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PSYCHOTHERAPISTS' DREAMING EXPERIENCES AND COUNTERTRANSFERENCE DREAMS FROM A PSYCHOANALYTIC PERSPECTIVE

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Psychotherapists' Dreaming Experiences and Countertransference Dreams from a Psychoanalytic Perspective

Psikanalitik Perspektiften Psikoterapistlerin Rüya Görme Deneyimleri ve Karşı Aktarım Rüyaları

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ABSTRACT

In the psychotherapeutic processes, the focus is mostly on the dreams of the clients, and psychotherapists' dreams can find an arena for investigation only in their own personal therapies, considering only their own internal dynamics. With the shift in the psychoanalytic thinking that put emphasis on relational, intersubjective point of views the psychotherapists' subjective presences which are in interaction with the patients in the therapy rooms have begun to be considered as significant as well. At this point, psychotherapists' dreaming experiences and their dreams about patients which are named as countertransference dreams have also begun to find themselves a place in the theory and practice more. In the literature which consists mainly of case vignettes, these dreams were associated mostly with hardships in the therapy process, therapists' competency concerns, intersubjectivity, projective identification, and/or unconscious communication. Nevertheless, there is not extensive empirical literature about this subject.

In the present study with 113 psychotherapists who participated in an online survey, a preliminary empirical exploration of this topic without having specific hypotheses is aimed. In the first part of the study, a general exploration of dreaming frequencies of psychotherapists and their associations with certain professional characteristics as well as variables such as psychotherapists' experienced difficulties during therapies and attitudes towards dreams were provided. In the second part of the study with 55 psychotherapists who remembered at least one of their countertransference dreams the specific characteristics of these dreams and the dreamt about client, information about therapists' understandings and gains from these dreams as well as their possible associations with the therapeutic relationships were collected.

According to the regression analysis, psychotherapists' experienced difficulties while conducting psychotherapies, their having psychoanalytical orientation, and general dream recall and processing frequencies were identified as significant predictors of countertransference dreaming frequency. Additionally, psychotherapists' bearing positive attitudes regarding dreams, their experience

levels, psychoanalytical orientation, working with adult clients, and their general dream recall and processing frequencies were found to be significant predictors of the frequency of processing dreams in clinical settings. In terms of the characteristics of reported countertransference dreams, a continuity between interpersonal interactions and feelings in the dreams and psychotherapists' evaluations of the therapeutic relationship as well as their countertransference reactions towards the dreamt about clients were observed. Detailed findings regarding these specific dreams were reported in the study. All findings were discussed considering the existing literature, and limitations of the study as well as future directions were provided.

Keywords: countertransference, psychotherapist dreams, psychotherapy, dreamwork, psychoanalytic

ÖZET

Psikoterapötik süreçlerde odak nokta çoğunlukla danışanların rüyaları üzerindedir ve psikoterapistlerin rüyaları çoğunlukla sadece kendi kişisel terapilerinde, yalnızca kendi iç dinamikleri göz önünde bulundurularak analiz edilir ve çalışılırlar. İlişkisel, öznelliklerarası bakış açılarının öne çıkmaya başladığı psikanalitik düşüncede yaşanan değişimle birlikte, terapistlerin terapi odalarındaki hastalarla etkileşim içinde olan öznel varoluşları da önemli bir yer tutmaya başlamıştır. Bu noktada, psikoterapistlerin rüya görme deneyimleri ve karşı aktarım rüyaları olarak adlandırılan danışanlarla ilişkili rüyaları da teori ve pratikte kendilerine daha fazla yer bulmaya başlamıştır. Ağırlıklı olarak vaka öykülerinden oluşan literatürde, bu rüyalar daha çok terapi süreçlerindeki zorluklarla, psikoterapistlerin yeterlilik kaygılarıyla, öznelerarasılıkla, yansıtmalı özdeşimle ve /veya bilinçdışı iletişimle ilişkilendirilmiştir. Ancak, bu konu hakkında kapsamlı bir ampirik literatür yoktur.

Çevrimiçi bir ankete katılan 113 psikoterapistle yapılan bu çalışmada, bu konunun, herhangi bir spesifik hipotez sunmadan, deneysel bir ön araştırmasının yapılması hedeflenmiştir. Çalışmanın ilk bölümünde, psikoterapistlerin rüya görme sıklıkları ve bunların mesleki özellikler ile terapide yaşanan zorluklar ve rüyalara yönelik tutumlar gibi değişkenlerle ilişkilerinin genel bir keşfi sunulmuştur. Karşı aktarım rüyalarından en az birini hatırlayan 55 psikoterapistin ankete devam ettiği ikinci bölümde ise bu rüyaların ve rüyada görülen danışanların bazı özellikleri, psikoterapistlerin bu rüyalara bakış açıları, bu rüyalardan elde ettikleri kazanımlar ve bu rüyaların özelliklerinin terapötik ilişki ile olası bağlantıları hakkında bilgiler toplanmıştır.

Regresyon analizine göre, psikoterapistlerin psikoterapi uygularken yaşadıkları zorluklar, psikanalitik yönelimlere sahip olmaları ve genel rüya hatırlama ve işleme sıklıkları karşı aktarım rüyası görme sıklıklarının yordayıcıları olarak belirlenmiştir. Ek olarak, psikoterapistlerin rüyalara yönelik olumlu tutumları, deneyim düzeyleri, psikanalitik yönelimleri olması, yetişkin danışanlarla çalışmaları ve genel rüya hatırlama ve işleme sıklıkları klinik ortamlarda rüyaları

işleme sıklıklarının yordayıcıları olarak bulunmuştur. Psikoterapistlerin seçtiği spesifik karşı aktarım rüyalarının özellikleri incelendiğinde, rüyalardaki kişilerarası etkileşim ve duygular ile terapistlerin rüyada görülen danışana yönelik karşı aktarım tepkileri ve bu danışanla terapötik ilişki değerlendirmeleri arasında bir süreklilik gözlemlenmiştir. Çalışmada, bu spesifik rüyaların özelliklerine ilişkin ayrıntılı bulgular rapor edilmiştir. Tüm bulgular, mevcut literatür dikkate alınarak tartışılmış ve çalışmanın zayıf yanları ile ileri çalışmalar için yönlendirmeler sunulmuştur.

Anahtar Kelimeler: karşı aktarım, psikoterapist rüyaları, psikoterapi, rüya çalışması, psikanalitik

INTRODUCTION

Dreams have been an important subject in the psychoanalytic literature both in theory and practice from the beginning of the birth of the psychoanalytic thinking with the writings of Sigmund Freud (1900/1955). Even though Freud (1900/955) made the first psychoanalytic explorations about dreams with the deep investigation of his own dreams, in general, the focus of the psychoanalytic literature has been remained on the patient dreams mostly, and dreams of the therapists have not attracted considerable attention. One of the significant reasons for this disinclination can be as attributed to the focus of the classical understanding being on the patient solely as if only the patient's psyche had an impact on the therapeutic interaction, until the rise of the psychoanalytic theories that acknowledge the presence of two individuals in the therapy room as the patient and the analyst/therapist.

Even though the therapeutic relationship which requires the acknowledgment of at least two subjectivities in the therapy room has a significant place in the current psychoanalytic thinking, the literature and empirical studies about patient dreams, specifically about the therapeutic relationship and especially therapists' dreams about the therapy process and patients are still scarce (Abramovitch & Lange, 1994; Lester et al., 1989, Spangler et al., 2009; Watson, 1994; Zwiebel, 1985). One special group among these dreams are called countertransference dreams which are classified as therapists' dreams in which patients are manifestly present (Lester et al., 1989; Zwiebel, 1985), or patients can be associated with the latent content (Rudge, 1998; Spero, 1984; Zwiebel, 1985).

Because of the lack of comprehensive information about dreaming experiences of therapists and specifically countertransference dreams, the principal aim of this study is to provide an extensive literature review about the dreams in and about the therapeutic process, countertransference dreams as well as advance the research about this topic. To be able to describe and understand the phenomenon of countertransference dreaming, possible predictors of the occurrence of these dreams such as age, gender, theoretical orientation, experienced difficulties in

therapies; specific characteristics of these dreams and their relations with psychotherapeutic relationship; various processing methods, utilization of these dreams, and therapists' theoretical understandings about the occurrence of such dreams are aimed to be explored in this study. Additionally, the factors that might influence the extent of processing dreams in clinical settings such as age, education, psychotherapy experience, theoretical orientation are aimed to be explored.

For these purposes, in the first chapter, a detailed literature review about the dream theories in the psychotherapy literature including both psychoanalytic theories and perspectives from different therapy schools, empirical studies about working with dreams in psychotherapy, and perspectives as well as studies about countertransference dreams will be presented. The second chapter will include the methodology of the current study, and the results of the study will be described in the third chapter. Lastly, discussions about the findings of the current study regarding the existing literature and possible clinical implications will be presented in the fourth chapter.

CHAPTER 1
LITERATURE REVIEW

1.1. THE DEFINITION OF DREAM AND THEORETICAL BACKGROUND

Since the beginning of the written history of humankind, dreams and dreaming have been a phenomenon that attracts curiosity, attention, and interest in understanding their meaning and function. This interest can be traced back to the writings of early philosophers like Plato, Aristoteles, Socrates (Bergman, 1966; Shaw, 2016) as well as to the healing arts practices of Hippocrates in ancient Greece (Sabini, 1981). Nevertheless, it would not be wrong to say that the era of investigation of dreams from a more theoretical and systematic perspective has begun with the groundbreaking book of Sigmund Freud, called "The Interpretation of Dreams" (1900/1955). Freud (1900/1955) specified the functions of dreams as being "the guardian of sleep" and providing a distinct way to reach the unconscious of the dreamer. Thus, in his theory, the concealed meanings of dreams have been stressed.

Later, with another groundbreaking discovery, namely, the Rapid Eye Movement (REM) by Aserinsky and Kleitman (1953) sleeping and dreaming have become a study of the neuroscientific discipline as well (Mancia, 2004; Shaw, 2016). Although early neuroscientific studies about dreaming which have the message that dreams are meaningless brain signals and activations during sleeping (Hobson & McCarley, 1977) had challenged the psychoanalytic perspectives, recent neuroscientific studies support the psychoanalytic views of dreams and theories of Freud about the unconscious and dreams (Johnson & Mosri, 2016; Mancia, 2004; Shaw, 2016; Solms, 2018). A broader message which can be derived from the current research is that dreams are not unnecessary by-products of the brain, and they deserve a deeper investigation for their understanding and utility.

Because dreaming and dreams are the topics of interest of a wide variety of disciplines, making a general definition of the phenomenon has not been preferred,

and most of the research in this area avoided giving a single definition of dreams (Pagel et al., 2001). However, regarding the consensus about dreams among the researchers from different perspectives in the dream research, Schredl (2010) broadly defines the dream as the subjective experience corresponding to the brain activity that continues during sleep. With a similar point of view, Glucksman (2001) defines the dream as an important instrument that gives valuable information about the subjective links between the brain activity during sleeping and individuals' affect, perceptions of self and others, recollections, wishes, conflicts, etc.

For a deeper understanding of dreams, different theories about the meaning, functioning, and utility of dreams from the perspectives of clinical psychology will be discussed in the following sections. As this study mainly focuses on the psychoanalytic perspectives of the phenomenon, first psychoanalytic theories about dreams will be presented in detail, and later other theoretical orientations' understandings will be briefly presented.

1.1.1 Psychoanalytic Dream Theories and Changing Perspectives

Psychoanalytic dream theory was introduced by Sigmund Freud and has undergone various changes both in terms of its conceptualization and its clinical utilization (Lane, 1997). These changes mainly follow the critical shift in psychoanalytic thinking and practice in the second half of the 20th century from one-person, drive-based, theories to two-person, relational understandings that underline the co-construction of people's mental lives as well as relationships (Dosamantes-Beaudry, 2007). Even though cardinal ideas of Freud about dreams that emphasize the inner workings of the enclosed mind still preserve their value in psychoanalytic thinking, alternative relational perspectives broadened these initial formulations to include the interpersonal context. In the following sections, various psychoanalytic theories about dreams and dream analysis, and the changes in understanding will be presented.

1.1.1.1 Freudian Dream Theory and Analysis

Freud (1900/1955) emphasized the significant role of the dreams as an important tool in psychoanalysis for accessing a patient's unconscious material that is unreachable without dreamwork. Freud partly conceptualized this idea with the thinking that the defense mechanisms of the ego, mostly repression, loosen while sleeping, and thus, unconscious elements of the psyche become symbolically visible in the dreams (Shaw, 2016). In the dream theory of Freud (1900/1955), dreams serve an important role in protecting sleep via regulating the tension released by the unconscious libidinal and aggressive impulses. A comprehensive statement that gathers these two interrelated ideas is that the dream is a compromise formation between the pressure of the psychic tension that is derived from the unconscious, unacceptable wishes and the necessity of staying in sleep. This compromise is fulfilled by the dreamwork that provides a partial expression of the unconscious material with concealment via turning them into symbolic representations that do not disturb the sleep (Freud, 1900/1955). Schneider (2010) claims that this understanding of the dreams suggests that the only task of the dreams is monitoring and calibrating the rise of what is repressed into the unconscious.

Freud (1900/1955) drew a significant distinction between the manifest content that is the plainly expressed surface layer and façade of the dream and the latent content that is the concealed actual meaning of the dream. The latent content of the dream is transformed into and thus, creates the manifest content regarding the principles of "condensation, displacement, and representation/symbolization" due to the reasons mentioned in the former paragraph. In this perspective, the tension and unconscious conflict can be resolved only with the analyst's interpretation of the dream by inverting the course of the dreamwork as starting from the manifest content and proceeding to the latent (Pesant & Zadra, 2004; Freud, 1916, as cited in Schneider, 2010).

The method that Freud used to work with dreams is almost the same as his usual classical psychoanalytic technique; free association (Sharpe, 1938). In this

method, the patient reflects each component of the manifest content of the dream with a free, uncensored mind as much as possible, and then the analyst interprets the dream considering their convictions about the patient, figurative meanings of the dream elements, and associations of the patient in order to reach the latent content (Hill & Knox, 2010; Pesant & Zadra, 2004).

1.1.1.2. Jungian Dream Theory and Analysis

As being the second leading psychoanalyst who proposes a dream theory and analysis of dreams, Carl Gustav Jung did not share the idea of dreams being the representation of repressed unconscious wishes with Freud (Shaw, 2016). In his theory, dreams have an important function of compensation via giving an expression to the certain perspectives of the ego that are in line with the waking life but remained unexpressed (Jung, 1974). Thus, regarding this conceptualization dreams can be thought of as a significant bridge that bonds the conscious and the unconscious (Hill & Knox, 2010).

Jung evaluated dreams as the uncovered, creative manifestation of the unconscious and the current status of the psyche. Thus, he did not disregard the manifest content as a deception of the actual meaning (Pesant & Zadra, 2004). In his method of dream analysis, different layers of meanings are tried to be discovered while preserving a close distance from the manifest content of the dream. Firstly, the meaning of the dream is interpreted via associations of the dreamer's waking life and then, deepening of the interpretations are provided with investigations of personal associations including memories, feelings, and ideas; cultural associations containing interpersonal elements in the dreamer's culture; and archetypal associations such as historical and spiritual attributions that are bound with the collective unconscious term of Jung (Hall, 1983).

1.1.1.3. Understanding Dreaming from the Perspectives of Bion and Ogden

Rather than focusing on the hidden meanings of dreams like Freud (1900/1955), Bion identifies dreams as a process of unconscious thinking (Schneider, 2010). Thus, in contrast to Freud's understanding of dreams that only the interpretation by the analyst can lead to resolution of conflicts that appeared in the dreams, Bion asserts an important function of the dream itself as giving meaning and resolving the unworked emotional experiences by transforming raw emotions which he called beta elements, into meaningful emotional components, alpha elements, and paving the way for unconscious psychological processing (Bion, 1962).

Schneider (2010) claims that, in this understanding, patients' voicing their dreams in the analytical setting does not mean that interpretation of the analyst is needed, but rather patients unconsciously aim to continue to dream the disturbing parts of the dreams which are not fully dreamt alone together with the analyst. Later, Bion suspected that the dreams, in fact, may show the inability or breakdown of unconscious thinking and resolution of some affective experiences which in turn leads to "visual hallucinations." Schneider (2010) combines the old and altered perspectives of Bion and suggests that dreams should be considered in the analytical setting as some parts of them have been already subjected to the psychological work by the patient's unconscious, and some parts are left untouched by the patient's unconscious. While dealing with the undreamable, hallucinatory parts of the dreams he suggests analysts to pay attention to their own reveries and sensory experiences during listening to the dreams of the patient (Schneider, 2010).

Like Schneider (2010), Ogden (2004) also follows the path of Bion in the understanding of dreaming and stresses the importance of analysts' having the capacity of forming and following their own reveries with a high psychological receptivity to be able to dream the undreamt or interrupted parts of patients' dreams along with the patient in the analytical setting. During this analytical process of mutual participation of the analyst and the patient in dreaming, Ogden (2004) claims that beyond the analyst's understanding the patient, the patient and the

analyst jointly live the formerly undreamable affective experience in the analytical interaction through transference and countertransference. Atlas (2013) embraces Ogden's perspective and identifies the dream analysis as a "shared third." She conceptualizes the analytical dream work by emphasizing the process as a path of co-created and shared space in which the patients can come into existence via owning their own minds (Atlas, 2013).

1.1.1.4. Changing Perspectives and Contemporary Psychoanalytical Dream Analysis

Even though Freud's assumption that dreams are the disguised representations of unconscious desires and impulses is still recognized as valid, especially for certain dreams or dream elements, it is believed that dreams further bear information about feelings, recollections, current and past conflicts, defense mechanisms, self and relationship perceptions, transference, and countertransference dynamics as well (Glucksman, 2001). Furthermore, despite discarding the manifest content and focusing only on the latent like Freud (1900/1955) most of the contemporary analysts adopt a perspective that is more similar to Bion and prefer to pay attention to the manifest content of the dream and its symbolic meanings more (Glucksman, 2001; Lane et al., 1995; Stolorow, 1978).

This preference has two underlying reasons that are (1) the assumption that manifest content gives valuable information (Rohde et al., 1992) and (2) the time-limited practices which hinder the time devoted to practicing intensive dream interpretation with taking associations of the patient about each element in the dream (Glucksman, 2001; Lane et al., 1995). Regarding the significance of the manifest content in the dream interpretation, Stolorow (1978) suggests taking the significant themes in the manifest content as departures for associations and claims that evaluations of these associations have the potential to reveal patients' subjective representational patterns that unconsciously form their experiences in and out of the therapy. Furthermore, Schwartz (1993) claims that the focus should

be on the manifest content that can reflect the current central conflicts and dilemmas of the patient rather than the deep investigation of the infantile wishes.

