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Exploring the Dreams of Hospice Workers

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Abstract

Nine adults who worked at least 1 year with patients at US hospice centers completed an in-person audiotaped dream session focusing on a dream about a patient. Data were analyzed using consensual qualitative research. Patients were generally manifestly present in participants’ dreams, and dreams were typically realistic (ie, not bizarre). In the dream, the dreamer typically interacted with the patient as a caretaker but was also typically frustrated by an inability to help as fully as desired. Dreams gave dreamers insight into the stress of hospice...
work, their own fears of death, and inter-/intrapersonal interactions beyond hospice work. Dreamers generally sought to take better care of themselves and find balance in their lives after the dream session. Implications for research and practice are discussed.

Keywords
hospice, death, dying, dreams, qualitative research

Imagine that a hospice worker dreams about walking away when a dying patient is asking for help. Or imagine that the hospice worker dreams that she or he becomes the patient. What might these dreams mean? What, if anything, do the dreams reveal about the hospice worker or the relationship between the hospice worker and the patient? Can hospice workers obtain insight by examining such dreams? These questions were the primary focus of this study.

Therapists’ Dreams About Their Clients
Although much has been written anecdotally about therapists’ dreams about their clients,1 only 4 empirical studies were found, which examined therapists’ dreams about their clients.2–5

In these studies, therapists had strong waking reactions to the dreams: They felt appreciative of positive dreams, given that these dreams alerted them to something about the client or because the dreams were pleasant or inspiring, but therapists felt unsettled and disturbed by negative dreams, given that they worried about what these dreams meant. All therapists had explored the dreams either by themselves or with others, seeking to understand their meaning. In addition, therapists used their understanding of the dreams in working with clients and in making changes in their own lives. Collectively, these 4 studies suggest that therapists’ dreams about clients often reflect unresolved feelings and perhaps influence the therapy process and outcome.

Hospice Workers’ Dreams About Their Patients
Although parallels exist between therapists conducting individual psychotherapy and hospice workers tending to the emotional, spiritual, and physical needs of a dying patient and his or her family, clear distinctions exist as well. Hospice workers spend time with the dying patient and the family in multiple environments, whether in the home, at a group or family meeting, or in an inpatient setting. Often, the dying patient may be involved with the hospice for a relatively short period of time; however, the work with the bereaved family may continue over weeks, months, and perhaps years.

Although there is no research on the dreams of those who work with the dying and bereaved, there is some literature suggesting that individuals frequently experience vivid and meaningful dreams during the dying process6 or during bereavement.7–9 Indeed, dreams as powerful revelations at the end of a person’s life, or after a loved one has died, have been reported in all cultures throughout the world.6,10

Research has also provided evidence that dreaming may help people envision future possibilities and serve an adaptive purpose.11,12 For someone who is dying, a predeath dream can “represent the final expression of that anticipatory function, preparing a person for the end of his or her life.”6 For both the dying and the bereaved, dreams can diminish fear and provide a new understanding of life and death. Perhaps most significantly, dreams can help bring closure and provide opportunities to resolve unfinished business.

Purpose of the Present Study
Given the intensity of the dreams of dying and bereaved individuals,6–10 as well as the research about therapists’ dreams about their clients,2–5 we were curious about hospice workers’ dreams about their patients. Although we
suspected that working with dreams of hospice workers could be a powerful tool for self-exploration and understanding, no empirical studies have actually examined this supposition. The current study thus proposed to explore hospice workers’ dreams about their patients using the Hill’s\cite{11,13} model of dream work (the most empirically tested dream model). We explored the content of these dreams, the insight gained from examining them closely via the dream model, and the actions the dreamers sought to take after this examination.

We examined the dream sessions using a consensual qualitative research method (CQR).\cite{14} Although qualitative research often relies on interview data, we adapted the method to examine the content of dream sessions, as did Sim et al.\cite{15} Rather than asking hospice workers about their dreams, we thought we would collect the richest data by conducting an actual dream session with them and seeing what emerged from working with the dreams.

