibility for stuff that happens in dreams. So I think it may be an interesting, you know, a different way to talk about difficult issues that puts you a little bit at arm's length from what's gone on [. . .] 'it wasn't under your control, it happened

> in your dream.' [. . .] it's a little bit just less, I guess, charged emotionally, if it's from a dream [. . .] It enables difficult things to be discussed maybe more because of that. (Interview 5)

The fourth participant also used her dreams as "a transportation device" (Interview 4), to guide therapy toward a particular topic of conversation, or discuss anything emotionally relevant to therapy, which she had trouble talking about directly with her first psychologist:

> This was my first therapist and I had a hard time verbally bringing up things. It was very uncomfortable, a bit scary so I would go home, write things down when they were fresh and new and sometimes dreams would be in there. And then I would give those letters to my therapist and then we would debrief in the session. (Interview 4)

She explained her experience: "I was not at the point where I could bring things up without feeling ashamed or feeling weak" (Interview 4). This fits well with proposed use of dream sharing to discuss personal problems as useful for clients seeking professional help for whom this is perceived as shameful within their culture (Tien, Lin, & Chen, 2006).

Importance of the Therapeutic Relationship and Safety

Most of the participants alluded to the way that safety from judgment or rejection were key to their willingness to share dreams in therapy. They attributed this to the revealing nature of dreams and their view of therapy as an appropriate place to expose more of one's self or one's emotions. This points to the central role that the participants saw the therapeutic relationship playing in relation to dream sharing. The association between intimacy and dream sharing could be seen in participants' comments about the importance of trust and a safe place being necessary to share dreams in therapy and in the first participant finding that taking her husband as a support for the first few sessions really helped her cope until she felt "more comfortable and not scared" (Interview 1). The fifth participant saw her dreams as an indication of the state of the therapeutic relationship as well as providing other relevant clinical information for her psychologist. She said,

> for me, it's a no-brainer for therapists to be open to discussing dreams if their client wants to because I just think it's part of your mental life as much as thoughts or feelings or reactions to things are in your waking life. (Interview 5)

Two participants spoke about deciding whether to share dreams about their therapist, especially dreams about abandonment or rejection. This supports the conclusions drawn from a study of trainee-therapists' and clients' dreams of each other, which found that therapists could use dreams to understand their clients better, especially around attachment difficulties (Hill et al., 2014). Other ways the participants spoke about their psychologists using dreams included as a diagnostic tool and to assist the client to "sit with it and process whatever's happening" (Interview 2).

Influence of Dream Beliefs

The participants often made sense of their dream sharing choices in therapy through their dream beliefs. An example of this was the second participant explaining that she shared dreams in therapy because of her belief that dreams are meaningful, revealing, symbolic, a message from the unconscious, or:

> a gentle reminder that something's not quite in balance and therefore I need to pay more attention. (Interview 2)

She identified the sources of her dreams beliefs, or at least influences on them:

> Probably, a fair amount from pop culture ≪laugh≫ movies and tv and seeing like what other people with dreams have and dream sequences and so much. I went to art school, there's a lot of symbolism in there and so trying to apply those things. (Interview 2)

She also noted that reading Jung or articles about dreaming, and academic and personal interests in consciousness and the unconscious influenced her views. Another participant cited personal interest in her unconscious mind and the influence of her lived experience on her dream beliefs:

> You have to have a belief that that sort of thing is real [the unconscious mind] and kind of chimes with your own experience of your own mental life. (Interview 5)

The third participant also alluded to her own experience as an influence on her dream beliefs, along with her religious beliefs:

> Just really my own experience. Really when it comes down to it. You know, I mean they are trying to tell me something and also a lot of them allude to my biblical beliefs as well, as in what's to occur as far as biblical prophecy as well. (Interview 3)

Several participants noted that their dream beliefs had changed over time due to their personal dream experiences and messages they received from positive therapeutic experiences differing from the broader societal views they had encountered in their upbringings, that dreams are meaningless or of no value.

Dream Sharing Rules—What Not to Share in Therapy and Why

The participants identified shame, embarrassment, unimportant or what they considered to be irrelevant dreams, time constraints, therapist expertise, and stage of therapy and its connection with levels of safety and trust, as the major reasons for choosing not to share particular dreams with their therapists. They also differentiated between trivial dreams and meaningful dreams through their use of terms like *just* to indicate the lesser value of this category of dreams that they chose not to share. This may suggest that the Western privileging of waking reality over dream experiences (Stefanakis, 1995) is present in some of Australian society.