From a similar token, Aron (1989) stresses the manifest content's narrative feature which is derived from the mind's intrinsic organizing principles of experiences and asserts that investigations of the thematic components of the manifest content can bring out aspects of dreamers' usual patterns of relating. It is found in the study of Lane et al. (1995) in which a patient's 11 dreams were analyzed via configurational approach that inferences that were derived solely from the examination of a patient's manifest dream contents by two researchers and her therapist's evaluations of the patient were in-agreement in most of the domains such as the patient's intellectual ability, attitudes in relationships, emotion regulation, and transference in the analysis. This research can be thought of as a support for the idea that the manifest content of the dream bears important symbolic messages beyond just serving as a disguise of the actual meaning (Glucksman, 2001).

Another significant change in the understanding of dreams stems from the important distinction in conceptualizing dreams as a one-person and intrapsychic product that serves wish fulfillment (Freud, 1900/1955) and as interpersonal, mutually constructed processes of the patient and the analyst from a relational perspective (Kron & Avny, 2003). As an example of the interpersonal perspective, Blechner (1995) suggests evaluating the dreams of the patients as tools for gaining insight about the transference and countertransference relationships with interpreting them together with the patient. Similarly, Friedman (2000) mentions about two aspects of dreams as dreaming which is mainly an intrapsychic process as well as creation and narrative of the dreams as an interpersonal process in a relational matrix.

From a relational perspective, Aron (1989) expresses his understanding and approach of dream interpretation by saying; "It is by moving back and forth from associations to manifest theme, from analysis to synthesis, that the diverging associations ultimately converge allowing the analyst and patient jointly to construct a meaningful dream interpretation." (p.124). Glucksman (2001) also describes his dream analysis practice as a collaborative free association and

working process of both the patient and the analyst to be able to gain a joint understanding. Thus, diverging from the classical analysis that requires free association of only the patient and interpretation of only the analyst, he describes a model of mutual work that both the patient and therapist join to each stage of analysis. With this way of patients' having an active role in the interpretation process, the meanings of the dreams become more accessible and powerful for the patients to take an action regarding the understandings which are derived from the dreams (Glucksman, 2001).

Beyond the different methods of interpretation of dreams, contemporary psychoanalysts, mostly from interpersonal and relational perspectives, stress the role of dreams and dream interpretation as a way of self-regulation and personal (Glucksman, 2001) as well as interpersonal communication (Aron, 1989; Blechner, 1995). Even before the contemporary shift to a more relational point of view, the communicative function of dreams, especially in psychotherapy was illustrated with an ingenious experiment by Whitman et al. (1963). In their experiment, two participants were asked to recall and tell their dreams to the experimenter after awakening them during their REM episodes in the sleep laboratory and later to a psychiatrist who interviews them about their dreams 1 hour or 1 day later from the laboratory experiment. The striking result was that the recalled and reported dreams were modified, added, or omitted regarding the recipient, the experimenter or the psychiatrist. The manifest as well as the latent dream contents that the dreamer may not consciously aware of affected the recall of dreams. Thus, regarding these results, researchers stress the communicative role of dreams via dreamers' conscious or/and unconscious appreciation of the meaning of the dreams, their fantasies about listeners' way of reacting to the dream content as well as present or/and transference relations with the listener (Whitman, 1963; Whitman et al., 1963).

In addition, Aron (1989) explains the point of view of the interpersonalists towards dreams as their evaluating dreams as communications instead of bearing hidden meanings that wait to be discovered. It can be thought that recalling and verbally expressing a dream in the presence of another supports its function as a

communication rather than concealing something (Blechner, 1995). Regarding their communicative aspects, Blechner (1995) and Kanzer (1955) put an emphasis on the supervisory role of the patient dreams about the therapeutic process and countertransference of the analyst. Blechner (1995) bases his understanding of this role of dreams on the thoughts of Ferenczi (1913) about the mutual analysis understanding which covers the interpretation of patient dreams as well. It is postulated that interpretation of patients' dreams by various qualified analysts can disclose a lot about their therapists' countertransference trends, and reenactment of these same reactions can be observed while therapists interpreting their patients' dreams (Levenson, 1983, as cited in Blechner, 1995). Blechner (1995) suggests several hints for therapists to suspect countertransference in the dream interpretation like jumping too quickly to the latent content interpretations that are loosely linked to the manifest content of the dream.

As a final point, Glucksman (2001) stresses the significant function of dreams as conveying valuable diagnostic and prognostic information as well as offering insight both to the therapist and the patient. Interpretation of dreams typically supports previous diagnosis and formulations of the therapists, and it can also signal new understandings about the dynamics and imminent actions of the patient, and warn the therapist about patients' self-destructions, possible harms to other people, psychotic attacks, and affective dysfunctions. Furthermore, transference feelings of patients and countertransference of the therapists both conscious and unconscious, therapeutic relationships, and impasses may initially manifest themselves in the dreams (Glucksman, 2001).

1.1.2. Dream Theories and Interpretation from Other Theoretical Perspectives

Even though dreams are more frequently used in psychoanalytic therapies compared to other perspectives, it is not true to say that they are only the subject of the psychoanalytical perspective (Schredl et al., 2000). Nowadays, the interest in dreamwork is growing in other therapeutic perspectives as well (Skrzypińska & Szmigielska, 2018), and in fact, the thoughts and ways about working with dreams

in other therapy perspectives are not substantially different from contemporary psychoanalytic understanding.

Understanding of dreams from the perspective of cognitive-behavioral perspectives dates back to Aaron Beck (1971/2002) who is one of the significant founding figures of cognitive therapy tradition and was actually trained in the psychoanalytic orientation (Skrzypińska & Szmigielska, 2018). In Beck's initial understanding (1971/2002), analysis of dreams for a hidden, unconscious meaning is unnecessary, and the themes of the manifest content of the dream parallel with the individual's waking life, psychopathology, and cognitive patterns of constructing meanings including the maladaptive and distorted ones. However, later Beck gave up his interest in dreams because of ideological and pragmatic motives (Skrzypińska & Szmigielska, 2018).

Freeman and White (2002) from a cognitive perspective, describes dreams as unique and personal representations of the individuals' point of view about themselves and the world, picturing their usual cognitions and emotions in their waking lives. Their principle of dream interpretation in therapy includes giving meaning to dreams based on themes of the dreams rather than evaluating them as symbols, and they stress dreams' unique relation to patients' waking life schemas (Freeman & White, 2002). Furthermore, Doweiko (2002) claims that even though the phenomenon of dreaming is not the interest of Cognitive Behavioral Therapy (CBT), the individuals' recalling, reporting, and interpreting the dreams in the waking condition are affected by their usual distortions in their cognitions and thus, can be a subject of psychotherapy. As an expansion of the CBT approach, dreams can also be utilized in the Schema Therapy as disclosers of schemas of the patient and constituting a starting point in the change step (Young, 2003, as cited in Skrzypińska & Szmigielska, 2018).

In the existential–phenomenological understanding, dreams are described as a kind of existence in line with waking life. Rather than focusing on discovering the meanings of the dreams, existentialist therapists give importance to every detail of the dream in order to patients relive it in the present therapeutic stage and they understand it as an authentic experience of living, not different than waking

experiences (Boss & Kenny, 1987, as cited in Pesant & Zadra, 2004). On the other hand, in the Gestalt understanding, all components of the dream are evaluated as projections of the individual's acknowledged as well as undesirable parts of the personality. Dreamwork, in this understanding, is utilized for the integration of different aspects of the patient's personality via reexperiencing and forming a dialog among different elements of the dream in psychotherapy rather than interpreting them solely from an intellectual standpoint (Perls, 1992, as cited in Pesant & Zadra, 2004).

Lastly, an integrative method of dream interpretation of Hill's (1996) Cognitive-experiential Model of dream interpretation can be mentioned briefly. This method of dream interpretation is a combination and adaptation of various theoretical approaches including humanistic, cognitive, Gestalt, and psychoanalytic. It consists of three steps as exploration, insight, and action. Several cardinal ideas of this model can be summarized as dreams' bearing personal meaning following the individuals' waking thinking, and schemas and therapy's having the goal of reorganizing the schemas to render them more adaptive via working dreams in cooperation with the patient whom the meaning of the dream resides (Hill & Rochlen, 2002).

1.2. EMPIRICAL STUDIES ABOUT UTILIZATION OF DREAMS IN PSYCHOTHERAPY

1.2.1. The Extent of Utilization of Dreams as Session Material

Research in this area indicates that utilization of dreams in psychotherapy practice is still common among psychoanalytically oriented therapists whereas therapists from other orientations are less likely to engage with dreams in their practice (Crook, & Hill, 2003; Hill et al., 2008; Schredl et al., 2000; Skrzypińska & Szmigielska, 2018). In their survey of 228 experienced psychologists from various theoretical orientations, Keller et al. (1995) found that 83% of therapists utilized dreams in their practice, but 53 % of them claimed using dreams only occasionally.

Also, most of the participants expressed that work of dreams was not proposed by therapists, instead clients brought them up in the sessions (Keller et al., 1995).

Schredl et al. (2000) surveyed 79 therapists from psychoanalytic, humanistic, and cognitive-behavioral perspectives about their extent of dreamwork in sessions and found that in total, 28% of the sessions had included dreams, and 49% of the patients had engaged in dreamwork at least once. Also, when therapeutic schools were compared, it is suggested that psychotherapists from psychoanalytic perspective utilized dreams substantially more in their therapies, found interpreting dreams in therapy more useful, and analyzed their dreams more often than therapists from other perspectives (Schredl et al., 2000).

In their study, Crook and Hill (2003) collected data from 129 psychotherapists who were mostly identified as eclectic with a tendency to cognitive-behavioral tradition. They reported that only approximately 15% of the patients mentioned their dreams in sessions in the past year and approximately 8% of the session time was spent dealing with dreams in their therapies with mostly exploring the dreams rather than interpreting them. Hill et al. (2008) replicated this study with 47 psychoanalytically oriented therapists and found similar results with Schredl et al. (2000) about psychoanalytic therapists' working more with dreams in their practice. Psychoanalytically oriented therapists also reported that they received more training, felt more competent while using dreams in therapies, and gave more importance to interpreting and gaining insight from the dreams compared to cognitive-behavioral psychotherapists in Crook and Hill's (2003) study.

Various reasons for the tendency of not utilizing dreams as a clinical material in psychotherapeutic approaches other than the psychoanalytic perspective can be mentioned. First of all, it is suggested that following Beck's withdrawal of interest from dreams, cognitive-behavioral therapists mostly abandoned their investment and interest in dreams (Skrzypińska & Szmigielska, 2018) with the effect of lack of training, research, and established manuals for working with dreams, and due to the bias that dreams are products of the unconscious (Freeman & White, 2002; Skrzypińska & Szmigielska, 2018). From a similar token Hill and

Knox (2010) specify the reason for this unwillingness as therapists' feeling incompetent and unprepared for working with dreams because of deficiency in the proper training about the subject. Also, Cartwright (1993) mentions the general loss of interest to dream interpretation in the mental health area stressing the rise of medications for psychological disorders, intensive leaning towards science, and loss of interest as well as trust in the subjective experiences and practices.

1.2.2. Benefits of Utilization of Dreams in Therapeutic Practices

Despite the divergences in the theories of dreams and the underutilization of dreams by therapists from several therapeutic schools, all perspectives mention the benefits of bringing the dreams to the therapeutic setting to work on them. In addition to claims of theories about the essentialness and/or fruitfulness of working with dreams in the therapeutic process, the effectiveness of it for therapy also supported with empirical evidence. In their review of empirical studies which examine the dreams in the therapy process, Eudell-Simmon and Hilsenroth (2005) identified four advantages and roles of the dream work as (1) easing the therapeutic process, (2) increasing self-awareness of the patients, (3) therapists' gaining further insight about the therapy process and patients, and (4) therapists' monitoring therapeutic progress. In a similar vein, in their review of clinical observations as well as empirical studies Peasant and Zadra (2004) identified three significant gains of dream interpretation in psychotherapies as (1) increasing insight of clients, (2) encouraging the active involvement of the clients to the sessions, and (3) enhancing understanding of therapists about clients and the degree of improvement in the therapy.

Several examples from studies about the effectiveness of dream interpretation in therapies can be mentioned briefly. In the study of Rochlen and Hill (2005) with 50 male students who participated in a single therapy session including dreamwork, participants rated the therapy sessions in which dreams were interpreted deeper than the clients in other studies in which routine therapy sessions were rated in terms of session depth. In addition, in Schredl et al.'s (2000) survey

with psychotherapists from various perspectives, therapists acknowledged that approximately 70% of their patients had taken advantage of working with dreams in therapy, signifying an important contribution to the progress in therapies. Hill et al. (2000) carried out a study with 14 patients who had disturbing dreams and experienced a recent loss by assigning half of them to a brief therapy focusing on their dreams and other half to a brief therapy focusing on their loss. They found that patients taking a dream-focused therapy had a faster involvement in the therapy process, enjoyed the therapy more, were more open to the therapists, and had higher therapeutic alliance ratings from their therapists (Hill et al., 2000).

In addition, Peasant and Zadra (2004) point out the facilitative function of dreams in sharing and discussing troublesome and hard to disclose issues in therapy via talking about dreams' preserving a safer distance with the reality and the material which can be derived from the dream. In an intriguing study with 48 patients who had a high risk of premature termination due to their restricted access and sharing of their emotions and inner life with others, Cartwright et al. (1980) demonstrated the benefit of a therapy preparation program in which potential patients were awakened in a sleep laboratory during their REM periods and their dreams were discussed in the subsequent morning for 2 weeks before starting the psychotherapy process. Patients who focused on their dreams before the therapy had a substantially lower drop-out rate, and they shared their inner life and expressed emotions more easily in the sessions (Cartwright et al., 1980). Based on the findings of this study, Cartwright (1993) further identified three distinct groups of patients who benefit significantly from dreamwork in psychotherapy as the alexithymics, depressed patients due to an experienced stressful incident, and patients who suffer from sleep terrors.

1.2.3. Transference and Countertransference in Patient Dreams

The studies reported above discussed the dreams of the client and the general role of dreamwork in the psychotherapy setting. On the other hand, there is another specific group of the client's dreams that can be directly associated with the

therapy process and/or therapist. These references also include important elements of the psychotherapy process which are transference and countertransference. Simply, transference can be defined as the patients' emotional reactions that are brought into the therapy room from patients' childhood or other sources, and as a form of displacement (Gitelson, 1952). In response, countertransference which will be presented in detail in the following sections can be simply defined as the therapists' all emotional reactions towards their patients (Heimann, 1950).

A direct expression of transference and countertransference reactions can be seen in the patients' dreams that the therapist appears unconcealed in the manifest content (Lane, 1997). Although these specific dreams are not very rare and constitute approximately 10% of the reported dreams of the patients (Rosenbaum, 1965) they are mostly overlooked in the literature probably due to the early understandings of this phenomenon (Civitarese, 2006) such as their signaling intense transference reactions, problems in transference reactions' as-if quality, a poor prognosis if they are the very first dreams of the patients, patients' being a transference object of the therapist, and/or a countertransference difficulty (Gitelson, 1952). Nevertheless, Rosenbaum (1965) found in his study with 22 analysts that these dreams do not correlate with poor or good prognosis, specific period of the analytic process, intense transference, and countertransference feelings.

Furthermore, Rohde et al. (1992) found in their study with 67 psychotherapists who reported dreams about their own therapists that more than half of these dreams were coded as having distinctly unpleasant feelings. The interactions between the patient and therapist in these dreams were friendly in 34.3 % of the dreams, aggressive in 20.9 % of the dreams, and sexual in 7.5% of the dreams. Also, they identified four broad themes in these dreams as "separation-rejection, seduction-antagonism, protectiveness-responsiveness, and praise" (p. 540). They mention several possible causes of the general negative feelings in these dreams including negative representations of therapists such as the general prevalence of unpleasant emotions in dreams, inherent adversity of psychotherapy processes, and patients' working to solve conflicts via these dreams. They also

claim that the themes of this kind of dream have the potential to reveal patients' dominant conflicts (Rohde et al., 1992).

1.3. COUNTERTRANSFERENCE DREAMS

Despite the rich theories about dreams in psychoanalytic understanding and empirically-based effectiveness and benefits of the dream work in the therapeutic process, one kind of dreams that is experienced by the therapists is disregarded substantially in both psychoanalytic practice and literature, namely countertransference dreams (Abramovitch & Lange, 1994; Lester et al., 1989, Spangler et al., 2009; Watson, 1994; Zwiebel, 1985).

The countertransference dream is defined broadly as the therapist's dream in which the patient is seen in the manifest content unequivocally (Lester et al., 1989; Zwiebel, 1985). Even though limiting the classification of the countertransference dreams to the manifest content of the dream is an oversimplification as the patient in the dream may represent another person or patient may be represented by another figure in a dream with different manifest content, this restriction is found necessary to be able to focus attention (Whitman et al., 1969). Nevertheless, some authors (e.g., Rudge, 1998; Spero, 1984; Zwiebel, 1985) include dreams that bear references to the patients in the latent content to the definition of countertransference dreams as well. Thus, in the literature regarding these dreams, there is not an absolute consensus about their definition.

In the following sections, firstly the definition of and changing views about countertransference will be presented to provide a basis for understanding the perspectives about countertransference dreams. Next, the studies and viewpoints about the frequency of occurrence of these dreams, the possible reasons for the lack of literature about this topic, Freud's Irma dream which is the first countertransference dream that is discussed in detail in the literature, possible factors that can impact the occurrence of these dreams, various perspectives about understanding and interpreting these dreams, studies about themes of and emotions

in countertransference dreams, and lastly research about how these dreams are processed and used in the therapeutical setting will be presented respectively.

1.3.1. Understanding of Countertransference and Changing Perspectives

The significant change in the understanding of psychoanalytic thinking that was mentioned in the previous sections has also impacted the frame of mind and position of the analyst in the analytic setting. In the early years of psychoanalytic thinking and practice, there was a rigid conviction that the analyst could and should be totally neutral, acting as a blank screen ready for the projections of patients. This conviction has changed in time turning into an understanding that emphasizes mutuality of the analyst and analysand as co-participants in creating the sense of self as well as the narrative of the patient in the therapy room (Aron, 1996).