**Method**

**Participants**

**Hospice Workers**

The 9 participants ranged in age from 35 to 64 (mean $[M] = 53.78$; standard deviation $[SD] = 8.89$) years; 8 were female and 1 was male. Of those who identified their race/ethnicity, 7 identified as White/Caucasian and 1 as Hispanic Indian. They had been in their current position for between 4 months and 20 years ($M = 10.20$, $SD = 7.39$ years), had between 4 months and 21 years of hospice experience ($M = 11.54$, $SD = 8.14$ years), and between 8 and 40 years of clinical experience ($M = 26.33$, $SD = 9.43$ years). With regard to current positions, 6 were nurses, 1 worked as a bereavement counselor, 1 as a medical director/physician, and 1 as a patient care technician. In all, 6 had nursing degrees, 1 a master’s of divinity, 1 a medical degree, and 1 had completed training as a patient care technician.

**Patients**

As described by the hospice worker participants, and for the 6 patients about whom we have such data, no particular demographic pattern emerged. In all, 2 were “young,” 2 had amyotrophic lateral sclerosis, participants had worked with 2 for 6 months or less, and with 2 for more than 6 months.

**Researchers**

The first author, who conducted all of the dream sessions, was a 59-year-old, female, European American counselor educator with a doctorate in counseling psychology, 15 years of experience doing dream work both clinically and in research, and extensive experience using CQR; the first author is now deceased. The second author, a 48-year-old female, is a European American counseling psychologist with some experience in the dream model and extensive experience in CQR. The third author, a 61-year-old female, is a European American counseling psychologist with extensive experience in dream work, dream research, and CQR. The fourth author, a 32-year-old female, is a European American–licensed professional counselor who had taken a graduate course in dream work and used dream work with clients and supervisees; this was her first experience with CQR. The fifth author, a 52-year-old female, is a European American postdoctoral fellow who regularly used dream work with her clients, had been involved in several studies of dreams, and had experience with CQR.

**Measures**

**Demographic Form**

The demographic form asked for age, sex, race/ethnicity as well as participants’ experience as a hospice worker. Participants were also asked to identify their degree and their field of study (social work, counseling, counselor education, counseling psychology).
Procedures for Collecting Data

Recruiting Participants
Potential participants were recruited via personal contacts and snowball sampling. Interested individuals contacted the first author who then provided the materials necessary for participants to decide whether or not to take part in the study (i.e., cover letter, informed consent forms, demographic form, and dream session information). Those who chose to participate completed and returned the consent form and the demographic form to the first author who then contacted the participant to arrange a time for the in-person dream work session.

Dream Session With Participants
The therapist (first author) worked with the participant to explore a dream that the participant had about a patient, using the Hill dream model.11,13 The model has 3 stages: exploration (the therapist helps the dreamer explore several images in great detail), insight (the therapist helps the dreamer try to make sense out of the dream), and action (the therapist helps the dreamer decide whether there is anything she or he would like to do differently in waking life based on what she or he learned from the dream work). All dream sessions were conducted in person and were audiotaped. Sessions typically were about 2 hours in length, with about half of the time spent in exploration and the rest of the time evenly split between insight and action.

Interviewing and Transcribing
All dream sessions were transcribed verbatim (other than minimal encouragers, silences, or stutters). Potentially identifying information was removed, and each participant was given a code number to protect confidentiality.

Procedures for Analyzing Data
Data were analyzed according to the CQR methods.14,16,17 In CQR, research team members reach consensus about both data classification and interpretation as they proceed through the 3 steps of analysis (domain coding, core ideas, cross-analysis); an auditor reviewed each step of the analysis. The judges worked consensually in teams of 3, with the composition of teams shifting over the course of the analyses.

Draft of Results
All participants received a draft of the study’s results and were asked to ensure that their confidentiality had been maintained. Participants’ remarks were incorporated into the manuscript.

Results and Discussion
We followed CQR guidelines14 in labeling category frequencies: Categories that emerged for all or all but one case (N = 8-9) were considered general, those that emerged for more than half of the cases (N = 5-7) were considered typical, and those that emerged for at least 2 and up to half of the cases (N = 2-4) were considered variant; findings that arose in a single case were placed into an “other” category and are not reported. To protect the identity of the 1 male participant, we randomly used gender-identifying pronouns.