Knowledge About Dreams and Therapy

Although all the participants saw therapy as a relevant place to share dreams, prior to seeing her second psychologist, the first participant said that she and her friends had not been aware that dream sharing in therapy existed. She searched online and assumed that dream work in therapy was rare as even the website of the psychologist with whom she shared dreams mentioned CBT, but not dreams. This may well speak to the marginalization of dreams in contemporary psychological practice (Leonard & Dawson, 2018).

Cultural and Individual Dream Beliefs

Participants provided several potential explanations for the rarity of dream work in Australian psychological practice, including the cultural devaluing of dreams. The fourth participant believed the general attitude toward dreams in Australia is that "dreams are considered of low value to the average Australian because they are seen as feminine":

> They're probably seen as not practical, artsy-fartsy [sic], esoteric or new wave, or like dumb and spiritual. But I don't know if it's Australia in particular or it's just like a very capitalist mindset, like everything that you do in your life must be productive or must earn money or generate money and stuff like that. So, maybe a general Western perspective or just like a late-stage capitalism perspective. (Interview 4)

She interpreted the silence around dreams in the media and the absence of dreams as a topic of conversation as there being a taboo around sharing some dreams.

Stage of Therapy and Taboo Topics

The stage of therapy influenced the participants' choices to not share certain dreams in therapy both in relation to fears about rejection and abandonment, and the need to have established trust and a strong therapeutic alliance. The fourth participant chose not to share dreams about abandonment when her therapist terminated therapy in her first therapy experience because she felt embarrassed, ashamed and weak at that stage of her therapy journey. This made her feel very awkward "like I was closed off, not just about the dreams but also everything else" (Interview 4).

The second participant identified some taboo dream topics for sharing in therapy but believed that this would be mediated by the client in question, the stage of therapy, and the therapeutic relationship. Below is an excerpt with her discussing what she thinks may or may not be appropriate to share with her therapist:

> Maybe things that would cause so much shame. Like if I were to dream about you know, going on a murdering spree. Then again, I would find that very compelling ≪laughs≫ I'd want to know why am I going on this murdering spree? ≪laughs≫ I think it depends. It depends on the client, it depends on the therapist. I have a bit of a rapport with mine now. I certainly wouldn't go to her with murdering dreams in the first few months ≪smiles≫. But, if I was murdering a whole bunch of people then yeah, I'd be like, what am I doing? ≪laughs≫ What's happening, what does my brain want me to know? ≪laughs≫. I think suicide, I would definitely talk to her about that because that has been a problem in the past, so that would be sort of a red flag that we could discuss. Um . . . sex stuff. Um . . . I kind of mostly talk about that with my partner. So even the embarrassing stuff because again, we just have a laugh about it. (Interview 2)

Dream Sharing Rules—the Influence of the Psychologist

The data show that clients do not arrive at therapy with a complete set of explicit shared rules around dream sharing. As with other social interactions, both people involved in the interaction can influence what occurs. The explanations that participants' offered for their experiences and choices around dream sharing in therapy appear to be in keeping with the social constructionist approach to understanding dream sharing in therapy (Stefanakis, 1995). This approach understands dream sharing as a culturally imbued social interaction or exchange, or cultural practice, which can only be understood in context, and in which the intentions or goals of clients when sharing dreams, are important considerations for therapists. The fourth participant provided an example of how even the *unspoken* can influence clients:

> I had different therapists who I wouldn't share dreams with because I felt maybe it wouldn't fit their style or it wouldn't fit the way that we were conducting sessions with each other. (Interview 4)

As this excerpt shows, psychologists can have a profound impact on clients' dream sharing without dreams ever being mentioned. Even the smallest of behaviors, such as writing something on a notepad can act as a cue to clients about what

the psychologist sees as important (second participant). The influence of the psychologist's style, theoretical orientation, relationship with the client, and their response to a client sharing a dream on the client's perception of the relevance of dreams to therapy, their future dream sharing behaviors, and their dream beliefs, were all evident in the interview with the first participant. She described a negative experience of dream sharing with her first psychologist, whose disinterest in her dreams led her to believe dreams were irrelevant to therapy. It was only when she saw another psychologist who talked about her dreams that she changed her mind:

> I didn't really understand the role of dreams at that point [with her first psychologist]. So I kind of just like "oh my gosh, she's not focusing on it then it mustn't be important in this situation," and it wasn't until I saw the therapist who did talk about the dreams that I went "oh, like, yeah, it actually does play a role." (Interview 1)

This different response to her dreams from her second psychologist played "a massive role in that it helped me to then tell my story without any fear" (Interview 1).