With this important change in psychoanalytic thinking, the understanding and utilization of countertransference have also altered significantly. Freud (1910/1957), in his classical psychoanalytic theory, considered countertransference initially as a drawback for the psychoanalytic work and stressed the importance of the analyst's going beyond his own internal conflicts and resistances with personal analysis to be able to overcome and eliminate its negative effects. The countertransference reactions were evaluated as the unwelcome influence of the analysands on the unconscious of the analyst (Freud, 1910/1957). Afterward, this unfavorable understanding of Freud about the countertransference had been left gradually, and its role as an important therapeutic tool that can be utilized in grasping the depths of the patients and their unconscious has been agreed upon. Heimann (1950) conceptualized countertransference as the totality of the affective reactions of the analyst corresponding to the analysand as well as a significant means of reaching and understanding the patient's unconscious. This perspective claims that the source of the countertransference reaction of the analyst lies under the analysand's unconscious rather than the analyst's (Zachrisson, 2009).

Later, Sandler (1976) mentioned the "role responsiveness" concept. He explained role responsiveness as the analyst's corresponding to the role offered by

the patients via unconscious enactments of relationships of the patients with their early objects in the analytical setting. It is asserted that the sole way of making what is unconscious conscious is analyst's playing this role with the patient. By the same token, he saw countertransference as a combination of the analyst's taking the role which is proposed by the patient and his own internal process (Sandler, 1976). As a continuation of Sandler's (1976) understanding of countertransference, Gabbard (2001) described the contemporary understanding of countertransference as patients' offering a role that comes from their internal dynamics to the therapists and therapists' molding this role with the impact of their own inner world and unconscious dynamics. In this understanding, neither the analyst nor the patient has the source of the countertransference reactions merely, but they are the unique products of co-construction of both the analysand and analyst in the analytical setting (Gubb, 2014).

Furthermore, Ogden (1994) stressed the intersubjective nature of the analytical field and claimed that neither the analysts nor the analysands can define themselves independent from the relationship between them in the analytical context. He names this intersubjective existence as the "analytical third." This unique construct is created with the interplay of subjectivities of both participants of the relationship but as a result, it becomes more than the sum of the two subjectivities. The analytical third and individual subjectivities in the analytical setting cannot be purified, and there is no need to separate these existences. All subjectivities in the analytical context including this third intersubjectivity generate and change each other via a constant interaction and tension between them. In addition, for the sake of the intersubjective understanding, Ogden does not support the idea of considering every experience of the therapist as countertransference and underlines the existence of the constant dialectic between the therapist's subjectivity and intersubjectivity in the analytical field (Ogden, 1994).

With the contemporary intersubjective, relational perspective that acknowledges the analyst's subjectivity in the analytical setting as well as the patient's, reactions of the analyst in any kind including countertransference have become more of an issue in the analytic process. Hence, countertransference

reactions of the analyst are not seen any longer as a drawback in the analytical work but are recognized as an important means for reaching the unconscious of the patient (Zachrisson, 2009). Rudge (1998) argues that the analyst either consciously or unconsciously is always a part of the transferential space and countertransference reactions are indicators of this necessary involvement. Lastly, despite the divergence in the theories and understandings of the countertransference reactions, all of them are of the same opinion about the necessity of working with these reactions for a successful and effective analytical work (Schwaber, 1992).

1.3.2. The Frequency of and General Indifference to Countertransference Dreams

Despite the importance that has been attached to countertransference reactions, the lack of extensive literature about the countertransference dreams that was mentioned in the first section raises questions about the actual frequency of occurrence of such dreams as well as the reasons for the unwillingness of speaking and writing about this topic. Thus, in this section, the studies about the extent of therapists' experiencing these dreams and thoughts about possible reasons for less than expected literature about this topic will be presented.

Spangler et al. (2009) interviewed 8 therapists about their dreams that their patients appear, and they reported in general that typically these dreams were first seen early in their practice, but at the same time manifestation of these dreams is typically infrequent. Nevertheless, Lester et al.'s (1989) survey of 95 analysts and candidates show that these dreams are not infrequent as thought because 78% of the participants reported experiencing countertransference dreams. In the study of Hill et al. (2014) with 13 therapists who had written their dreams in journals for one year, nine of them (69%) saw their patients in their dreams at least once, and the ratios of such dreams to the total count of reported dreams were between 0 and .19.

Whitman et al. (1969) examined Freud's dreams that he wrote in "The Interpretation of Dreams" (Freud 1900/1955) and concluded that three of 50 dreams of Freud contained his patients in their manifest content, and patients could be

associated in the latent content of 17 dreams. Based on these numbers and their own as well as colleagues' observations, they declared a rough statistic as in the 6% of therapists' dreams patients can be identified in the manifest content and the 34% of their dreams in the latent content. Thus, their claim was that occurrence of this kind of dream is substantially more than enounced (Whitman et al., 1969).

As mentioned earlier, the countertransference dreams get considerably little attention and the reasons for this disinclination deserve to be emphasized. According to Zwiebel (1985), there are three primary reasons for this indifference to countertransference dreams as general lack of interest in dream work in the therapy, therapist's unwillingness to discuss their own dreams about patients due to evaluating them as disturbances in themselves, and the difficulty of distinguishing manifest and latent content of the dreams. In this regard, Lester et al. (1989) emphasized the disregard of studying the dreams taking their manifest content as a basis.

Furthermore, therapists' reluctance to reveal their countertransference dreams can be understood from their unwillingness to disclose themselves to both patients and colleagues because presenting a dream means their presenting their own inner worlds, fantasies, infantile wishes, and weaknesses as well (Heenen-Wolff, 2005; Pollack-Gomolin, 2002). In addition, as possible reasons for the repression of these dreams, traditional beliefs such as these dreams' being typically signs of flaws in the therapeutic process (Spangler et al., 2009; Watson, 1994) and/or poorly analyzed therapist (Rachmani, 2018; Watson, 1994) who bears neurotic countertransference (Abramovitch & Lange, 1994) are suggested. The thought that can be derived from these traditional assertions that healthy, well-analyzed therapists do not have countertransference dreams, and such dreams cannot have a therapeutic role (Abramovitch & Lange, 1994). Hence, Whitman et al. (1969) mentioned the hesitation of therapists in sharing these dreams by saying that there was a clear elimination process of the reported dreams by therapists, regarding recalling and willingness to share the particular dream with others.

1.3.3. First Countertransference Dream: Freud's Irma Dream

Despite the lack of interest in countertransference dreams, the first dream which was analyzed in depth by Freud, namely the renowned "Irma's injection," was actually the very first countertransference dream that was reported (Heenen-Wolff, 2005; Lester et al., 1989; Rachmani, 2018; Whitman et al., 1969). Briefly, the dream is about one of Freud's ex-patients who, as Freud found out, was not fully cured and experienced continuing discomfort after her analysis. Despite the abundant associations of Freud in his self-analysis, the main point is that he evaluates this dream as an infantile wish-fulfillment of not being responsible for the continuity of his patient's disturbance and getting revenge from Otto who informs Freud about the condition of his ex-patient because in the dream the illness of Irma was due to Otto's giving an unclean injection to her (Anzieu, 1986; Heenen-Wolff, 2005; Zwiebel, 1985).

Later the interpretation of this dream as a wish-fulfillment by Freud, Anzieu (1986) shed light on the countertransference aspect of this dream. Freud's countertransference reactions towards his hysterical patients can be seen as symbolized with Irma in the dream, and the fulfilled desire was actually not acting towards and tempted by their transferred unconscious incestuous desire via not giving Irma a fantasied injection in the dream (Anzieu, 1986). Furthermore, it can be suggested that the manifest content of the dream discloses the anxiety of Freud about his competency and performance as an analyst (Abramovitch & Lange, 1994; Zweibel, 1985). At the same time, Watson (1994) underlines Freud's intention to gain more understanding about his patient as well as his relationship with his patient via analysis of this dream.

1.3.4. Causes of Occurrence of Countertransference Dreams

The factors that influence the occurrence of such dreams are articulated and studied from different perspectives. Heenen-Wolff (2005) claims that dreaming a patient signifies an elevated preoccupation about the patient in the analyst's mind,

and this preoccupation leads the analyst to psychically think him in the dreams as well. She continues by saying that the preoccupation of the patient in the dream is significantly more than ordinary, and it conveys information that was unspotted in the waking life. The different reasons for this increased preoccupation might be the patient's exciting the analyst or more probably making therapists anxious like instances that the therapy reaches an impasse and/or the point of breaking up (Heenen-Wolff, 2005).

From a more conservative stance, Cohen (1952) defines the countertransference with therapists bearing anxiety or defensive operations against this anxiety either consciously or unconsciously. Considering Gitelson's (1952) thoughts, she sees the appearance of patients in the dreams of therapists as one of the signs of therapists' anxious or defensive relationship with the patients. She categorizes the possible reasons for the anxiety of therapists as situational factors including therapists' competency concerns, neurotic conflicts of the therapists, and patients' conveying their own anxiety to the therapist. In the situational factors, she also mentions the possible causes which can sabotage the therapeutic role such as therapists' helplessness in helping the patients; patients' regarding the therapists as a target of fright, hate, belittling, or criticism; attributing therapists to the role of a magic healer; patients' trying to develop a romantic or another form of intimate relationship with the therapists. Also, in taking the patients' anxiety, she touches on the fact that some people' being more prone to be alert and absorb the tensions of the other, and also certain patients like psychotics conveying more anxiety and fear to the therapist (Cohen, 1952).

Furthermore, Spangler et al. (2009) found in their interviews with eight therapists that the dreams contained patients who were compelling for them, and they occurred when therapists had difficulty with making clinical decisions about the patient, intense countertransference, or feelings of excessive bonding with the patient. Some therapists in the study of Spangler (2007) linked the occurrence of these dreams to some extent to the destructive overidentification or too much empathic attunement which mostly young therapists may experience. Also, some therapists claimed that these dreams manifested themselves when high work stress

was reported (Spangler et al., 2009). As a similar result, Robertson and Yack (1993) and most therapists in the research of Hill et al. (2014) stated that such dreams occurred at conflictual times when they experienced struggles with the patient.

Zwiebel (1985) asserts that in addition to countertransference dreams indicating difficulty and trouble in the therapeutic relationship, most of them are signifiers of analyst's anxiety about or denial of the loss of analytic competency when they bear traumatic features because of their coinciding with analysts' own conflicts. Zwiebel (1985) and Lester et al. (1989) explain this competency as an analyst's skills of dealing with the tension, emotions, and conflicts in the analytical relationship and patient's transference reactions by noticing, understanding, enduring, and interpreting these reactions. This competence also requires analysts' willingness to acknowledge and work on their own countertransference reactions and conflicts with self-analysis to be able to utilize them in the analytic work (Zwiebel, 1985).

Anxiety about the loss of this analytic competency shows itself when analyst's and patient's resistances to recognize these reactions and eventually the resolution of these reactions are left unworked in the analytical setting (Lester et al., 1989). From this point of view, Zwiebel (1985) suggests that these dreams can be seen mostly when working with patients who suffer from early traumas or intense personality disorders with mainly using projective identification mechanism for communication and also when intense, conflictual countertransference reactions are present. Thus, inexperienced therapists may be more inclined to have countertransference dreams due to having more fears and actual losses of competence as well as insufficient self-analysis. Lastly, he adds that if these dreams are analyzed properly, they reconstruct and even increase the once lost competence (Zwiebel, 1985).

As a case example for the assertions of Zwiebel (1985), the vignette of Angel (1979) can be given in which he mentions his dream about a contemptuous, criticizing woman patient who makes him self-doubting about his competence and anxious as well as fearful about the risk of losing his trust to himself completely. Also, Abramovitch and Lange (1994) mention an initial dream of a therapist about

a patient and link the dream to some extent to the performance and competence-related anxiety provoking nature of the first encounters with a new patient.

As empirical support to the claims of Zwiebel (1985), Lester et al. (1989) found in their survey of 95 candidates and analysts that the majority of the reported countertransference dreams occurred when patients depicted their intense erotic or aggressive transference reactions which can be classified as "instinctualized transferences" in the sessions. In addition, it is found that candidates and analysts had these dreams also in the instances which they felt that they could not understand the patient, patient began to improve with the analyses, or with a smaller percent, the analyst was planning to offer something new. Furthermore, analysts who claimed not understanding the patient were mostly reported erotic or aggressive transference as well. Thus, these transferences can be evaluated as leading resistances in the analyst's countertransference and consequently have the potential to impend the analytical competence of the analyst (Lester et al., 1989). Nevertheless, contrary to Zwiebel's (1985) thought of the tendency of inexperienced therapists having more countertransference dreams, Lester et al. (1989) did not find any difference in these dreams' frequency among different experience levels.

Lastly, Bernstein and Katz (1987) reported a rare experience of both the therapist's and supervisor's dreaming about a particular patient. They speculated about the reasons for this shared incident as the patient's overflowing unconscious and the anxiety of the therapist in response to this intense material as well as anxiety of the supervisor in assisting the therapist to become eased. Also, they mentioned the possible impact of the fine calibration and interplay of the unconscious of the patient, the therapist, and the supervisor.

1.3.5. Interpretation of Countertransference Dreams

There are different approaches about how to interpret the therapist's dreams which patients appear in them. Kron (1991) suggests that if the dream interpretation is made from the domain of countertransference, it limits it to the therapist's

intrapsychic process leading to the therapist's alienation from the patient in the interpretation. In contrast, interpretations from a perspective of object relations as seeing these dreams as projective identification rule out the analyst and evaluate the dreams as projections of the patient's unconscious dynamics. Thus, in these two approaches dreams are either the sole projection of the patient or the analyst (Kron, 1991). Even so, Kron (1991) suggests that these dreams can be utilized by the analyst to open a channel for communication between the analyst and the patient if analysts are willing to reach and communicate with their unconscious. To be able to work on them effectively, Heenen-Wolff (2005) suggests the analysis of the dream to be able to differentiate the elements belonging to the analysts themselves as wish fulfillment and the parts that originate from the patients. While analyzing the dreams of their own, analysts can use their associations in differentiating these elements, but this of course is only approximate (Heenen-Wolff, 2005).

On the other hand, from an interpersonal perspective, Kron and Avny (2003) argue that the common presence of the patient and the therapist together in a social interaction in dreams indicates the interpersonal aspect of seeing patients in dreams beyond therapists' own intrapsychic representations. Watson (1994) asserts that the interpersonal approach to such dreams prioritizes the interaction and interpersonal affective reality between the therapist and the patient in the dream and how these interactions mirror some attributes of the real relationship of the therapeutic process. Thus, the focus and aim of the interpretation of these dreams remain on uncovering the real status of the therapeutic process and possible conflicts which can arise rather than the traditional point of view of enhancing the understanding about the dynamics of the patient. Also, in this perspective disclosure of the dream can be considered to resolve an impasse if there is a strong therapeutic alliance in a long-run therapy (Watson, 1994).

In addition, Kron and Avny (2003) stated that they were expecting masochistic themes which infer undesirable and distressing plots in these dreams because therapists deal with both patients' and their own hardships, emotionally charged conflicts to be able to process them in the therapeutic setting. They also claimed that these dreams can be utilized to resolve these issues. They evaluated

these dreams from the perspective of Jung and argued that they are the signs of the view that analysts are also in the analysis just like the patients throughout the analytic work. From the Jungian perspective, unconscious interplays in the therapeutic setting, as well as therapists' being influenced by the patient, bear important therapeutic potentials that should not be missed to notice. Thus, the dreams of the analysts should be a part of the analytical work like patient dreams and an element of communication with the patient (Kron & Avny, 2003).

Similarly, Lester et al. (1989) assert that the existence of countertransference dreams demonstrates the emotionally charged oscillation between the therapists' and patients' transferences on different levels of both conscious and unconscious. From a relational and intersubjective point of view, Wilner (1996) evaluates the resonance between the patient and the therapist as a function of the shared psychological arena that is constructed from the personal and congruent domains of psychologies of both parties in the therapy. He considers the patient dream of the therapist as a way of primarily unconscious communication of the patient to transmit information about himself which the therapist does not aware clearly on a conscious level (Wilner, 1996). From a similar point of view, Ferguson (2020) evaluates her countertransference dreams as a creative and unique product of the joint therapeutic region that is originated from the interpenetration of the subjectivities of both participants.

Sánchez-Medina (2018) underlines the intersubjective nature of dreams and the "analytical third" concept of Ogden (1994) about this phenomenon. He explains the mechanism of this oneiric communication with the "projective identification and counter-identification" terms as the unconscious transmission of the mental content from one to the other partner, and the process of the other making them conscious via dreaming about them (Sánchez-Medina, 2018, p.385). Wilner (1996) suggests actively engaging with dreams in the therapy room with the patient, emphasizing the mutuality and wholeness of the process and claims that therapists may share their dreams with the patients to combine the unconscious and conscious work. Furthermore, Ferguson (2020) touches upon the benefit of disclosure of these dreams after a self-reflection process in some cases and asserts that this sharing can

be a part of mutuality and intersubjectivity of the shared psychological sphere of the therapeutic process.

From a similar point of view, Brown (2007) claims that the therapist's dreaming about the patient may be a way of unconscious communication and knowing of the patient through mechanisms of projective identification for the analyst's containing and modifying unreachable and uninterpretable mental content of the patient. Heenen-Wolff (2005) presents one of her countertransference dreams and following Bion's concepts she stresses the healing function of this kind of dream as therapists' dreaming their patients' unreachable affect and transforming them to secondary thoughts via giving them meaning in the analytical context of countertransference and transference. It is also suggested that in this way analyst has an opportunity to unconsciously know the patient which is what Bion called transformation in O (Brown, 2007) via analyst's becoming patient's unbearable parts and discovering the symbolic representations of contents which the patient cannot mentalize within himself (Bion, 1965, as cited in Brown, 2007). In this way, borrowing Ogden's concept, Brown (2007) and Ferguson (2020) stress the role of countertransference dreams as "dreaming the patient into existence" (Ogden, 2005) via patients' emotionally becoming alive in the minds' of therapists.

In addition, it can be speculated that the intersubjective arena that is created in the analytical context may not be confined with the physical limits of the classical frame and the countertransference dreams can be specific examples of this continuing process (Rachmani, 2018). As an illustration, Rachmani (2018) presents three of her dreams that she saw her severely traumatized ex-patient months after the patient's abrupt cessation of the therapeutic process with leaving the therapist with feelings of insufficiency, shame, resentment, and helplessness. Also, Pollack-Gomolin (2002) defines countertransference dreams as an unconscious extra-analytic communication that bears significant clinical data.