Dream Content
Information about dream content came primarily from the work done in the exploration stage of the session, during which participants actively explored the dream images in depth. Of the 9 dreams described, 7 were nonrecurring and most had not occurred recently. In a few cases, the dreams occurred close to time of death, or imminent death, of the patient or a member of the participant’s family. The dreams were quite diverse, as the following 3 examples illustrate.

One participant dreamed that her patient was in a sling under the hospital bed. The participant put the patient back in bed, and the patient looked at the participant “with forgiveness in her eyes.” The patient’s eyes were a
blue color “to indicate that the patient was on her way somewhere.” The participant then saw blood bubbling up from the patient’s head and face, covering the patient. When the participant helped turn the patient’s head, the participant got blood on her and was surprised that this did not bother her.

In another dream, the participant was in the patient’s home with the patient’s family. The home was dark, the patient was in bed, and the patient’s sister was acting erratically (being demanding and anxious). The participant took the sister aside and told her to calm down, then left the room, and went to another disheveled area of the house to pray with the patient’s family. The patient then died, and the sister said to the participant, “You were right. I get it. Thank you.”

In another dream, the participant was taking care of a young married woman with children. The patient was out of control in her bed, trying to stab the participant with a large kitchen knife. The patient’s husband was sitting on the bed with the patient and did nothing to help. The participant grabbed the blade of the knife, cut her hand, and bled profusely. She called for help, someone came to assist, and the participant was free to have her hand attended to.

Several themes emerged regarding the content of the dreams. Participants’ feelings related to the dreams were rich and complex, with participants generally having some negative feelings and also typically having some positive feelings. Among the negative feelings, one participant expressed sadness at remembering how much the patient suffered at the end of her life, and another reported feeling overwhelmed and out of control; several became quite distressed as they reexperienced the feelings in the dream session. As examples of positive feelings, 1 participant felt calm after resolving the dilemma posed by the dream, and others expressed catharsis and relief as a result of the session.

These results show that participants experienced a range of affect, with negative emotions more prominent than positive emotions. Such a finding is not surprising, given the intense and often quite difficult circumstances that hospice workers experience on a daily basis. The potency of this affective content also parallels that found in therapists’ dreams of their clients as well as of those experiencing bereavement, and those working with patients with AIDS. Each day, hospice workers interact with those actively dying, certainly an emotionally evocative and potentially troubling context. The inherent poignancy of this work clearly stays with them not only in their waking lives but also in their dreams. The very act of dreaming, however, may decrease the intensity of these negative emotions, in effect providing a “housekeeping function” of the affective remnants of the prior day.

With regard to the presence of the patient in the dream, patients were generally manifestly present in the dream (eg, the patient was in bed, eyes open, and smiling at the participant). Variantly, however, the participant noted that the dream was related more globally to the hospice work overall, and the patient had only an indirect or referred presence (eg, the participant connected the stiffness and pain she felt in the dream to her anxiety about not being able to control the patient’s pain). Thus, the patients themselves maintained a prominent presence in these participants’ dreams, for their dying process was a clear stimulus for the dreams’ content, mirroring McCormick’s findings that dreams of the deceased are common.

With respect to the presence of the patient’s family in the dream, they were typically not present (eg, no mention of family presence). Only variantly were they present (eg, the participant was in the patient’s home, with the patient’s family, among them a sister acting erratically). Thus, patients’ families were much less present in the dreams than were the patients themselves. On one hand, these results are somewhat surprising, given the frequent role of families in patients’ lives during their time in hospice. Hospice workers, though, likely spend more time with and devote more energy to the patients themselves than they do to the patients’ families.
Thus, given the patients’ role as the primary focus of the hospice workers’ waking life attention, this primary role similarly emerged in the dreams.