Training and Theoretical Orientation

Therapists were seen to frame, understand, and respond to dreams in different ways because of their training, theoretical models of therapy and goals. To illustrate this point, the fifth participant said her nightmares are seen as an undesirable symptom for her psychiatrist to address through medication adjustments so she rarely shares dream content with him. In contrast she tells her psychologist about recurring, disturbing dreams that affect her the following day and dreams that may reflect her relationship with her psychologist, noting that she tells her everything, and dreams are just a part of what might help their work together.

The participants' discussions about the influence of theoretical orientation on dream sharing in therapy, aligned with previous findings about dreams and theoretical orientation (see Alder, 2017; Freeman & White, 2002; Montangero, 2009; Schredl et al., 2000). When asked about her psychologists not initiating dream work, the fourth participant attributed it to many Australian psychologists being trained in CBT, which she had not heard of being a dream-focused type of therapy. The second, fourth and fifth participants differentiated between the more a rigid adherence to manualized and skills-focused models of therapy, such as CBT or dialectical behavior therapy (DBT), and more client-led, flexible approaches that allow space for dream sharing:

> I think a lot of therapists are CBT-focused. Um . . . I'm not really sure how that relates to dreams. But it seems a little bit rigid and not as open to exploration. (Interview 4)

The therapeutic relationship and trust were also seen as essential for dream sharing in therapy. The second participant described her experience of one CBT-oriented therapist she saw and how it influenced her dream sharing choices:

> There was no room and there was no real trust. [. . .] So it was just very clinical. It wasn't really therapeutic ≪short laugh≫ It was just going through the motions [. . .] I didn't feel like talking to him about a dream would have gotten anywhere. Nor did I feel comfortable bringing it up. So it was more like him leading the sessions. It was more, just, retraining my brain and dreams just didn't seem to factor in. It wasn't a comfortable space. (Interview 2)

Rejecting Dreams

When asked about the possibility of psychologists rejecting shared dreams or refusing to work with clients' dreams, four participants said they would not work with a psychologist who did not work with dreams, particularly in long term therapy.

This was attributed to the connection between emotions and dreams, the role dreams play in the participants' lives and identify, and the relevance of dreams to therapy. The fourth participant said,

> I would probably feel like I couldn't share as much as I wanted to about myself with them. So even if it wasn't dreams-related, I would probably hold back on other things too. (Interview 4)

In response to being asked about a therapist not working with dreams, one participant said,

> I would just find it weird that they would say one aspect of your experience, you can't talk about here. I would just find that really weird and think what are they scared of or like isn't that just part of life or you know? To me it just wouldn't make sense to exclude one [. . .] I would not welcome censorship on what I could say and what I couldn't say. (Interview 5)

The third participant's response to the question was as follows:

> It's such a huge part of my life if that therapist doesn't understand or doesn't care to understand about that, we would have no connection whatsoever. I would think even generally, a therapist should have some kind of interest or knowledge or . . . I can't understand anyone who would say something like that. I can't even fathom any therapist who would think like that. I don't think they should be a therapist. (Interview 3)

The participants' advice for psychologists focused on respecting the vulnerability of clients and recognizing the impact that their behavior and responses can have on a client. They advised against rejecting dreams. Instead, they recommended that psychologists approach dreams with an open mind and provide a safe space without pressure for clients to share dreams, irrespective of their own theoretical orientation and goals, as clients are probably bringing up a dream because they wish to explore it or are seeking validation from the psychologist. The fifth participant advised,

> Just take people seriously and don't give them the feeling that they can't bring up that stuff. (Interview 5)

Limitations of the Current Study

IPA research delves deeply into a specific experience to gather rich, relevant data and is not designed for broad generalizations. Samples are therefore small and may not represent all relevant experiences around a topic like dream sharing. This means that for the current study, sampling factors, such as the recruitment of people wishing to talk about their experiences of sharing dreams in therapy, or other factors asked about in the profile data, are likely to have produced findings that would differ had another group of participants been recruited.