Rachmani's (2018) dreams were evaluated taking Ogden's (2005) concepts into consideration as analytic third's dreaming the previously "undreamt dreams" via analyst' containing her patient's projections of "beta elements" and carrying out Bion's "alpha function" (Ferguson, 2020; Rachmani, 2018; Sedlak, 1997). Sedlak

(1997) describes this process as analysts' taking beta elements and think through, analyze them, in this scenario the dreams, if they have enough capacity to negotiate within themselves what belongs to them and what to the patients and tolerate staying in the uncertainty with the feelings of discomfort. He warns that therapists' response to the projected beta elements can also be unconsciously disposing of them just like the patients without practicing this psychoanalytic process. Also, departing from the evaluation of his two cases he asserts that patients with early objects who have low empathy and mentalization skills are more prone to need to use their therapists as containers of these beta elements (Sedlak, 1997). From a similar point of view, Pollack-Gomolin (2002) evaluates these dreams as a dimension of the adjustment of therapists' psyches in response to preverbal patients instead of seeing them as a sign of disturbance.

As a final point to mention, Favero and Ross (2002) departing from the complementary countertransference term which means "therapists' identification with the patient's infantile object relations" coins the term "complementary dreams" (p. 212). They evaluate these dreams as a product of subconscious communication of the therapeutic pair and as a means of sublimation of countertransference reactions. Through these dreams' interpretation, therapists can gain awareness about and experientially comprehend personal dynamics, conflicts, and covered risks of therapeutic failures and with this way prevent disruptive countertransference enactments. With this understanding, they do not relate the occurrence of these dreams with the amount of transference but with the complementary identification process. Also, interpreting these dreams always regarding the relationship is suggested (Favero & Ross, 2002).

Taking these more contemporary understandings into consideration, Brown (2007) criticizes evaluating these dreams still as problematic and a signal for analysts to return to their own psychoanalysis and reminds the recent shift in paradigm that is the understanding of the countertransference as a necessary and valuable aspect of the psychotherapy.

1.3.6. Themes and Characteristics of Countertransference Dreams

After the review of the theories about the possible causes and interpretations of this kind of dream, the question of whether these dreams bear specific themes or characteristics in addition to the presence of the patients can be raised. As expected from the causes of the countertransference dreams, Kron and Avny (2003) found in their research with 22 therapist dreams that more than half of the reported dreams had masochistic themes such as loss, abandonment, being attacked, negative self-representations in their manifest content. They designated nine common themes as "therapist-patient role reversal, attending/remaining, cancellation of therapy session, sexuality between patient and therapist, physical and/or verbal aggression, presence versus absence, non-verbal relationship and communication, time, driving versus stopping" (pp. 323-324). Spangler (2007) and Spangler et al. (2009) had also suggested that countertransference dreams in their research had mostly negative interpersonal interactions containing oddity, aggression, or breaches in boundaries. Also, in another qualitative research, four main contents of countertransference dreams were classified as patients being helpless, aberrant therapy setting, patients being aggressive or attacking, and lastly therapists' worries about ethical violations (Hill et al., 2014).

In the research of Lester et al. (1989), there was a striking gender difference among analysts in terms of the contents of the countertransference dreams. Out of 41 dreams reported, 21 of them were categorized as sexual and 19 of them were reported by male analysts. Among these 19 dreams which have erotic/sexual content, 15 of them were identified with the patient's dense erotic transference. In addition, all the dreams that were classified as competitive or sadistic belonged to the males whereas those which contain intrusive content or struggles with non-sexual closeness belonged to the females (Lester et al., 1989).

In addition to what is mentioned above, reported countertransference dreams in the study of Spangler et al. (2009) were typically recently seen (less than one year), quite salient, and had a setting that was different than the therapy.

Regarding the presence of characters in this kind of dream, Spangler (2007) found that typically patients were manifestly seen as themselves in the dreams, and dreams contained interpersonal themes. Also, Kron and Avny (2003) identified in their study that in 31 dreams reported, therapists themselves and patients were present, and there were personal interactions in each of them. Furthermore, the most common settings were the therapy room with 11 dreams and the road or home with seven dreams each (Kron & Avny, 2003). Lastly, in the study of Hill et al. (2014) with a total of 19 dreams reported, six of them coincided with the beginning and 12 of them with the middle of the therapy processes.

1.3.7. Emotions in Countertransference Dreams

In line with the reported negative themes of these dreams, therapists who see their patients in the dream reported negative feelings both about having such a dream and in dreams in most cases. In the research of Hill et al. (2014), there were three categories of negative feelings in dreams as fear, guilt or shame, and feeling that there is something unpleasant about the patient. Also, some therapists in the research reported surprise because of the dream (Hill et al., 2014). In the study of Lester et al. (1989), 20% of the analysts felt guilt or shame about the dream. In the qualitative investigation of Spangler (2007) the typical theme was therapists' having a combination of both negative and positive emotions for instance one therapist's experiencing relief, pleasantness, fear, and hope in the same dream.

Furthermore, Kron and Avny (2003) found in their research that most of the therapists shared similar negative emotions about the countertransference dreams and were depicted as being vulnerable in the dreams. Among these negative feelings, there were threat, fear, worry, and confusion mostly due to aggressive behaviors of patients and therapists' sense that their personal space was overrun by the patient. Also, therapists experienced themselves in the dreams as deceived, abandoned, and deserted by the patient. In contrast, patients were depicted as more competent in the dreams despite bearing negative affect as well (Kron & Avny, 2003).

Brown (2007) mentions several unsettling feelings which therapists can experience due to having such a dream. These feelings may be related to boundary violations which can be thought of as therapists' bringing the patient into their exclusive dream life or patients' intruding the therapists' private sphere, depending on the waking experience of the therapists. In both situations, the therapist is mostly left with an odd feeling because even though there was an intimate interplay with the patient, only the therapist has the knowledge about this experience and insights gained about the patient. He also refers to the unwillingness of therapists in sharing these dreams with colleagues due to bearing shame or/and guilt of having this kind of dream (Brown, 2007).

1.3.8. Ways of Utilization and Gains of Countertransference Dreams

Subsequent to the literature reported above about the causes, interpretations, characteristics of countertransference dreams, it is necessary to refer to the importance of these dreams considering their gains and also to the ways and methods of processing and utilizing these dreams in the clinical settings.

It is found that therapists use different means to explore these dreams such as keeping dream journals, taking part in dream groups, self-reflection, discussing the dreams with colleagues, disclosing them to patients (Spangler et al., 2009), or sharing these dreams with their own therapists (Degani, 2001). After the exploration and gaining understanding with the dream, therapists in the study of Spangler et al. (2009) generally utilized these dreams in their therapeutic work. Some of them preferred to disclose these dreams to patients to construct therapeutic alliance, talk about the state of the therapeutic relationship, or discuss the meaning of the dream but disclosure of these dreams was rare in general. Others chose to withhold the dreams and utilized them for professional progress, self-exploration, deciding to make changes in their personal lives, and personal care (Spangler et al., 2009).

In that regard, Kron and Avny (2003) claimed that the masochistic themes in these dreams may show therapists' being "wounded healers" and they can use this understanding to increase their self-understanding as well as avoid intertwining

of their issues and patients' (p. 333). For instance, Spero (1984) mentioned one of his countertransference dreams that enabled him to notice the overflow of his countertransference feelings between his patient and his son and process this conflict via the self-analysis of the dream.

In addition to what is mentioned above, countertransference dreams have a potential to reveal new insights or increase the awareness of psychotherapists about their clinical understanding of the patient's condition and their countertransference responses or identifications with the patients (Myers, 1987; Spangler et al., 2009). 75% of the analysts in the survey of Lester et al. (1989) reported increased insight after the dream. Hill et al. (2014) also found in their research that working on these dreams provided therapists insights about themselves, their feelings and attitudes towards clients, patients' diagnosis, and/or therapeutic process. In line with these findings, Bernstein and Katz (1987) recommended therapists and supervisors to discuss their countertransference dreams to gain new insights about the therapy. Robertson and Yack (1993) presented support to this recommendation by showing the two benefits of dealing with the dream in supervision for the therapists: resolving an impasse in the therapeutic relationship and progressing their abilities in countertransference management.

These gains of the utilization of such dreams indicate that these dreams are not solely signs of adversities about the therapeutic process or anxieties of therapists, but also important tools that can be used in order to attract attention to significant matters about the therapy, patient, or therapist, provide solutions about them, support therapists' clinical decisions, or encourage therapists for self-care and self-development (Spangler et al., 2009). From a similar token, Zwiebel (1985) stresses the healing function of these dreams as their guiding therapists for identifying troubles in the therapeutic relationship. Also, Degani (2001) mentions one of the functions of these dreams in her qualitative investigation as therapists' evacuating distressing emotions.

Rudge (1998) writes about one of her countertransference dreams that warn her about the seriousness of her patient's condition, and she stresses these dreams' role of alerting therapists about the need for symbolic elaboration while at the same

time of their being a part of this symbolic process as well. As previously mentioned in earlier chapters, Sedlak (1997) stresses the role of these dreams in carrying out the alpha function. He asserts that rather than the gained insights alone, the process of reaching them is more important because this process actually gives them valuable meaning and steers the change. Thus, this use of projective identification is considered healthy since patients throw these undreamable elements with the hope of their being contained and metabolized by the therapist via unconsciously regarding the capabilities of the therapist as well as the need for this process to be experienced for developing their own capacities to dream (Sedlak, 1997). Furthermore, Civitarese (2006) and Ferguson (2020) underline the role of these dreams in providing a stage for the patients' unsymbolized wounds, conflicts, experiences, and their significant influence on the therapists to be transformed into the stories and representations.

To illustrate what is mentioned above, Seward's (2018) case vignette may be given. She dreams about one of her patients who was highly dissociative with having multiple selves, changing several times even in a single session. The altering and darker self-states of the patient were unreachable in the therapy because of the patient's unwillingness. In the dream of Seward, she and the patient tour a house with various rooms containing pleasing and darker, frightful rooms. Sometime later from the occurrence of this dream, the therapist shares the dream with the patient, and the patient who thought that no one can understand her deep agony stuns with the therapist's acknowledgment of and survival from her misery and horror. After a while in the therapy, the patient's darker, terrifying self-states begin to appear in the sessions. She considers such dreams as a part of therapists' nonverbal experiences with the patient and as a means that can be utilized to deepen and enrich the therapeutic process and relationship (Seward, 2018).

In conclusion, even though these dreams can be evaluated as indications of resistances in the countertransference reactions of the therapist, regarding the many insights derived from the dreams they include critical tools to uncover and deal with these resistances and impasses as well (Lester et al., 1989; Rachmani, 2018; Robertson & Yack, 1993). Also, rather than their signaling incapability of the

therapists they indeed may show the capabilities of the therapists in opening their psyches to be affected by their patients as well as for containing, symbolizing, and metabolizing the "undreamable" parts of their patients and the shared intersubjective third (Brown, 2007; Civitarese, 2006; Ferguson, 2020; Heenen-Wolff, 2005; Pollack-Gomolin, 2002; Rachmani; 2018; Rudge, 1998; Sedlak, 1997).

1.4. PRESENT STUDY

Even though there are several case studies (e.g., Abramovitch & Lange, 1994; Angel, 1979; Brown, 2007; Ferguson, 2020; Heenen-Wolff, 2005; Myers, 1987; Pollack-Gomolin, 2002; Rachmani, 2018; Robertson & Yack, 1993; Rudge, 1998; Sedlak, 1997; Seward, 2018; Spero, 1984), qualitative investigations (Degani, 2001; Kron & Avny, 2003; Spangler, 2007; Spangler et al., 2009) and few quantitative studies (Hill et al., 2014; Karcher, 1999, Lester et al., 1989) about this topic, research on psychotherapists dreams and how they process them is scarce. These studies' sample sizes are very small and/or consist of mostly inexperienced trainee analysts. Thus, unlike existing literature, this study aims to explore dreaming experiences of psychotherapists mainly focusing on countertransference dreams using a quantitative methodology with a larger sample size including psychotherapists from different theoretical orientations and experience levels.

Present research consists of two successive parts. The first part of the study aims to identify factors that are associated with and uniquely predict psychotherapists' countertransference dreaming as well as clinical dream processing frequencies. The factors that will be examined are psychotherapists' experienced difficulties in psychotherapies, attitudes towards dreams, certain demographic and professional characteristics such as gender, age, theoretical orientation, professional experience, and personal psychotherapy experiences. Psychotherapists' experienced difficulties variable was chosen to be examined regarding the previous literature that links countertransference dreams with difficulties in therapeutic processes (e.g., Hill et al., 2014; Spangler et al., 2009;

Zwiebel, 1985). Also, only one quantitative study (Hill et al., 2014) examined the possible association between attitudes towards dreams and countertransference dreaming frequency. Thus, this variable was chosen to be further examined and controlled in the present study. Based on the literature, countertransference dream frequency is expected to correlate positively with psychotherapists' level of experienced difficulties in psychotherapies. Nevertheless, due to limited empirical research in this area, no hypothesis was specified for this study.

In the second part of the study, participants will be asked to answer the questions considering a specific dream in which one of their clients is present. In this way, this part of the study aims to deeply explore feelings and interactions in countertransference dreams, how psychotherapists give meaning, process, and use these dreams. Also, the characteristics of the dreamt about client as well as the associations between therapist's bonding with and countertransference reactions towards the client who is dreamt about and feelings, interactions in these dreams will be explored. Based on the existing literature, interactions and feelings in these dreams are expected to be negatively toned. Nevertheless, again, there is no hypothesis specified due to scarce previous empirical literature on this topic.

CHAPTER 2
METHOD

2.1. PARTICIPANTS

A total number of 115 psychotherapists who work in Turkey completed the survey. Among these 115 participants, one participant was discarded from the data due to conflicting information, and one participant was removed from the data because of not having any psychotherapy practice experience. Hence, the final sample of the first part of the study consisted of 113 psychotherapists. Of these 113 participants, 55 of them continued to the second part of the study which includes specific questions and scales about one of their countertransference dreams. Some of the demographic characteristics and professional background information of the participants are presented in Table. 2.1.

Of 113 psychotherapists, 95 (84.1%) defined their gender as female, 15 (13.3%) as male, and 3 (2.7%) participants did not prefer to disclose their gender. The age of the participants ranges between 24 and 49 (M = 29.65, SD = 4.87). Regarding their educational level, 5 (4.4%) participants were BA graduates, 48 (42.5%) were graduate students, 54 (47.8%) of them were MA graduates, and 6 (5.3%) participants were PhD students or graduates.

According to the reported professional titles, the majority of the participants (N = 102; 90.3%) defined themselves as Psychologist and/or Psychotherapist whereas 5 (4.4%) participants were Psychological Counselors and 6 (5.3%) participants stated to have additional titles as Psychoanalyst and Psychological Counselor in addition to Psychologist or/and Psychotherapist. In terms of the population that they worked with, 64 (56.6%) of the participants claimed to work with solely adult clients, 17 (15%) of them with children and/or adolescents, 13 (11.5%) with adults and adolescents, and remaining 19 (16.8%) with a mixed population including adults, children, adolescents, couples, and families.

Table 2.1 *Demographic Characteristics and Professional Background of Participants*

			N	%
Gender	Female		95	84.1
	Male		15	13.3
	Other or not Specified		3	2.7
Education	BA Graduate		5	4.4
Level	MA Student		48	42.5
	MA Graduate		54	47.8
	PhD Student or Graduate		6	5.3
Therapy	Adults		64	56.6
Population	Children or/and Adolescents		17	15
	Adults and Adolescents		13	11.5
	Mixed		19	16.8
Theoretical	Single	Psychoanalytic/Psychodynamic	64	56.6
Orientation		Cognitive-Behavioral	13	11.5
		Other (Systemic, Humanistic, Schema etc.)	6	5.3
	Multiple	Psychodynamic/Psychoanalytic + Other	21	18.6
		Other Combinations	9	8
Self-	Currently going		79	69.9
Therapy	Naturally terminated		10	8.8
Status	Prematurely terminated		15	13.3
	Never gone		9	8

Regarding the theoretical orientation of the participating psychotherapists, 64 (56.6%) of them solely adhered to Psychoanalytic/Psychodynamic orientation, 13 (11.5%) to Cognitive-Behavioral approach, 6 (5.3%) to other theoretical approaches such as Systemic, Humanistic, Existential, and Schema Therapy. The remaining 21 (18.6%) participants were reported to have multiple orientations besides the Psychoanalytic/ Psychodynamic Approach, and 9 (8%) identified themselves to embrace multiple orientations other than

Psychoanalytic/Psychodynamic such as Humanistic, Cognitive-Behavioral, Systemic, EMDR.

Participants' years of professional experience had a broad range between 2 months and 20 years, with a mean of 42.10 and a standard deviation of 45.17 months. When they were asked to rate their experience levels themselves on a 5-point Likert scale, the ratings were ranged from 1 to 5, with a mean of 2.73 (*SD* = .92). The number of active patients of psychotherapists was between 0 and 55 *(M* = 9.12, *SD* = 8.27), and their weekly working hours were ranged from 0 to 50 (*M* = 10.54, *SD* = 8.98). Furthermore, the self-rated workload of the participants on a 5-point Likert scale, ranging from 1 to 5 had a mean of 2.99 (*SD* = 1.11).

When participants' personal psychotherapy experiences were taken into consideration, 79 (69.9%) participants claimed that they were currently continuing their psychotherapy processes, 15 (13.3%) of the participants prematurely terminated, 10 (8.8%) participants reported that they naturally terminated their self-therapy processes, and 9 (8%) participants did not receive any psychotherapy. Of 104 participants who had a personal therapy experience, 77 (68.1%) of them reported that their own psychotherapists adhered to purely Psychodynamic/ Psychoanalytic orientation, 12 (10.6%) participants to multiple approaches including Psychodynamic/Psychoanalytic, and 15 (13.3%) participants to other approaches such as Cognitive-Behavioral, Humanistic, Systemic. The years spent in personal therapies ranged between 0 to 13 years, with a mean of 37.52 months (*SD* = 33.33).

To sum up, the participants in this study were mostly female Psychologists and/or Psychotherapists from various theoretical approaches with an inclination to the Psychoanalytic/Psychodynamic approach. Even though participants' ages were diverse they were mostly young and had an average of 3.5 years of professional experience. Also, the majority of the sample had gone or were currently going to their own psychotherapies with an average duration of 3 years.

2.2. INSTRUMENTS

The instruments which were used in the first step of the study were Demographic Information and Professional Background Form, Therapists' Experienced Difficulties Questionnaire, Attitudes Towards Dreams Scale, and Dream Recall and Processing Frequency Scale.

For the second step, participants were asked to focus on a countertransference dream they had and expected to answer questions about the dream and the client of reference, and further to fill-out the Affective Bonding subscale of the Working Alliance Inventory Therapist Form (WAI-TF), and Countertransference Questionnaire Short Form regarding the client of reference.