In terms of **interaction between participant and patient**, typically the dreamer did interact with the patient (eg, the participant sat with the patient as he struggled to breathe). In these interactions, the participant was typically in a **direct caretaking role** (eg, the participant put the patient to bed and attended to the patient). In addition, participants typically expressed **frustration regarding their inability to fully help** (eg, when the patient became angry that the participant did not help the patient leave the basement, the participant became tense because she did not know what to do or how to help the patient, leading both patient and participant to panic) and variantly reported no such frustration. Thus, in these dreams, hospice workers found themselves again assuming a caretaking function yet also being frustrated by limitations on their ability to fully help the patients, all of which no doubt parallels the realities of their waking life hospice work.19 These results also are consistent with the continuity hypothesis, which posits that waking life activities and psychological concerns are reflected in the dream content.23–25 Further, research results have indicated that work concerns and activities are reflected in the dream content and that job-related dreaming occurs less frequently when an occupation has fewer stressors.26–28 Thus, as much as hospice workers devote their professional time and energy to caring for their patients, they are indeed limited in what they can do to ease patients’ distress and forestall death. Despite their ministrations, death will come. The inevitability of the outcome, then, may be painful not only for the patients but also for the hospice workers, as depicted in the content of their dreams.

With regard to the **realism of the dream**, the dreams were typically close to waking life (eg, the patient was typing on her computer, “Help me get out of here”). A few were weird, bizarre, or not realistic (eg, a baby asked the participant to let him be free, and at the end of the dream floats away from the participant). Finally, in terms of **the presence of death**, death typically was referred to or occurred in the dream. For example, one participant was working with an infant patient but did not know how to help; she saw the infant and knew that he was dying. Little extant research comments on the realism versus nonrealism of dreams, but such findings do parallel those found by McCormick19 who described the dreams of AIDS volunteers as containing traditional images of death.

**Insight into Dream**
Data related to the insight into the dreams came from work done in the insight stage of the session. Again, all participants seemed to be eager to gain insight into their dreams.

Exploring the dream generally led to **insight about the stress related to hospice work**. For instance, one participant noted that she struggled with feeling helpless in working with patients, and another remained bothered by how the patient had died. Thus, participants believed their dreams to reflect the fundamental challenges of hospice work. As noted above, despite their best efforts, their patients will soon die. Hospice workers, then, cannot look forward to their patients’ recovery from illness and restoration of healthy functioning, as is the case in much of the medical profession.18 Instead, their goal is to ease patients’ dying process both physically and psychologically.18 Hospice workers must therefore accept the reality that they cannot alter the ultimate outcome, which may evoke feelings of helplessness.19 They can, however, hope to make the journey to that outcome more merciful, but doing so is surely not accomplished easily.

The dreams also typically yielded **insight related to dreamers’ own fears or experiences related to mortality, death, or dying**. As an example, one participant reported that having the same birth year as her patient reminded her of her own mortality; in another case, the dying baby reminded a participant of her own infant son’s death. Thus, participants had to confront their own feelings about mortality and death and perhaps relive the losses of important people in their lives, reflecting Freud’s assertion that dreams relate to waking life
experiences. In their dreams, then, these participants continued to work through potentially difficult experiences, achieving a new understanding of both life and death.6

In addition, examining the dream also typically led to insight about dreamers’ waking life outside of hospice work. More specifically, dreamers typically gained insight into both their interpersonal actions and their intrapersonal concerns. Interpersonally, one participant indicated that the darkness of her dream may have been related to her difficulty with her own children; another noted that she had the dream when dealing with stress, chronic pain, and feeling unheard in her family. Intrapersonally, one participant reported that he connected his own experiences of forgiving his father for his abuse to his patient’s ability to forgive others; another participant stated that she related her dream to her own uncertainty about how much to hold back versus take risks and trust her gut. Hence, the dreams provided insight into participants’ waking life struggles, both inter- and intrapersonal. Here, too, there was a sense of struggle and hard-won growth, for in working on the dreams participants gained a deeper understanding of past or present difficulties,8 an understanding that many sought to act on in the future (see below). Just as their patients struggled to make sense of … to reconcile … their final days of life, these hospice workers struggled to make sense of, and best use, the gifts of understanding bestowed by their dreams.2–5

Actions Taken/Hoped to Take Related to Dream
Data related to action came from the work in the action stage of the session. All participants thought of some actions that they could take as a result of their understanding gained from working with the dreams.