Implications for Research and Practice

The participants used references to a range of individual, social, and cultural influences to explain their dream sharing experiences, choices, and understandings of the role of dreams in therapy. Larger scale studies could identify cultural dream beliefs and practices present in the wider society, for uses such as validation or normalization of client experiences, which has been identified as an important factor in clients' experience of a therapist in general (Amos et al., 2019). Such data could also assist psychologists in developing culturally sensitive approaches to dreams, like the one described by Schubert and Punamäki (2016). Furthermore, this study provides

another example of how including the client voice in clinical research can produce data relevant in the development of clinical practice guidelines, improving outcomes for clients.

Finally, the way that participants explained their experiences and perceptions suggests that sharing a dream is a contextualized narrative of an experience, imbued with personal, social, and cultural meanings, emotions, rules, and expectations. The findings support the need to consider performative and social/cultural practice conceptualizations of the introduction of dream material in therapy, rather than limiting approaches to dream work to a decontextualized application of a particular model of therapy. A performative or social exchange (gift) view of dream sharing comes from a position that understands there are multiple, cultural, social, and individual influences on clients' choices to share particular dreams (or not) in particular contexts and that there is a need to consider these when engaging in therapy with a client, irrespective of the psychologist's theoretical orientation. The impact of psychologist responses on clients' experience of dream sharing, their dream beliefs, future in-therapy behaviors, and decisions around working with a particular psychologist, shows that psychologists' responses to dreams are important for not just the dream that is shared, but also for psychological practice more broadly. Awareness of the impact that these unspoken elements of exchanges around dreams can have on therapy could help ensure that these elements are not misinterpreted or missed altogether.

Conclusion

IPA's emphasis on context has enabled the application of a social/cultural practice framework as an explanatory model for the participants' accounts of their experiences and understandings around the use of dreams in Australian psychological practice. This framework sees exchanges and interactions that occur during therapy, as existing within a broader cultural context of beliefs, rules, and expectations. The data show that dream sharing is one such exchange, or cultural practice, in which intimate, personal, and subjective experiences are selected by clients for various reasons to be shared (or not shared) with their therapists. Cues from the psychologist can influence client choices to share dreams, the client's experience of dream sharing in therapy, and the client's future dream- and therapy-related beliefs, expectations, and behaviors.

From the client's perspective, the ways that dreams are used in therapy and the role that dreams play in contemporary Australian psychological practice, may vary considerably between each experience of therapy, and from one client to the next. The participants emphasized that dream sharing can be a risky and vulnerable experience. It can both increase the intimacy of the therapeutic relationship and act as a barometer of an already strong therapeutic relationship. Openness to clients sharing their dreams, and the creation of a safe space, and personalized, culturally sensitive responses to shared dreams, can assist in preventing damage to the therapeutic alliance, and the client's future choices about, and experiences of, therapy. Consideration of the context, and inclusion of the client voice, in therapeutic dream sharing research, and in general psychological practice research, could potentially further

improve the knowledge base around the topic being researched, and inform practice guidelines and psychologist training, helping to improve client outcomes.

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Appendix L: Prompts about dreams in psychological practice

Reflexive practice for psychologists around dreams

My data and my reading into critical reflexivity practices led to a growing list of memos about potential reflective questions for psychologists. My list included observations and questions that I shaped into a series of questions for use by psychologists wishing to reflect on dreams in psychological practice. The list is neither prescriptive nor exhaustive as it is designed as scaffolding or a starting point within a broader reflexive process.

Boundary prompts

1. Do I believe that dreams belong within psychological practice or not?
2. What do I think that my colleagues' attitudes towards dreams in therapy are?
3. What do I think that the profession of psychology's position on dreams is?

For each of the above questions/your answers, consider the following:

    a. Where did I get that message or how did I come to that conclusion?
    b. How does that influence how I feel about the possibility of raising the topic of dreams or dreams with my colleagues and clients? What assumptions am I making about how my colleagues and clients would perceive me if I were to raise the topic of dreams with them?
    c. Going forward from here, what do I want to do about this and how will I do it?