2.2.1. Demographic Information and Professional Background Form

Demographic Information and Professional Background Form (see Appendix A) contains 15 questions about the professional title, education level, gender, age, years and level of professional experience, current professional workload, theoretical orientation, client population, and personal psychotherapy experiences. Depending on the characteristics of the questions some of them are multiple-choice and others are open-ended. Also, participants were asked to rate their current workload and professional experience levels on a 5-point Likert scale (1: *very little* to 5: *very much*). This form was adapted from the study of Samsa (2017) in which the adaptation of Orlinsky and Rønnestad's (2005) Development of Psychotherapists Common Core Questionnaire (DPCCQ) by Bilican and Soygüt (2015) was used.

2.2.2. Therapists' Experienced Difficulties Questionnaire

Therapists' Experienced Difficulties Questionnaire (see Appendix B) aims to explore psychotherapists' difficulties that they experience while conducting psychotherapy, including three factors as having "professional self-doubt,

frustrating treatments, and negative reactions" to the patients. The Cronbach's alpha scores of factors are .77, .67, and .74, respectively. This scale contains 18 items with 5-point Likert scale ratings (1: *never* to 5: *very frequently*).

It is a subscale of Development of Psychotherapists Common Core Questionnaire (DPCCQ) which was developed by Orlinsky and Rønnestad (2005). Guneri-Minton (2006) used this scale first in Turkish. Then, the Turkish adaptation was revised by Bilican and Soygüt (2015). Reliability scores were not reported in these studies. However, Samsa (2017) reported the Cronbach alpha for the Turkish adaptation of the scale as .92 in her MA thesis. In addition, in the current study, the Cronbach alpha was found as .87, indicating good reliability.

2.2.3. Attitudes Towards Dreams Scale

Attitudes Towards Dreams Scale (see Appendix C) was developed by Schredl et al. (2019b) to measure positive and negative attitudes towards dreams separately. It is suggested in their study that these two facets of the construct correlated differently with other variables such as age and dream recall. Thus, they added 16 items to the former Attitudes Towards Dream Scale in the Mannheim Dream Questionnaire (MADRE; Schredl et al., 2014). The final scale consists of a total of 22 items with 15 of them measuring positive attitudes and 7 of them assessing negative attitudes. The Cronbach's alpha scores of these subscales were found to be .94 and .90, respectively. All items are rated with a 5-point Likert scale depending on how much the raters agree with the items (0: *not at all*, 1: *not that much*, 2: *partly*, 3: *somewhat*, and 4: *totally*).

Turkish adaptation of the scale was conducted for the current study. The items were translated into Turkish by the researcher and back translated by an independent translator. Translations were reviewed by the researcher and the advisor of the study. The Cronbach alpha scores of the Turkish adaptation of the subscale in this study were calculated as .92 for Positive Attitudes Subscale and .80 for Negative Attitudes Subscale, indicating excellent and good reliabilities, respectively.

2.2.4. Dream Recall and Processing Frequency Scale (DRPFS)

Dream Recall and Processing Frequency Scale (see Appendix D) was developed by the current study's researchers in order to gather information about two main subjects. One of them was the psychotherapists' dream recall frequencies which contain information about their general dreaming and/or recall frequencies, dreaming frequencies with different interactional contents, and how much clients and psychotherapy sessions' effects appear in their dreams. The frequency of countertransference dreaming was aimed to be measured with four questions about the frequencies of dreaming including clients as themselves, images that represent clients, and the degree of positive as well as negative effects of psychotherapy sessions on psychotherapists' dreaming. The other subject was psychotherapists' frequency of processing dreams of their own as well as their clients in different contexts such as the therapy sessions which they conduct, supervisions, and their own personal therapies.

The scale consists of a total of 17 items. 10 of them aim to measure dream recall frequency, and 7 of them aim to assess dream processing frequency. The items of the scale were developed regarding several retrospective dream questionnaires (Bernstein & Roberts, 1995; Schredl, 2004; Schredl et al., 2014), literature about countertransference dreams (e.g., Lester et al., 1989; Spero, 1984; Zwiebel, 1985), and the observations of the researchers. Participants were asked to evaluate their experiences for each item on a 7-point Likert scale (0: *never* to 6: *very frequently*). Since this was a newly developed scale for the purposes of this study, component and reliability analyses were conducted in the current study, and the details of the analyses were reported in the Results section.

Shortly, three components were identified via Principal Component Analysis as clinical dream processing, general dream recall and processing, and countertransference dreaming. The Cronbach's Alpha scores of the components were .86, .76, and .77, respectively, indicating acceptable and good reliabilities. Four items about the general dreaming frequencies regarding various thematic contents were excluded statistically due to their low factor loadings and

semantically due to the disruption to the theoretical soundness of the components. Thus, the final scale consisted of 13 items. The Cronbach's alpha score for the total scale was calculated as .82, indicating a good internal consistency.

2.2.5. Questions about Specific Dream Characteristics and Processing

The researcher developed several questions (see Appendix E) which were derived from the literature about countertransference dreams (e.g., Hill et al., 2014; Kron & Avny, 2003; Lester et al., 1989; Spangler et al., 2009) and various measures of dreaming (Bernstein & Belicki, 1996; Bernstein & Roberts, 1995; Domhoff, 1996; Schredl, 2004) to explore the contents, characteristics, feelings, and processing of the specific dream including one of the clients of the participants.

Following the instruction to focus on a specific countertransference dream, participants were asked to specify the recency and vividness of the dream; the period of the therapy which this dream coincided with; characters, locations, and interpersonal interactions in the manifest content of the dream; emotions in and/or about the dream, how they processed the dream, their gains of seeing this dream if any, and their thoughts about reasons for seeing this dream as well as to whom this dream belongs. The vividness of the dream was rated on a 9-point Likert scale (0: *not vivid, unclear*; 9: *very vivid, clear*; Hill et al., 2001). The intensity of interpersonal interactions in the dreams, namely friendly, sexual, and aggressive which includes three items as boundary crossings, verbal, and physical attacks were asked to be rated on a 5-point Likert scale (0: *none*; 4: *very much*). To evaluate the feelings of the dream, participants were requested to rate the experienced intensity of 13 emotions on a 7-point Likert scale (1: *never*; 7: *very*). The emotion list was adopted from Cavdar (2020), and item "anxiety" was added to her list for the purposes of this study. Other questions were arranged as multiple choice with a possibility of choosing multiple options and participants' adding their own options regarding their thoughts.

2.2.6. Questions about the Dreamt about Client

Three questions (see Appendix F) which were age, gender, and diagnosis/formulation of the dreamt about client were asked. The age and formulation/diagnosis information of the clients were collected via open-ended questions. Participants had the option of not answering these questions.

2.2.7. Working Alliance Inventory Therapist Form (WAI-TF) - Affective Bonding Subscale

Working Alliance Inventory was developed by Horvath and Greenberg (1989) to be able to assess the degree of the therapeutic alliance between the therapist and the client. It consists of three subscales, namely affective bonding, goals, and tasks. In their study, the Cronbach alpha scores of the Therapist Form were found as .93 for the whole scale and .92 for the affective bonding subscale. The reliability and validity of the scale were supported (Horvath & Greenberg, 1989). The whole scale consists of 36 items with seven-point Likert scale ratings (0: *never* to 6: *always*). The affective bonding subscale (see Appendix G) which was used in this study contains 12 items.

The Turkish adaptation of the scale was done by Soygüt and Işıklı (2008). The Cronbach alpha scores of the Turkish adaptation of the scale were reported as .96 for the whole scale and .83 for the affective bonding subscale. Also, the criterion and construct validity of the scale's Turkish adaptation were supported (see Soygüt & Işıklı, 2008). The Cronbach's alpha score of the bonding subscale was found to be .83 in the current study, indicating good reliability.

2.2.8. Countertransference Questionnaire Short Form (CTQ-SF)

The original version of the Countertransference Questionnaire (CTQ) was developed by Betan et al. (2005) to measure psychotherapists' countertransference reactions including thoughts, emotions, attitudes, and behaviors towards a patient

or in general in the psychotherapies which they carry out. The original scale consists of 79 items. Therapists rate the suitability of each item for themselves on a 5-point Likert scale. In the manual of the questionnaire eight factors were specified as "Disengaged, Helpless/Inadequate, Hostile/Mistreated, Overwhelmed/ Disorganized, Parental/Protective, Positive/Satisfying, Sexualized, Special/ Overinvolved" (Conklin & Westen, 2005).

To be able to increase the feasibility of the study to reach a higher number of voluntary participants, researchers preferred to shorten this scale. Each heading of the 8 factors that were reported above was converted to one or two items regarding comprehensibility. This short version of the scale (see Appendix H) consisted of 14 items and participants were asked to rate each item according to the frequency which they experience with the dreamt about client on a five-point Likert scale (0: *never* to 4: *very frequently*).

Since this version was used for the first time in this study, a Principal Components Analysis (PCA) with varimax rotation with Kaiser Normalization was conducted to identify the components. Before conducting the PCA, assumptions about the factorability of the sample were examined. The Kaiser-Meyer-Olkin measure of sampling adequacy was calculated as .700, supporting the adequacy of the sample, and Bartlett's test of sphericity was significant ($\chi 2(78) = 288.088$, $p = .000$), indicating factorability of the scale.

The cut-off value for factor loadings was determined as .50, and 3 components were identified as insufficiency, dislike, and parenting. Two items (Item 1 and 13) were discarded due to low factor loadings, and item 12 was removed from the scale because of multiple factor loadings. Thus, the final scale consisted of 11 items with 5 of them belonging to the insufficiency component (factor loadings ranged between .678 and .871), 3 items to the dislike component (loadings between .744 and .832), and 3 items to the parenting component (loadings between .667 and .842). The Cronbach's alpha scores for the factors were calculated as .87, .76, and .73, respectively, suggesting good and adequate internal consistencies. Also, the Cronbach's alpha score for the whole scale was found as .76, indicating adequate reliability.

2.3. PROCEDURE

Following the ethics approval of the institutional review committee of Istanbul Bilgi University, the study was announced on social media platforms and shared in mailing groups that included psychotherapists from different backgrounds. Data was collected by delivering study materials to the voluntary participants via an online survey tool (www.surveymonkey.com).

At the beginning of the study, an Informed Consent Form (see Appendix I) was given to all participants, and only those who approved to participate continued to the study. All voluntary participants were asked to complete the first step of the study which contains Demographic Information and Professional Background Form, Therapists' Experienced Difficulties Questionnaire, Attitudes Towards Dreams Scale, and Dream Recall and Processing Frequency Scale. These scales were presented in the listed order to all participants. After the completion of the first step, only the participants who recalled at least one dream about their clients were requested to continue to the second step.

In the second step, participants were asked to recall and select one dream about one of their clients and complete the rest of the survey only considering this specific dream and the client. First, questions about specific dream characteristics and processing were asked. Later, three questions about the client were given. Participants were free not to answer these three questions about clients due to the possibility of bearing confidentiality concerns. Afterward, the Affective Bonding subscale of the Working Alliance Inventory Therapist Form (WAI-TF) and Countertransference Questionnaire Short Form were presented to the participants.

As the first part of the study focuses on the general experience of dreams and dreaming, and the second part focuses on a specific dream, in order to reduce priming and increase face validity these parts were offered in the same order to all participants. Within the second part, in order to orient the participant to a specific dream, the questions were intentionally ordered, thus could not be randomized.

The completion of each step lasted approximately 10 minutes and a total of 20 minutes. Participants were free to withdraw from the study at any time. The

information which can reveal the identity of the participants was not collected at any part of the study, and all data was stored confidential.

2.4. DATA ANALYSIS

All analyses of the present study were conducted with Statistical Package for the Social Sciences (SPSS), version 26. The data analyses that were carried out in the current study can be grouped under three main headings. First, preliminary analyses were conducted and presented. These analyses included Principal Component Analysis of the newly developed Dream Recall and Processing Frequency Scale (DRPFS), analyses of descriptive statistics of the study variables, and Pearson, Spearman correlations and one-way analyses of variance (ANOVA) for investigating the initial associations among participants' demographic/professional characteristics and the study variables. Also, internal consistency analyses of all scales were conducted at the very beginning of the analyses.

Study variables of the present study are attitudes towards dreams which was measured by the Attitudes Towards Dreams Scale, psychotherapists' level of experienced difficulties in conducting psychotherapy that was measured by Therapists' Experienced Difficulties Questionnaire, and general dream recall and processing, countertransference dreaming, and clinical dream processing frequencies that were measured with Dream Recall and Processing Frequency Scale (DRPFS).

In the second step of the analyses, two Multiple Stepwise Analyses were carried out to identify factors predicting the dependent variables. The dependent variables of the current study are countertransference dreaming frequency and clinical dream processing frequency. The independent variables that were consisted of certain study variables and background characteristics of psychotherapists were determined specifically for each dependent variable regarding the preliminary analyses and were reported in the related section. With these analyses, the effect of each independent variable that was found associated in the initial inspections in

predicting dependent variables could be controlled and their unique contributions could be determined.

In the third step, the data of the second part of the study was analyzed. The descriptive statistics and frequencies of the information collected about the specific countertransference dreams and clients of reference were investigated. Furthermore, the associations of countertransference dream characteristics with certain aspects of the therapeutic relationship which were measured with Working Alliance Inventory Therapist Form (WAI-TF) - Affective Bonding Subscale and Countertransference Questionnaire Short Form were explored with Spearman correlation analyses.

CHAPTER 3
RESULTS

The findings of the study will be conveyed in three sections. Results of preliminary analyses, stepwise regression analyses for detecting factors that predict countertransference dream frequency and clinical dream processing frequency, and lastly descriptive statistics of countertransference dreams that were collected in the second part of the study and their associations with therapeutic bond and countertransference reactions of the therapists will be presented in the reported order. Lastly, additional observations that were needed for the discussion of the findings were reported.

3.1. PRELIMINARY ANALYSES

Preliminary analyses that will be reported in this section include Principal Component Analysis (PCA) of newly developed Dream Recall and Processing Frequency Scale (DRPFS), descriptive statistics of variables that were used in the study, and initial analyses to inspect possible links among demographic/professional background characteristics of therapists and study variables. The Principal Component Analysis of Countertransference Scale – Short Form and results of internal consistency analyses of all scales that were used in the study can be found under the related sections of the Method chapter.

3.1.1. Psychometric Properties and Principal Component Analysis of Dream Recall and Processing Frequency Scale (DRPFS)

The Dream Recall and Processing Frequency Scale (DRPFS) was created for the purposes of the current study and used in this study for the first time. Hence, a Principal Component Analysis (PCA) was conducted to identify internally consistent components. Upon the preliminary inspection, 4 theme-based items (Items 6, 7, 8, and 9 which can be seen in Appendix D, e.g. How often do you have

dreams with a sexual theme?) were excluded from the scale and analysis due to low factor loadings and as they could not be incorporated into the theoretically sound component structure. Thus, the analysis proceeded with the remaining 13 items.

Before conducting the analysis, tests that show whether the sample and data are factorable or not were performed. The Kaiser-Meyer-Olkin measure of sampling adequacy was .741, and Bartlett's test of sphericity was found significant ($\chi 2(78) = 628.246$, $p = .000$). These results indicated respectively that the sample was sufficient for PCA, and the correlation matrix of the items was factorable. Anti-image correlations as well as communalities additionally supported the suitability of the item correlations for analysis.

Regarding the results of the analysis, 3 components with eigenvalues more than 1 were identified, and this three-component structure explained 64% of the summed variance. To increase the interpretability of the structure, Varimax rotation with Kaiser Normalization was carried out, and the rotation converged in 5 iterations. The minimum value for factor loadings was designated as .50, and all 13 items had factor loadings above .60. The components and pattern matrix of item-factor loadings of the DRPFS can be seen in Table 3.1.

Table 3.1 *Principal Component Analysis (PCA) Results: Item-Factor Loadings of DRPFS*

Dream Recall and Processing Frequency Component and Item	Loading
Component 1 Clinical Dream Processing	
16. How often do you work on the dreams of your clients in the therapies that you carry out?	0.924
14. How often do your clients tell their dreams in the therapies that you carry out?	0.877
17. How often did/do you work on the dreams of your clients and/or yours during the supervisions you take?	0.845
15. How often do your clients talk about the dreams that they saw you?	0.670
4. In your individual therapy process, how often did/do you work on the dreams that you had?	0.605

Component 2 General Dream Recall and Processing	
1. Regardless of whether you remember the content of the dream or not, how often do you dream in general?	0.787
3. How often do you try to make sense of your dreams by yourself?	0.751
2. How often do you remember your dreams when you wake up?	0.654
5. How often do you tell your dreams to others aside from your psychotherapist?	0.639
Component 3 Countertransference Dreaming	
10. How often do you dream about your clients as they are (in their current appearance / as themselves)?	0.820
13. How often do the negative feelings and experiences that you have during your sessions affect your dreams?	0.761
11. How often do you see images in your dreams that you think to represent your clients, even if they do not appear as your clients manifestly?	0.715
12. How often do the positive emotions and experiences that you have in your sessions affect your dreams?	0.607

The first component contained 5 items that assess the extent of processing dreams in the clinical settings including participants' own personal therapies, therapeutic processes that they carry out, and supervisions. Regarding the content of the items, the component was named as "Clinical Dream Processing." The second one consisted of 4 items about frequencies of dreaming and processing dreams in general. Thus, it was labeled as "General Dream Recall and Processing." The last component contained 4 items that question the frequency of countertransference dreaming which include items about the appearance of patients in the manifest and latent content of the dreams as well as the extent of positive and negative experiences in the therapy sessions' affecting the dreams. Considering the aim and content of the items, this component was called "Countertransference Dreaming." The components' internal consistency scores were calculated as .86, .76, and .77, respectively, suggesting good and acceptable reliabilities.

Furthermore, the total scale was found to have a good internal consistency with the Cronbach's alpha value of .82.

3.1.2. Descriptive Statistics of Study Variables

Scale scores that were used in the further analysis were calculated. Therapists' experienced difficulties in the therapies that they carry out was computed via calculating the mean score of all items in the Therapists' Experienced Difficulties Questionnaire. Positive and negative attitudes of the therapists towards the dreams were calculated separately as summing the related items for each as instructed by the developers of the Attitudes Towards Dreams Scale. Lastly, the component scores of the Dream Recall and Processing Scale were computed by averaging the scores of items in each component that was reported in the previous section. The descriptive statistics of all study variables with minimum, maximum, mean, and standard deviation values can be seen in Table 3.2.