After having explored the dream, dreamers generally sought to better attend to self-care and find greater balance in their life. For example, 1 participant decided to begin her days with a spiritual focus and do exercises that enabled her to be her best self. Another wanted to remind herself that it is ok to fear death. A third sought to be more genuine and real in her life. Thus, all sought to extend to themselves the level of care and compassion they gave to their patients. Given the troubling content of, and accompanied by the insights gained from, the dreams, they intended to better address their own needs, whether physical, emotional, or spiritual; some had already taken such measures, and others were planning to do so in the near future. Such action took the form of new daily practices at home and/or at work, deliberate expressions of thankfulness for what they treasured in their life, and continued work on their dreams. These dreams, then, paralleling the findings of therapists’ dreams about clients,2–5 functioned as a provocative stimulus for participants, propelling them to examine who, what, and how they were in the present when compared to who, what, and how they wished to be in the future. In doing so, they served as fertile fodder to help the dreamers envision a different future.11,12

Variantly, participants expressed gratitude (eg, 1 participant wanted to keep a daily journal and record what he is thankful for and what he has learned). Participants also variantly continued to reflect or work on the dream (eg, 1 participant wanted to do additional examination of the dream, especially as it related to her father). Finally, participants variantly altered their work behaviors (eg, 1 participant now makes sure to explore patients’ wishes in front of their family). Echoing the work of Spangler et al,5 these dreams spurred personal growth, whether via an increased appreciation for one’s own life, a desire to continue to examine the content reflected in the dream, or a desire to make healthy changes.

Limitations
Although this study provides important information regarding hospice workers’ dreams about their patients, it nevertheless does have limitations. First, the data are based on in-person dream sessions in which a single dream was discussed with a single researcher. Given the intensity and evocativeness of some of these sessions, it is possible that different data would have emerged had the sessions been conducted via phone, or by a different researcher, and with different dreams. Dream sessions also followed the 3-stage model described by
Hills: different models for discussing dreams may have elicited different data. Participants held different positions in hospice, so their roles with patients varied, which may have resulted in greater variability in the data than if participants had all had similar roles. All but 1 participant was female, all but one was White/Caucasian, and most had extensive hospice and clinical experience. It is possible that men, as well as those of different races/ethnicities or with fewer years of professional experience, would have yielded different findings. Finally, participants were self-selected, so we do not know how many hospice workers have dreams about their patients.

Implications
These hospice workers’ dreams were affectively intense, realistic, and often depicted participants in a distressingly limited caretaking role in which the most they could do was provide comfort and support for patients who would soon die. As one participant commented, however, the patients’ deaths were an expected outcome, and thus the provision of such comfort and support was nevertheless fulfilling. The examination of such content led to insight about the inherent stress of hospice work, stirred up difficult elements of their own waking lives, whether inter- or intrapersonal, and also spurred participants to make changes in their lives.

Implications for Practice
The opportunity to work with such dreams seemed quite helpful to the participants and thus suggests the potential benefits of working with hospice workers’ dreams. In the same way that hospice workers themselves seek to comfort the dying and the bereaved, so, too, might employers of hospice workers seek to support those who work with the dying/bereaved. Dream groups run by persons familiar with hospice work but not affiliated with the workers’ place of employment would be one means of providing such a forum. Additionally, educating hospice workers about the possibility that they may dream about patients may also be prudent, for doing so may normalize what could be a disconcerting experience.

Implications for Research
We note that much of the affect related to these dreams was negatively laden. What types of more pleasant dreams might hospice workers have, and how might we understand what stimulates unpleasant versus pleasant dreams? And how might we understand why some hospice workers dream about patients and others do not? These dreams’ recency varied (though, as noted above, all had occurred within the past 2 years). We thus wonder about the effects, on both hospice workers and their patients, of working with such dreams very soon after they occur. How, also, do hospice workers’ dreams compare with those in other professions who experience similar feelings of death-related loss and helplessness (eg, emergency responders, firefighters, nurses, physicians, police) or those in other high-stress occupations? In addition, how do those who identify with a particular cultural, religious, or spiritual framework experience and understand such dreams?

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