Multiple influences and therapeutic relationship prompts

1. What factors influence my choices when practising psychology? List all that come to mind e.g. service or programme parameters, referrer expectations and opinions, theoretical orientation, time and money constraints, colleagues', managers' or clients' opinions, training and perceived confidence and competence, ethical codes, assumptions about clients, client opinions and influences, my personal and professional values, my ontological and epistemological assumptions, my practice

expertise, my definitions of and understandings of core psychologist competencies and evidence-based practice

Consider the following:

a. Which of these influences do I use to justify my choices in my work e.g. whether I should work with dreams in therapy?
b. Which of these influences do I agree with/do I find problematic (and why)?
c. What biases are there in the research that makes up the evidence upon which practice guidelines are based? Are my clients represented in the research literature? Whose voice is privileged in the research I read/do and who is advantaged or disadvantaged by it? What influences are there on decisions about which topics, methodologies and theories are used in psychology research? What ontological and epistemological assumptions are made in the research literature I read and practice guidelines are based on?

What can I, or psychology as a profession, do about these influences (whether they are positive, neutral or negative influences)

Dream beliefs:

1. What are my personal and professional dream beliefs? Are the two in conflict? How do my personal beliefs and experiences influence my professional dream beliefs and practices? e.g. do I believe that dreams are dangerous, trustworthy, real or not real?
2. Do I believe there are different types of dreams or that there is a difference between nightmares and dreams? If so describe and consider how it affects your practice?
3. Can I tell (and does it matter) if my client is lying about a dream or forgets a detail?
4. Do dreams have meaning and if so, is there only one correct meaning (what are the implications if I do not interpret the ‘correct’ meaning?) Are dreams symbolic and do they require interpretation?

5. Do I believe that dreams should be worked with in a different way, which does not require interpretation or even that may not be psychological at all?
6. Who do I consider to be dream experts in our society?
7. Where/who did I learn my dream beliefs and practices from?

Assumptions:

1. What assumptions have I made about dreams and dream work and how can I check the veracity of those assumptions?
2. When doing literature searches for topics with which I am unfamiliar, how might my search terms influence what results I am shown? Specifically, how might my search terms influence my knowledge about current dream research and theoretical development? For example, if searching for dreams, do I use general terms like dreams and therapy, or do I use terms like Freud, Jung, or CBT, which are linked with particular theoretical orientations?

Theoretical orientation:

1. How might my dominant theoretical orientation influence my view of dreams?
2. Where can I find if there are models of dream work associated with my dominant theoretical orientation?

Clients:

1. How do I find out what my clients' dream beliefs, practices, and expectations of dream work in therapy are, and what do I do in response to them?
2. How might the public perception of the profession of psychology's attitude towards dreams interact with my clients' willingness to engage in dream work or in therapy in

general? How might it influence my clients' perception of my (and other psychologists') expertise in areas outside of dreams?

3. What differences and similarities might there between my client's and my cultural backgrounds that may influence our therapeutic relationship, and expectations and engagement in dream work? What training, reading and other resources do I need to be able to work ethically and professionally with each of my clients?
4. How might the profession address structural and systemic issues that impact psychological practice generally, and dream work more specifically, in relation to working with clients from diverse backgrounds?

Therapeutic relationship prompts

1. What are my beliefs about therapy and the therapeutic relationship?
2. How do I evaluate the therapeutic alliance with a particular client?
3. What factors influence the therapeutic relationship? How might these influence my choices in my practice? How might they influence my response to a shared dream or influence a client around their choice about sharing a dream?

Psychologist influence prompts

1. What cues (verbal, nonverbal) may I be giving clients about my attitude towards dreams and what impact might that have on therapy, on the client's perception of dreams and choice whether to share dreams, or on their perception of either therapy or me as a psychologist?

Sense of disquiet prompts

1. How do I feel and how do I respond, when a client introduces a topic I know nothing or very little about? How is this the same or different to when a client shares a dream in therapy?
2. How do I know when I am experiencing discomfort or a sense of disquiet during therapy?

a. In retrospect, what do I do when I experience discomfort?
b. What do I at the time when I realise that I am experiencing discomfort?
c. What do I want to do in the future in relation to this? What resources e.g. practice knowledge, supervision, therapeutic skills, life experience, reflexive skills, emotional regulation skills do I have that I could draw on?

3. How can I access relevant training that might support me to feel more confident and competent around working with clients' dreams (or other areas of practice where I feel uncomfortable or incompetent?)
4. Who is advantaged or disadvantaged and whose voice is privileged by my current approach to dreams and dream work?