Table 3.2 *Descriptive Statistics of Study Variables*

	Min.	Max.	*M*	*SD*
Therapists' Experienced Difficulties	1.06	3.89	2.37	.47
Positive Attitudes towards Dreams	19	60	44.22	9.15
Negative Attitudes towards Dreams	.00	18	1.91	2.97
Clinical Dream Processing	.00	6	2.85	1.45
General Dream Recall and Processing	.00	6	4.02	1.08
Countertransference Dreaming	.00	4.50	1.81	1.08

Furthermore, significant outliers and normality distributions of these scale scores were examined. Except for the negative attitudes towards dreams, all variables could be regarded as approximately normally distributed with no significant outliers. The negative attitudes towards dreams variable was considerably positively skewed, and this skewness can be expected in the therapist

population as higher scores indicate very negative views about dreams. Due to this skewness, this variable was not included in the further analysis.

3.1.3. Associations of Demographic/Professional Characteristics with Countertransference Dreaming and Clinical Dream Processing Frequencies

The associations of categorical variables about demographic and professional characteristics of the participants with countertransference dreaming and clinical dream processing frequencies were examined by conducting a one-way between-subjects analysis of variance (ANOVA). When necessary, Tukey's HSD was used for post-hoc analyses. The descriptive statistics are presented, and the significance of the mean differences are noted in Table 3.3.

Table 3.3 *Mean Comparisons of Categorical Variables regarding Countertransference Dreaming and Clinical Dream Processing Frequencies*

	Countertransference Dreaming		Clinical Dream Processing	
	M	*SD*	*M*	*SD*
Education Levels				
BA Graduate	2.30	1.27	1.29**	1.23
MA Student	1.79	1.79	2.60	1.39
MA Graduate	1.76	1.76	3.14**	1.35
PhD Student or Graduate	2.04	1.15	3.43	1.91
Education Levels (Grouped)				
Degree of expertise (MA/PhD Graduate)	1.79	1.01	3.17**	1.40
No degree of expertise	1.84	1.16	2.48**	1.42
Theoretical Orientation				
Psychoanalytic/Psychodynamic	2.04**	.99	3.42**	1.27
Other (CBT, Systemic, Humanistic etc.)	1.11**	1.06	1.43**	.97
Psychoanalytic with Other Orientations	1.99**	.98	2.91**	1.24

Multiple Orientations except Psychoanalytic	1.28	1.25	1.58**	1.17
Theoretical Orientation Grouped				
Psychoanalytic	2.03**	.98	3.30**	1.28
Other than Psychoanalytic	1.16**	1.10	1.48**	1.01
Client Population				
Only Adults	1.84	1.11	3.25**	1.47
Adults and Adolescents	1.96	.97	3.16**	1.34
Children and/or Adolescents	1.67	1.23	1.84**	.95
Mixed	1.73	.94	2.19**	1.16
Personal Therapy Status				
Currently Going	1.92	1.01	3.15**	1.29
Naturally Terminated	1.55	1.18	2.68**	2.05
Prematurely Terminated	1.63	1.27	2.45	1.17
Never Gone	1.41	1.23	1.00**	.98
Personal Therapy Orientation				
Psychoanalytic/Psychodynamic	1.96	1.05	3.31**	1.30
Psychoanalytic/Psychodynamic with Other	1.63	.92	2.57	1.51
Other (CBT, Humanistic, Systemic etc.)	1.44	1.19	1.80**	.81

** Univariate F is significant at the 0.01 level (2-tailed).

On countertransference dreaming frequency scores, no significant differences were identified among genders, $F(2, 110) = .242$, $p = .785$; education levels, $F(3, 109) = .471$, $p = .703$; client population which therapists work with, $F(3, 109) = .227$, $p = .877$; self-therapy status such as continuing to go, naturally terminated, $F(3, 109) = 1.020$, $p = .387$; and their personal therapists' theoretical orientation, $F(2, 101) = 1.857$, $p = .161$. On the other hand, there was a significant effect of therapists' theoretical orientation on their countertransference dreaming frequencies, when both two categories, $F(1, 111) = 15.295$, $p = .000$; and four categories that were reported in the Table 3.3 were compared, $F(3, 109) = 5.086$, $p = .002$. Therapists with psychoanalytic orientation only ($M = 2.04$, $SD = .99$) or with additional approaches ($M = 1.99$, $SD = .98$) were identified to have

significantly more countertransference dreams compared to therapists who were adhered to other orientations such as Humanistic, Systemic, CBT solely (M = 1.11, SD = 1.06). For a clearer picture when these categories were grouped, therapists who adhere to psychoanalytic orientation solely or in combination with other therapeutic schools reported to experience countertransference dreaming (M = 2.03, SD = .98) significantly more than therapists who do not embrace psychoanalytic approaches at all (M = 1.16, SD = 1.10).

On clinical dream processing frequency scores, there were significant effects of therapists' education levels, when the categories were grouped $F(1, 111) = 6.796$, $p < .05$, or there were four categories $F(3, 109) = 3.724$, $p < .05$; theoretical orientations, when they were grouped $F(1, 111) = 46.888$, $p = .000$, or not grouped, $F(3, 109) = 16.726$, $p = .000$; client population which they work with, $F(3, 109) = 6.826$, $p = .000$; personal therapy status $F(3, 19.989) = 11.637$, $p = .000$; and their personal therapists' theoretical approaches $F(2, 101) = 9.769$, $p = .000$. The homogeneity of variances assumption was not satisfied in the personal therapy status variable; thus, the Welch F-ratio was reported. Also, there was not an effect of gender on the extent of clinical dream processing, $F(2, 110) = .150$, $p = .861$.

Firstly, therapists with MA degree (M = 3.14, SD = 1.35) had significantly higher clinical dream processing scores compared to therapists with only BA degree (M = 1.29, SD = 1.23). In the post hoc tests, no other significant differences were found between education level categories. When the education levels of therapists were grouped under two categories, therapists who have a degree of expertise with completing their graduate education (M = 3.17, SD = 1.40) reported processing dreams in the clinical settings significantly more compared to therapists who only have an undergraduate degree or are MA students (M = 2.48, SD = 1.42). Therapists with psychoanalytical orientation (M = 3.30, SD = 1.28) were stated to clinically process dreams significantly more than therapists from other orientations (M = 1.48, SD = 1.01). The descriptive statistics of all theoretical orientation categories can be found in Table 3.3. Also, therapists working with solely adults (M = 3.25, SD = 1.47) reported to work with dreams in clinical settings more than therapists working with children and/or adolescents (M = 1.84, SD = .95) and mixed population (M =

2.19, *SD* = 1.16). In addition, the difference between therapists working with both adults and adolescents (*M* = 3.16, *SD* = 1.34) and therapists working with children and/or adolescents was also significant in terms of clinical dream processing.

Regarding therapists' personal therapy experiences, therapists who had never gone to their personal therapies (*M* = 1.00, *SD* = .98) claimed to process dreams in clinical settings significantly less compared to therapists who were currently going to their personal therapies (*M* = 3.15, *SD* = 1.29) and therapists who had naturally terminated their own therapy processes (*M* = 2.68, *SD* = 2.05). There were no significant differences between therapists who prematurely terminated their personal therapies (*M* = 2.45, *SD* = 1.17) and other groups. Finally, therapists who have/had personal therapists with psychoanalytic orientation only (*M* = 3.31, *SD* = 1.30) reported working clinically on dreams significantly more than therapists whose personal therapists adhere to other therapeutic schools (*M* = 1.80, *SD* = .81).

The associations of continuous variables about demographic/professional characteristics of psychotherapists namely, age, years of experience, number of clients, weekly working hours, therapists' self-rated experience levels and workload evaluations, and personal therapy durations in months with countertransference dreaming and clinical dream processing frequencies were examined via Spearman correlation analyses. Spearman correlation was chosen for these analyses because of the presence of outliers in certain variables and self-rated evaluations' being single items that were assessed on a 5-point Likert scale. The Spearman correlations are presented in Table 3.4.

Regarding the results of Spearman Correlation analyses, a significant positive correlation at moderate levels between countertransference dreaming and personal therapy duration in months was found, $r(111) = .367$, $p < .01$. Also, clinical dream processing frequency was found to be positively correlated at moderate levels with age, $r(111) = .395$, $p < .01$; years of psychotherapy experience, $r(111) = .416$, $p < .01$; self-rated experience, $r(111) = .344$, $p < .01$; weekly working hours, $r(111) = .350$, $p < .01$; number of clients, $r(111) = .366$, $p < .01$; and at a strong level with personal psychotherapy duration $r(111) = .574$, $p < .01$.

Table 3.4 *Spearman Correlations of Demographic/Professional Characteristics with Countertransference Dreaming and Clinical Dream Processing Frequencies*

	Countertransference Dreaming	Clinical Dream Processing
Age	.036	.395**
Years of Experience	.081	.416**
Self-Rated Experience	.124	.344**
Weekly Working Hours	.042	.350**
Number of Clients	.027	.366**
Self-Rated Workload	.154	.156
Personal Therapy Duration	.367**	.574**

**$p < .01$.

3.1.4. Associations of Countertransference Dream and Clinical Dream Processing Frequencies with Other Study Variables

Apart from the therapists' demographic and professional characteristics, the effects of participants' experiences in conducting psychotherapy, their attitudes regarding dreams on countertransference dreaming and clinical dream processing frequencies were examined as well. Also, participants' general dream recall and processing frequencies were measured. As this is the first study that examines these links with this methodology, their associations with each other were investigated before moving on to further analyses.

Correlations among study variables which are therapists' level of experienced difficulties in psychotherapies, positive attitudes towards dreams, general dream recall and processing frequencies, clinical dream processing, and countertransference dreaming frequencies were calculated with Pearson correlation analyses. The Pearson correlation coefficients are shown in Table 3.5.

Table 3.5 *Pearson Correlations of Study Variables*

	Countertransference Dreaming	Clinical Dream Processing
Experienced Difficulties in Therapies	.308**	-.063
Positive Attitudes towards Dreams	.287**	.484**
General Dream Recall and Processing	.361**	.284**
Clinical Dream Processing	.264**	1

**$p < .01$.

According to the Pearson Correlation analyses; there were moderate positive correlations between countertransference dreaming and experienced difficulties while conducting psychotherapy, $r(111) = .308$, $p < .01$; and general dream recall and processing frequencies, $r(111) = .361$, $p < .01$. Also, countertransference dreaming frequency was found to be significantly positively correlated at weak levels with positive attitudes towards dreams, $r(111) = .287$, $p < .01$ and clinical dream processing, $r(111) = .264$, $p < .01$. Lastly, clinical dream processing was positively correlated with positive attitudes towards dreams almost at a strong level, $r(111) = .484$, $p < .01$ and weakly but significantly with general dream recall and processing, $r(111) = .284$, $p < .01$.

3.2. PREDICTING COUNTERTRANSFERENCE DREAMING AND CLINICAL DREAM PROCESSING FREQUENCIES

One of the main aims of the present study is to identify factors that can predict the frequency of countertransference dreaming and clinical dream processing. For this aim, two Stepwise Regression Analyses were carried out with taking countertransference dreaming and clinical dream processing frequencies as dependent variables to be able to assess the unique and comparative impacts of several factors on these frequencies. Predictor variables of each dependent variable were determined separately considering the preliminary analyses that were reported above.

In both of these regression analyses, two participants who were significant outliers in the objective measure of professional experience level that is years of professional experience and another two participants who were significant outliers in terms of weekly working hours were excluded and thus, a total of 109 participants were designated as the sample of these analyses.

3.2.1. Predicting Countertransference Dreaming Frequency

In the stepwise regression analysis for countertransference dreaming, all variables that were found associated with countertransference dreaming frequency in the preliminary analyses, namely therapists' theoretical orientation (Binary), their level of experienced difficulties while conducting psychotherapy, positive attitudes towards dreams, general dream recall and processing frequencies, and the time that they spent in their personal therapies were identified as predictor variables. Clinical dream processing frequency was not involved in the analysis due to its being another dependent variable of the present study, and not contributing to the regression analysis in the preliminary inspection. The summary of the model is shown in Table 3.6.

Table 3.6 *Model Summary of Stepwise Regression Analysis for Countertransference Dreaming*

Model	R	R^2	Adj. R^2	SE of the Estimate	R^2 Change	F Change	df1	df2
1	.325[a]	.106	.096	1.010	.106	11.569	1	98
2	.435[b]	.189	.172	.967	.083	9.977	1	97
3	.500[c]	.250	.227	.935	.061	7.847	1	96

a Predictors: (Constant), Experienced Difficulties
b Predictors: (Constant), Experienced Difficulties, Theoretical Orientation
c Predictors: (Constant), Experienced Difficulties, Theoretical Orientation, General Dream Recall and Processing

According to the results of stepwise regression analysis, therapists' experienced difficulties in their practice contributed significantly to the model at step one, $F(1, 98) = 11.569$, $p = .001$, and it explained 10.6% of the variance in countertransference dreaming. In the second step, therapists' theoretical orientation entered the model and accounted for an additional 8.3% of the variance, $F(2, 97) = 11.303$, $p < .001$. At the last step, general dream recall and processing frequency entered into the equation and explained additionally 6.1% of the variance of countertransference dreaming, $F(3, 96) = 10.683$, $p < .001$. Hence, the final model contains experienced difficulties in therapies, theoretical orientation of therapists, and general dream recall and processing as significant predictors. In total, these three factors explain 25% of the variance in the countertransference dreaming frequency. Positive attitudes towards dreams and personal therapy durations did not contribute to the regression model significantly.

Table 3.7 *Coefficients of the Significant Predictors of the Stepwise Regression Analysis for Variables Predicting Countertransference Dreaming*

	B	B SE	Beta	t	Sig.
(Constant)	-1.440	.625		-2.305	.023
Experienced Difficulties	.706	.211	.297	3.341	.001
Theoretical Orientation	.647	.217	.265	2.980	.004
General Dream Recall and Processing	.269	.096	.250	2.801	.006

Furthermore, the coefficients and beta values of the identified significant predictors are presented in Table 3.7. Regarding the coefficient values, experienced difficulties in therapies is the strongest predictor of countertransference dreaming, and each unit of increase in experienced difficulties leads to an increase by .706 in countertransference dreaming. The theoretical orientation of therapists is the second strongest predictor of countertransference dreaming, and having a psychoanalytical orientation causes an increase by .647 in countertransference dreaming. Lastly, as

the general dream recall and processing increases by one unit, countertransference dreaming increases by .269. In general, their predictive strengths are close to each other.

3.2.2. Predicting Clinical Dream Processing Frequency

In the stepwise regression analysis for clinical dream processing frequency, all factors that were identified as associated with clinical dream processing regarding the initial analyses, namely months of professional experience, weekly working hours, positive attitudes regarding dreams, general dream recall and processing, education levels (Binary), theoretical orientation (Binary), client population (Binary), and variables related to the psychotherapists' personal therapies which are whether they are actively going to the therapy or not, the theoretical orientations of personal therapy processes (Binary), and their durations were determined as independent variables. Because the objective measures of experience and workload were found more correlated than subjective ratings and at the same time, they were highly correlated with each other, only objective indicators were used in the analysis. The summary of the regression model can be seen in Table 3.8.

At the first step of the regression analysis, therapists' positive attitudes towards dreams entered the equation and explained the 25.1% of the variance in clinical dream processing, $F(1, 89) = 29.871$, $p < .001$. In the second step, the professional experience levels of the therapists entered into the model with accounting for an extra 14.3% of the variance $F(2, 88) = 28.650$, $p < .001$. At step three, theoretical orientations of the therapists were contributed to the model with explaining additionally 8.8% of the variance of the frequency of clinical dream processing, $F(3, 87) = 27.009$, $p < .001$. At step four, the patient population that therapists work with entered into the equation and accounted for an extra 4.1% of the variance, $F(4, 86) = 23.552$, $p < .001$. Finally, at the last step, general dream recall and processing frequency was added to the model and explained an additional 3% of the variance, $F(5, 85) = 21.006$, $p < .001$.

Table 3.8 *Model Summary of Stepwise Regression Analysis for Clinical Dream Processing*

Model	R	R^2	Adj. R^2	SE of the Estimate	R^2 Change	F Change	df1	df2
1	.501[a]	.251	.243	1.166	.251	29.871	1	89
2	.628[b]	.394	.381	1.054	.143	20.788	1	88
3	.694[c]	.482	.464	.980	.088	14.765	1	87
4	.723[d]	.523	.501	.947	.041	7.307	1	86
5	.743[e]	.553	.526	.922	.030	5.689	1	85

[a] Predictors: (Constant), Positive Attitudes
[b] Predictors: (Constant), Positive Attitudes, Experience
[c] Predictors: (Constant), Positive Attitudes, Experience, Orientation
[d] Predictors: (Constant), Positive Attitudes, Experience, Orientation, Population
[e] Predictors: (Constant), Positive Attitudes, Experience, Orientation, Population, General Dream Recall and Processing

In summary, therapists' positive attitudes towards dreams, experience levels, theoretical orientations, patient population, and general dream recall and processing frequencies were identified as factors that significantly predict their clinical dream processing frequencies, and in total all these factors explained 55.3% of the variance in clinical dream processing. All other independent variables that were found associated in initial analyses and mentioned above did not contribute to the variance in clinical dream processing significantly.

In addition, the unstandardized coefficients and standardized beta values of significant predictors are presented in Table 3.9. According to the coefficients, clinical dream processing scores increase by .041 for each unit of increase in positive attitudes towards dreams, by .014 for each unit of increase in professional experience, and by .265 for each unit of general dream recall and processing scores. Furthermore, having a psychoanalytical orientation leads to an increase by .999, and working solely with adult clients causes an increase by .603 points in clinical dream processing scores.

Table 3.9 *Coefficients of the Significant Predictors of the Stepwise Regression Analysis for Variables Predicting Clinical Dream Processing*

	B	B SE	Beta	t	Sig.
(Constant)	-1.716	.611		-2.810	.006
Positive Attitudes towards Dreams	.041	.013	.260	3.098	.003
Professional Experience	.014	.003	.386	5.261	.000
Theoretical Orientation	.999	.262	.305	3.817	.000
Patient Population	.603	.203	.224	2.962	.004
General Dream Recall and Processing	.265	.111	.183	2.385	.019

Regarding the comparisons of standardized coefficients, professional experience is the strongest predictor with a standardized coefficient value of .386, and it is followed by theoretical orientation with a beta of .305, positive attitudes towards dreams with a beta of .260, patient population with a beta of .224, and lastly general dream recall and processing with a beta of .183.

3.3. COUNTERTRANSFERENCE DREAM CHARACTERISTICS AND PROCESSING

In this section, statistical analyses of the second part of the study which contains questions about characteristics of a specific countertransference dream that was chosen by the participants, the dreamt about client, and certain aspects of the therapeutic relationship with this particular client, including therapeutical bond and countertransference of the therapist will be presented. As previously mentioned, 55 participants continued to this part of the study, and thus, statistics of 55 countertransference dreams constitute the data of the second part.

In the first part of this section, descriptive statistics of the questions such as the recency of the dream, characters that were manifestly seen in the dream, interpersonal interactions and emotions in the dream will be presented. In the second part, psychotherapists' processing of, gains from, and theoretical points of

views about the chosen specific dream will be reported. Then, the descriptive statistics of the questions about the client of reference and variables related to the therapeutic relationship with this client will be displayed. In the last part, correlations among certain interpersonal interactions, emotions in these dreams, and therapeutic relationship qualities will be presented.

3.3.1. Characteristics of the Selected Countertransference Dream

In this section, frequencies and percentages of certain characteristics of the selected countertransference dreams, namely recency of the dream, time of occurrence of the dream regarding the therapy process, locations, characters, emotions, and social interactions in the dreams according to the evaluations of the psychotherapists who had these dreams are reported, and the summaries of the descriptive statistics are presented in Table 3.10.

Table 3.10 *Frequencies and Percentages of Selected Countertransference Dream Characteristics*

	Frequency	Valid Percent
Dream Recency		
In This Week	8	14.5%
In This Month	10	18.2%
In the Past Few Months	14	25.5%
In This Year	15	27.3%
In the Past Several Years	8	14.5%
Time of Occurrence of the Dream Regarding Therapy		
Beginning of the Process	13	23.6%
Middle of the Process	32	58.2%
Termination Sessions	6	10.9%
After the Termination of the Process	4	7.3%

Characters in the Dream			
Only Patient or Patient with Others		4	7.3%
Patient and Therapist		17	30.9%
Patient, Therapist, and Others		26	47.3%
Not Recalled/Unclear		8	14.5%
Location of the Dream			
Therapy Room		8	14.5%
Outside of Therapy Room		35	63.6%
Both Therapy Room and Outside		8	14.5%
Not Recalled/Unclear		4	7.3%
Interpersonal Interactions			
Friendly Interactions	Present	40	72.7%
Boundary Violations	Present	40	72.7%
Verbal Aggression	Present	23	41.8%
Physical Aggression	Present	12	21.8%
Sexual Interactions	Present	14	25.5%

Regarding the recency, the reported countertransference dreams were in general recently seen as 58.2% of the participants were reported to experience the dream in the past several months or sooner whereas 27.3% claimed to see the dream in this year and 14.5% in the past several years. Also, participants rated the vividness of the reported dreams with scores ranging from 1 to 9, and the mean of 5.38 (*SD* = 2.36) indicated that these dreams were overall relatively vivid. Regarding the timing in the therapeutic process, the majority of the dreams (58.2%) were seen during the middle of the therapeutic process while 23.6% in the beginning sessions, 10.9% in the termination sessions, and only 4 dreams (7.3%) after the termination of the therapy.

In general, both the patient and the therapist were manifestly present in dreams with other people (47.3%) and without others (30.9%). Only in four dreams (7.3%) the patient appeared without the therapist, and 8 participants (14.5%) reported that they did not clearly recall the characters. As to the setting of the dream,

most of the dreams were located outside the therapy room (63.6%) whereas 8 dreams (14.5%) were in the therapy room, and 8 dreams (14.5%) took place both in and outside the therapy room. Also, 4 participants (7.3%) did not recall or distinguish the locations in the dreams.

Lastly, in terms of social interactions, most dreams contained friendly interactions (72.7%) as well as violations of boundaries with the same percent (72.7%). Verbal aggression was present in 23 dreams (41.8%), physical aggression in 12 dreams (21.8%), and sexual interactions in 14 dreams (25.5%) according to the self-evaluations of the participants. The minimum, maximum, mean, and standard deviation values of participant therapists' self-ratings about the intensities of each type of interpersonal interaction are displayed in Table 3.11.

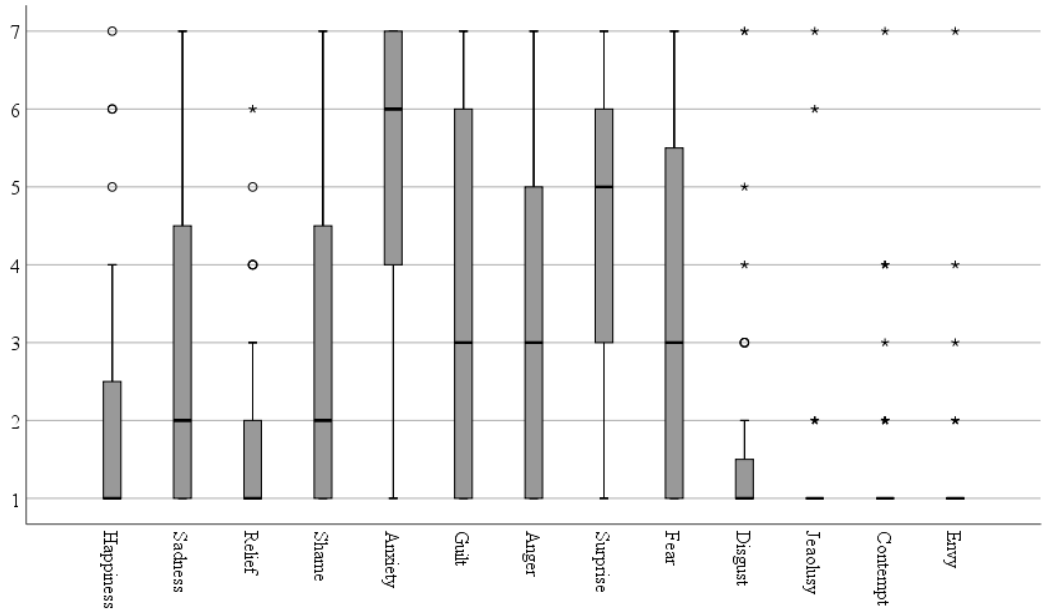
Table 3.11 *Descriptive Statistics of Interpersonal Interactions in the Reported Countertransference Dreams*

	Min	Max	*M*	*SD*
Friendly Interactions	0	4	1.55	1.21
Boundary Violations	0	4	2.07	1.57
Verbal Aggression	0	4	.86	1.25
Physical Aggression	0	4	.56	1.21
Sexual Interactions	0	4	.55	1.09

In general, participants rated the friendly interactions (M = 1.55, SD = 1.21) and boundary violations (M = 2.07, SD = 1.57) as slightly higher in intensity as compared to the quite low ratings of verbal (M = .86, SD = 1.25) and physical aggression (M = .56, SD = 1.21), as well as sexual interactions (M = .55, SD = 1.09).

Regarding emotions experienced in these dreams, anxiety (M = 5.06, SD = 1.89), surprise (M = 4.80, SD = 1.89), guilt (M = 3.66, SD = 2.28), fear (M = 3.64, SD = 2.28), and anger (M = 3.16, SD = 2.12) had the highest ratings. The boxplot of the emotions in the dreams is presented in Figure 3.1.

Figure 3.1 *Boxplot of Emotions in the Dream*



3.3.2. Processing of the Selected Countertransference Dream

In this section, the results examined in terms of how the selected countertransference dreams were processed, understood, and what were the gains of these dreams regarding the reports of the participants. The summary of findings of the processing, interpreting the specific countertransference dreams and their gains are presented in Table 3.12.

Table 3.12 *Frequencies and Percentages of the Processing, Gains of and Various Understandings about Countertransference Dreams*

	Frequency	Valid Percent
Processing		
Processed in Clinical Setting	39	70.9%
Not Processed in Clinical Setting	16	29.1%

Gains of the CT Dreams		
Increased Awareness	22	40%
New Awareness	2	3.6%
Both Increased and New Awareness	30	54.5%
No Gain	1	1.8%
Gains of the CT Dreams Grouped		
Awareness Only about Therapists Themselves	2	3.6%
Awareness Only about Therapeutic Process	6	10.9%
Awareness about both Therapist and Process	46	83.6%
No Gain	1	1.8%
Reason/Function of the CT Dream		
(Percentages of Agreement)		
Part of Unconscious Communication	27	49.1%
For Discharge of Negative Emotions towards Client	22	40%
As a Wish Fulfillment	13	23.6%
For Resolution of Unconscious Conflict about the Client	23	41.8%
Projection of own Intrapsychic Conflicts	20	36.4%
No Special Meaning or Function	0	0
Understandings about CT Dream Grouped		
Two-Person Based Understandings	24	43.6%
One-Person Based Understandings	10	18.2%
Mixed	21	38.2%
Views about "owner" of the CT Dream		
Only Reflecting Therapists' own Psyches	12	21.8%
Only Reflecting Patients' Psyches	0	0
Reflecting both Patients' and Therapists' Psyches	42	76.4%
None	1	1.8%

The majority of the therapists (70.9%) claimed that they processed these dreams in the clinical settings, namely their own personal therapies, clinical supervisions, and/or therapy sessions that they conducted. Furthermore, clinical

gains of these dreams were examined under two headings. Firstly, 54.5% of the therapists reported that they had both new and increased awareness with the effect of the specific countertransference dream while 40% had only increased insight, 2 participants (3.6%) gained completely new insights, and 1 person (1.8%) gained no insight. In terms of the content of these new and/or gained insights, 83.6% of them were about both the psychotherapists themselves and psychotherapy including insights about clients, countertransference reactions, and process. Only 10.9% of participants related the insights solely to the therapeutic process and 3.6% solely to themselves.

Participants' understandings about the reasons for the occurrence of these reported countertransference dreams and/or their functions were examined, and participants could specify more than one reason. Regarding their interpretation of their own specific countertransference dreams, 49.1% of the psychotherapists agreed with the understanding that these dreams are part of the unconscious communication between the therapist and the patient while 36.4% of them saw the dream as the projection of their own inner conflicts unrelated to the clients, completely or in combination with other understandings. All frequencies and percentages of whether the therapists related their countertransference dream to the specified reasons and functions of these dreams can be seen in Table 3.12.

When the responses of participants about these specified reasons and/or functions of countertransference dreams were grouped under two broad categories based on the psychoanalytic conceptualization of one-person and two-person psychologies, 43.6% percent of the psychotherapists gave meaning to their specific countertransference dream from a two-person, relational perspective, 18.2% of them from a one-person, drive-based perspective, and point of views of 38.2% of the psychotherapists were classified as mixed of both one-person and two-person understandings. Lastly, the views of the participants were questioned about to whom the specific dream belonged. The majority (76.4%) of the participants saw the dream as the reflection of the inner lives of both themselves and the patients whereas 21.8% addressed only their own psyches. None of the therapists attributed

the dream solely to the projection of the patient, and only 1 person (1.8%) related the dream to no one.

3.3.3. The Client and the Therapeutic Process of the Selected Countertransference Dream

First, information about the client that the chosen countertransference dream was about was investigated. The majority of the referred clients were female (72.7%), and their ages at the time of the occurrence of the countertransference dreams were between 7 and 60 with a mean age of 25.58 (*SD* = 8.94). Also, 41 psychotherapists reported the diagnosis and/or formulation of the patient. When these diagnosis/formulations were grouped as much as possible without changing the original definitions of the therapists, the dominant diagnoses can be identified as narcissistic (24.4%) and borderline (17.1%). All identified diagnosis/ formulations can be seen in Table 3.13.

Table 3.13 *Diagnosis/Formulations of the Dreamt about Patient*

	Frequency	Valid Percent
Narcissistic	10	24.4%
Borderline	7	17.1%
Psychotic	3	7.3%
Hysteric	3	7.3%
Obsessive	3	7.3%
Neurotic	5	12.2%
Multiple Diagnosis	4	9.8%
Other	6	14.6%

Two constructs that were thought to reflect the therapeutic process with the client of reference were examined. The Therapeutic Bond score was computed via summing the items of the Affective Bonding subscale of the Working Alliance

Inventory (WAI-TF). Also, components of the short form of the Countertransference Questionnaire that was developed for this study and reported in the Method section were calculated via taking the mean values of related items for each component. The descriptive statistics of these scale scores are displayed in Table 3.14. Also, the distributions of these scores were found approximately normal with no significant outliers.

Table 3.14 *Descriptive Statistics of Therapeutic Bond and Countertransference Reactions*

	Min.	Max.	*M*	*SD*
Therapeutic Bond	33	72	50.38	9.84
Countertransference - Dislike	0	4	1.22	.86
Countertransference - Parenting	0	3.33	1.67	.99
Countertransference - Insufficiency	.20	3.60	1.75	.85

3.3.4. Associations of Therapeutic Bond and Countertransference Reactions with Countertransference Dream Characteristics

The associations of interactions and emotions in countertransference dreams with therapy process-related variables, namely therapeutic bond and several countertransference reactions of therapists towards the dreamt about clients were analyzed with Spearman correlation analyses. Several of the interpersonal interactions, namely, verbal, physical aggression, and sexual interactions as well as certain emotion variables, namely, jealousy, contempt, envy, disgust, and relief were not included in the analyses because they had problematic distributions as mentioned in the first section. Due to the non-normal distributions and social interactions and emotions' being measured with single items Spearman correlation analysis was preferred. The summary of correlation coefficients can be seen in Table 3.15.

According to the Spearman correlation coefficients, significant positive associations between therapeutical bond and friendly interactions, $r(53) = .316$, $p <$

.05; as well as happiness, $r(53) = .341$, $p < .05$, were identified at moderate levels. Furthermore, therapeutical bond was obtained to be negatively correlated at weak levels with sadness, $r(53) = -.279$, $p < .05$; and at moderate levels with boundary violations, $r(53) = -.348$, $p < .01$; anxiety, $r(53) = -.396$, $p < .01$; anger, $r(53) = -.384$, $p < .01$; and fear, $r(53) = -363$, $p < .01$.

Table 3.15 *Spearman Correlations of Therapeutic Bond and Countertransference Reactions with Interpersonal Interactions and Emotions in the Countertransference Dreams*

	Bond	Countertransference Reactions		
		Dislike	Parenting	Insufficiency
Friendly Interactions	.316*	-.259	.019	-.248
Boundary Violations	-.348**	.499**	-.009	.393**
Emotions				
Happiness	.341*	-.270*	-.017	-.438**
Sadness	-.279*	.201	.107	.151
Shame	-.183	.313*	.315*	.252
Anxiety	-.396**	.390**	.141	.506**
Guilt	-.219	.244	.318*	.455**
Anger	-.384**	.594**	.029	.416**
Surprise	-.053	.182	.130	.092
Fear	-.363**	.394**	.106	.437**

*$p < .05$, **$p < .01$.

When the associations of three countertransference components with interactions and emotions in the dreams were considered, there were strong positive correlations with dislike component and boundary violations, $r(53) = .499$, $p < .01$; and with feeling anger in the dream, $r(53) = .594$, $p < .01$. Also, dislike component's moderate positive associations with feeling shame, $r(53) = .313$, $p < .05$; anxiety, $r(53) = .390$, $p < .01$; and fear in the dream, $r(53) = .394$, $p < .01$ were observed.

On the other hand, feeling happiness was negatively correlated with dislike component of the countertransference, $r(53) = -.270$, $p < .05$ at a weak level.

In addition, moderate positive correlations of parenting component of the countertransference scale with feeling shame, $r(53) = .315$, $p < .05$ and guilt in the dream, $r(53) = .318$, $p < .05$ were identified. Lastly, regarding the correlation coefficients of the insufficiency component of the countertransference, its strong positive correlation with feeling anxiety in the dream, $r(53) = .506$, $p < .01$; moderate positive correlations with boundary violations, $r(53) = .393$, $p < .01$; feeling guilt, $r(53) = .455$, $p < .01$; fear, $r(53) = .437$, $p < .01$; and anger in the dream, $r(53) = .416$, $p < .01$; as well as moderate negative correlation with feeling happiness in the dream, $r(53) = -.438$, $p < .01$ were found.

3.4. ADDITIONAL OBSERVATIONS

To further understand and discuss the associations between countertransference dreaming and certain background characteristics, associations between these characteristics and general dream recall and processing frequency were investigated. Firstly, to test whether there was a difference among theoretical orientations in general dream recall and processing frequencies, a one-way between-subjects ANOVA was carried out. As homogeneity of variances assumption was violated, Welch *F*-ratio was reported. No differences were found between psychoanalytically oriented therapists and others, $F(1, 33.175) = 2.868$, $p = .100$. Secondly, the association between general dream recall and processing and personal therapy duration was examined with Pearson Correlation analysis, and no significant correlation was found neither, $r(111) = .140$, $p > .05$.

In addition, to be able to discuss the results of stepwise regression analysis for countertransference dreaming, the possible association between therapists' theoretical orientation and their personal therapies' duration was explored with a one-way between-subjects ANOVA. Due to not meeting the homogeneity of variances assumption, Welch *F*-ratio was taken into consideration. It is found that therapists with psychoanalytical orientation ($M = 46.25$, $SD = 33.90$) spent

significantly more time compared to therapists with other therapy adherences (M = 12.63, SD = 13.12), $F(1, 100.951) = 53.058$, $p = .00$.

CHAPTER 4
DISCUSSION

The current study's purpose was to explore therapists' dreaming experiences with a special focus on countertransference dreaming as well as to gather additional information about the clinical processing of dreams in psychotherapy settings. Regarding these aims, certain associations of countertransference dreaming and clinical dream processing with other elements such as several background characteristics, attitudes towards dreams, experienced difficulties in psychotherapy processes were examined. Also, considering the specific focus of the study on countertransference dreaming, the second part was solely devoted to exploring this phenomenon, and thus its characteristics and certain correlates were investigated.

In this section, summaries of the results of the explorations will be presented with discussing the possible meanings of these results regarding the literature. The current study will be discussed in five main parts: (1) measurement of dream frequency and content and scale development, (2) associations of and factors predicting countertransference dreaming frequency, (3) correlates and predicting factors of clinical dream processing, (4) characteristics and associations of countertransference dreaming characteristics with the therapeutic relationship, and lastly (5) therapists' reports about processing and gains of countertransference dreams. After the discussions about the findings, clinical implications of the results and then, limitations and future recommendations will be presented, respectively.

4.1. MEASURING DREAMING AND SCALE DEVELOPMENT

In the present study, all information about dreams was collected via self-report, retrospective dream questionnaires, and a scale for measuring psychotherapists' dreaming experiences was developed. In this regard, utilization of this methodology was chosen as the first topic to be discussed rather than a measurement-based limitation but in terms of the nature of the construct. The

indications that were discussed in this section underlie the results and further sections of the discussion.

4.1.1. Retrospective Dream Questionnaires

As being a mental process that occurs while sleeping, measuring dreams has been always possible only via indirect methods, and in all measures, there are always two borders that are needed to be surpassed, the boundary between sleep and wake and the time interval between seeing and recalling, reporting the dream (Schredl, 2010).

There are three main but indirect methods of empirically studying and collecting information about dream frequency and content, namely sleep laboratory studies, keeping dream journals, and self-report dream questionnaires (Schredl, 1999; Zadra & Domhoff, 2011). Each of these methods has its own advantages and disadvantages. For instance, while laboratory studies and dream diaries have an advantage on retrospective questionnaires in terms of decreased time interval and thus, faulty memory, in these methods the measurement technique can affect the frequency and content of the dreams (Schredl, 2002). For example, it is found that keeping dream journals and laboratory awakenings increase the dream recall frequency (Cohen, 1969; Schredl, 2002), and also, the contents of the dreams are impacted by the unnatural laboratory setting with causing references to the laboratory (Schredl, 2008) while decreasing aggression and sexual content in the dreams (Zadra & Domhoff, 2011). Also, collecting data from sleep laboratories or dream journals require more time and resources devoted to the research to be able to collect a meaningful number of dreams whereas with questionnaires data from a substantially bigger population about dreaming patterns can be collected easily (Bernstein & Belicki, 1996; Bernstein & Roberts, 1995; Schredl, 2002; Zadra & Domhoff, 2011).

Regarding the resources and aims of the current study, information about dreaming frequencies in the first part as well as data about the characteristics of a specific countertransference dream in the second part were collected with self-

report dream questionnaires. Even though there are mentioned advantages and disadvantages of each measurement method and there are questions about which method is more valid, the reliability and validity of measuring dreams with retrospective questionnaires were supported in general (Bernstein & Belicki, 1996; Bernstein & Roberts, 1995; Cohen, 1969; Schredl, 2014; Zadra & Domhoff, 2011). Also, it is suggested that in terms of measuring the associations between dreaming and trait personality characteristics or in other saying more general patterns, as in the purpose of the present study, questionnaires are better than other methods (Bernstein & Belicki, 1996).

In addition, for the second part of this study about a relatively rare and exceptional group of dreams using a questionnaire was identified more rational as these dreams do not occur frequent enough (Zadra & Domhoff, 2011), and it can be argued that the subjective experience in terms of the salience of the dream is important to be able to gather a distinct picture of the specific phenomenon. Also, an important point to be considered is that Schredl and Doll (1998) found in their study that while the self-ratings about the emotions in the dreams were balanced in terms of negative and positive feelings, ratings of external judges about the dream emotions were negatively oriented, and the emotions of the dream were significantly underestimated by judges compared to the subjective experience of the dreamers in their own self-ratings. In another study, similar underestimations by external coders of the intensity were also found in the ratings of bizarreness (Schredl & Erlacher, 2003).

Regarding these studies, it can be suggested that dream content analysis by external coders considering the written dream reports may not be a valid way of measurement for some characteristics of dreams which the subjectivity is more prominent like emotions and bizarreness and thus, they may not correspond to the actual subjective experience of the dreaming (Schredl & Erlacher, 2003). From a similar standpoint, participants' rating the intensity of interpersonal interactions of their own dreams can be discussed to be more representative of the original subjective experience as well. Thus, in the second part of the study rather than collecting dream reports and dream content analysis, participants' rating their own

dreams were preferred both in terms of the present study's focusing on the subjective experience and the feasibility of this methodology.

4.1.2. Developing the Dream Recall and Processing Frequency Scale (DRPFS)

The Dream Recall and Processing Frequency Scale (DRPFS) was developed for the present study to measure the psychotherapists' dreaming and dream processing frequencies including countertransference dreaming as there was not any scale measuring specifically dreaming experiences of psychotherapists. As it was newly created, a Principal Components Analysis (PCA) was carried out to differentiate reliable components of the scale with the sample of this study including 113 psychotherapists. Regarding the internal consistency analyses of the scale and components that were reported in the method section, the scale was found reliable.

Three components were identified as (1) Clinical Dream Processing, (2) General Dream Recall and Processing, and (3) Countertransference Dreaming. The first component contained items about working with the dreams of therapists and/or patients in clinical, therapeutic settings. The second component, as can be derived from the component name, consisted of items including questions of dream recalling and processing in general. Lastly, the final component presented a reliable and theoretically sound measure for the frequency of countertransference dreaming.

As it was mentioned in the literature review, there is no consensus about which dreams exactly should be considered as a countertransference dream. Some for the purpose of objectivity choose to regard the countertransference dream as only with the manifest appearance of the patient in the dreams (e.g., Lester et al., 1989; Whitman et al., 1969). On the other hand, others, maybe from a more psychoanalytic point of view, include the dreams that the patients can be identified in the latent content to the countertransference dreaming phenomenon as well (e.g., Rudge, 1998; Spero, 1984; Zwiebel, 1985). Items regarding these two manifestations of countertransference dreaming were included in the scale. Also, in this study, items that question the possible negative and positive effects of the

therapy sessions on dreams were incorporated with the purpose of supporting the link between the effects of patients and the therapists' dreams' content.

It can be argued that the statistical analysis of the current study presented preliminary support for the idea that countertransference dreams should not solely cover the manifest appearance of patients in dreams via showing internal consistencies of the items including the manifest and the latent appearance of patients in the dreams as well as conducting therapies' positive and negative effects on psychotherapists' dreaming. It can be argued that regarding Heimann's (1950) conceptualization of countertransference as containing all feelings and reactions of the therapist intended for the patient, the countertransference dreams should include all effects of patients and therapeutic processes on the dreams of therapists as well.

4.2. COUNTERTRANSFERENCE DREAMING

4.2.1. Countertransference Dreaming Frequency

Regarding the descriptive statistics of the components of the Dream Recall and Processing Frequency Scale, it is observable that the maximum and average scores of the countertransference dreaming component for this sample were found relatively low. This result could be expected and in line with the literature. Even though, countertransference dreams are not rare phenomena as previously mentioned in the literature (Hill et al., 2014; Lester et al., 1989; Whitman et al., 1969), it can be discussed that their frequency of occurrence is not expected to be common enough to be seen in every night's sleep neither. This result can also be supported with Hill et al.'s (2014) finding with 13 therapists who had kept dream journals for one year. In their study, even though during the year nine of the therapists reported seeing at least one countertransference dream including the manifest appearance of one of their patients, the proportion of countertransference dreams regarding all reported dreams were low in general (Hill et al., 2014).

Furthermore, another possible explanation of the result of comparatively low scores on countertransference dreaming can be linked to the literature about

hesitations of therapists in declaring having countertransference dreams and/or repression of these dreams due to evaluating them problems in competency or therapeutic process (Spangler et al., 2009; Watson, 1994) and/or their intrapsychic processes (Rachmani, 2018; Watson, 1994). Also, with a similar perspective with Zwiebel (1985), it can be suggested that it is not quite easy to distinguish the content of the dreams and identify the patient and/or therapies' effects on the latent content of the dreams. Thus, it can be thought that awareness about the actual frequency of countertransference dreaming can also be comparatively low.

4.2.2. Associations of Countertransference Dreaming Frequency with Background Characteristics

When the possible associations of demographic and professional background characteristics of participant psychotherapists with countertransference dreaming frequency were investigated, only two characteristics were found significantly associated, psychotherapists' theoretical orientations and the time that they spent in their personal therapies. Their gender, age, education and experience levels, work-load indicators, client population that they work with, and theoretical orientations of their personal psychotherapists did not yield significant differences.

In terms of the theoretical viewpoints of the participants, psychotherapists with psychoanalytical orientation reported having significantly more countertransference dreams in comparison to other theoretical approaches such as Cognitive-Behavioral, Existential or Systemic Therapy. One reason for this difference can be thought of as psychoanalytically oriented therapists' focusing on and working more with the dreams compared to other approaches (Crook, & Hill, 2003; Hill et al., 2008; Schredl et al., 2000; Skrzypińska & Szmigielska, 2018). It can be discussed that the more you process dreams in general the occurrence and recall frequency of dreams might increase as a result of this special focus (Schredl et al., 2000). Nevertheless, in their survey with psychotherapists from different approaches, Schredl et al. (2000) could not find any differences between psychoanalysts who focus on dreams significantly more and therapists from other

theoretical orientations in terms of general dream recall frequency. Furthermore, in the further investigations of the present study, in line with the results of Schredl et al. (2000), no differences were found in general dream recall and processing frequency between psychotherapists with psychoanalytic orientation and others. Thus, further investigation and explanations for the specific association between the countertransference dreaming frequency and theoretical orientation are needed.

Another support for the first argument above can be derived from the other significant association of countertransference dreaming frequency. It is found that psychotherapists' duration of their personal therapies was significantly and positively correlated with countertransference dreaming frequency. As known from the literature that going through a psychotherapy process including dreamwork substantially increase the dream recall frequency (Schredl et al., 2000). Thus, this result supports the idea that the more you process dreams the more you will see and/or remember them (Schredl et al., 2000). Another argument for this finding can also be that psychotherapy may increase dream recall via enhancing psychological mindedness (Eudell-Simmon & Hilsenroth, 2005), psychological functioning, and/or access to the unconscious (Myers & Solomon, 1989).

Nevertheless, interestingly, when further investigations were carried out in the current study it was found that there was not a significant correlation between general dream recall and processing frequencies and durations of psychotherapists' personal therapies. This result might be due to not measuring solely the general dreaming frequencies in the present study but also having items about processing dreams in non-clinical settings. It might be the case that therapists who go their own therapies may need less to process dreams on their own or tell them to others apart from their therapists. Nonetheless, regarding the results of the present study, rather than an increase in the dreaming or dream recall in general with an increase in the time spent in personal therapies, a more specific association between countertransference dreaming and the personal therapy process should be discussed.

An important point that can be discussed about the above findings could be that the psychoanalytic therapies' leaning more on the intrapsychic and unconscious

processes might increase the communication with the unconscious via dreams as well as the capacity of both patients and therapists for absorbing, containing, and processing the mental material of their own and others. In the research of Myers and Solomon (1989) patients in psychoanalysis were found to recall and report more dreams compared to patients in psychoanalytic therapy. They consider two main explanations for this result, (1) patients who are suitable for psychoanalysis having more access to the unconscious material at the beginning and (2) treatment methods' further stimulating effect on production and/or remembering of the dreams (Myers & Solomon, 1989). It can be expected that these differences can also be between psychotherapists with psychoanalytic orientation who bear a special focus on the unconscious in their practice as well as in their way of thinking and psychotherapists from other therapy schools. Also, the access to the unconscious might enhance with the duration in the personal psychotherapy as mentioned above (Myers & Solomon, 1989).

Furthermore, the contemporary conceptualization of countertransference dreaming as a way of unconscious communication (e.g., Brown, 2007; Heen-Wolf, 2005; Lester et al., 1989, Rachmani, 2018, Wilner, 1996) can be discussed regarding these results. The contemporary, relational psychoanalytic therapies' special focus on the therapeutic relationship, transference and countertransference; the thinking of mutual interaction and construction; its more flexible and open-ended nature and thinking style; special interest in the unconscious as well as nonverbal behavior (Kassaw & Gabbard, 2002; Shedler, 2006; Shedler, 2010) might pave the way for a more strong unconscious, nonverbal communication between the patient and the therapist and thus, the countertransference dreaming in comparison to other therapeutic approaches.

For the second point that was mentioned above, Bion's view which evaluates dreams as unconscious thinking and working through of emotional material (Schneider, 2010) and the contemporary look on countertransference dreaming as its having a function of therapists' performing Bion's alpha function for the patient via containing and metabolizing the unprocessed, unthinkable emotional material (Brown, 2007; Ferguson, 2020; Heenen-Wolff, 2005;

Rachmani, 2018; Sedlak, 1997) can be considered. As for therapists to perform this function for patients, therapists having a capacity at a certain level to be able to carry out the psychoanalytic process of working through the projected beta elements without unconsciously discarding them can be needed (Sedlak, 1997). Thus, it can be argued that a contemporary psychoanalytic point of view that makes room for an intersubjective field (e.g., Lester et al., 1989; Sánchez-Medina, 2018; Wilner, 1996), and a personal therapy process that can enhance the psychological functioning as mentioned above (Myers & Solomon, 1989) may offer significant advantages for the development and/or utilization of this capacity in psychotherapies. Nevertheless, for all these speculations that were mentioned above further support is needed.

4.2.3. Associations of Countertransference Dreaming with Dream Recall, Dream Processing, Attitudes towards Dreams, and Experienced Difficulties in Psychotherapies

When the correlations among countertransference dreaming frequencies and other study variables were considered, medium-level positive correlations were found with general dream recall and processing and with the level of experienced difficulties while conducting psychotherapy. Also, countertransference dreaming was found weakly but significantly and positively correlated with positive attitudes towards dreams and clinical dream processing.

The positive correlations among countertransference dream frequency, general dream recall and processing frequency, and clinical dream processing were expected as it was not a surprise that therapists who have and/or recall more dreams in general also see more dreams that contain their patients or vice versa. A similar finding was found in the study of Hill et al. (2014) with 13 therapists at the doctorate level that therapists who experienced countertransference dreaming during the year of the study also had more dreams in general according to their dream journals, and their estimations of dream recall frequency were higher compared to the therapists who did not see their patients in their dreams. Also, as mentioned above discussions,

it is plausible that people having more dreams have a more chance to process dreams, and processing dreams may lead to increases in dreaming and/or recalling dreams as well (Schredl et al., 2000).

Furthermore, the positive correlation between positive attitudes towards dreams and countertransference dream recall frequency can be also regarded as in line with the dream literature because similar associations between dream recall frequency in general and positive attitudes regarding dreams were found in the previous studies as well (Schredl et al., 2019a; Schredl et al., 2019b; Schredl & Göritz, 2017). Nevertheless, in their study about countertransference dreaming, Hill et al. (2014) could not find any difference in terms of attitudes towards dreams between the therapists having countertransference dreams and not. The possible reason for this conflicting result can be the low number of participants who may not be diverse enough in the study of Hill et al. (2014) and a ceiling effect might be identified regarding the mean scores of attitudes towards dreams in their study. In contrast, the participants of the present study can be considered as more diverse compared to the study of Hill et al. (2014). Nonetheless, further support is needed for this association.

Finally, the prominent finding of the present study may be the positive association between psychotherapists' experienced difficulties in conducting therapies and their frequency of countertransference dreaming. Regarding the literature about the coincidence of countertransference dreams with conflictual, hard to manage, and difficult periods of therapies and/or patients (e.g., Heenen-Wolf, 2005; Hill et al., 2014; Lester et al., 1989; Spangler et al., 2009; Zwiebel, 1985), a question whether the psychotherapists who experience more difficulties during therapies in general might have more of this kind of dreams was raised. Preliminary support for this assumption was found in the present study with the above-mentioned positive correlation even though causation is not known.

On top of the situational factors that make difficulties in therapies, it can be argued that some psychotherapists may experience more difficulties or may be more sensitive to the hardships of the patients in general. Thus, the mediator in this association can be the anxiety of the psychotherapists. Rather than the

psychotherapists' who reported experiencing more difficulties actually having more difficulties while conducting psychotherapy, their higher anxiety about competency might be the reason for this reported experience. Also, as it was broadly mentioned in the literature review, there are significant views that see the anxiety of the therapist as the cause of the countertransference dreams (Cohen, 1952; Heenen-Wolff, 2005; Lester et al., 1989; Zwiebel, 1985).

In addition, another possible mediator can be that psychotherapists who experience countertransference dreams may have thinner boundaries compared to other psychotherapists (Hill et al., 2014). According to Hartmann and Kunzendorf (2006) and Harrison et al. (2006) having thin or thick boundaries is considered as a part of individuals' personality, and rather than being a dichotomous feature, it is evaluated as a continuum from very thin to very thick, impermeable. In the psychological research about dreams and personality, various aspects of the boundary concept were investigated widely such as boundaries among different states of consciousness, the boundary between sleeping and waking states, or interpersonal boundaries. It is suggested that even though individuals' thickness of boundaries may differ depending on the aspect of the boundary, they were in general compatible with each other. Also, an important finding considering boundaries is that thinness of boundaries was associated with higher dream recall frequency (Harrison et al., 2006; Hartmann & Kunzendorf, 2006).

Furthermore, in terms of the interpersonal boundaries, having thin boundaries is considered as necessary for a successful empathy and sensitivity to others' feelings at a healthier part, and it is also associated with primary defenses and communication styles like introjection and projection at an unhealthier end (Harrison et al., 2006). Thus, Hill et al. (2014) discuss that therapists' seeing their patients in their dreams might be related to having thin boundaries which may lead both recalling more dreams and being more ready to introject patients' distress. Similarly, Cohen (1952) mentioned about some individuals having a tendency of more easily absorbing the anxiety of others. Also, this can be the reason for these psychotherapists experiencing more difficulties in psychotherapies. These possible mediations can be examined in further research. Nonetheless, in general, this study

provided empirical support for the link between countertransference dreaming and experiencing difficulties in psychotherapies.

4.2.4. Factors That Predict Countertransference Dreaming

The significant associations between certain background, study variables and countertransference dreaming frequency that were discussed above raised questions about the unique effects of each on the countertransference dreaming frequency when other variables are controlled and whether they significantly predict the countertransference dreaming or not. Thus, a stepwise regression analysis was conducted to find answers to these questions.

In the regression analysis, psychotherapists experienced difficulties in therapies, having a psychoanalytic perspective, and general dream recall and processing frequencies significantly predicted the countertransference dreaming, and they, in total, accounted for 25% of the variance in the countertransference dreaming. Increases in experienced difficulties and general dream recall and processing led to increases in countertransference dreaming as well. The comparisons of the strength of these factors in predicting countertransference dreaming were in line with the above-reported order, but their strengths were approximate to each other. The discussions about the associations of these significant predictors with countertransference dreaming can be found in the previous sections.

In contrast to findings of preliminary associations, psychotherapists' duration of personal therapies and positive attitudes towards dreams did not enter the equation significantly. Regarding the personal therapy duration, it might be the case that its significance in the preliminary analyses might at some level came from the effect of psychotherapists' theoretical orientation, and thus, this significance might be disappeared when the theoretical orientation variable was controlled in the regression analysis. As further investigations in the current study showed that psychoanalytically oriented psychotherapists' personal therapy durations were significantly more than other psychotherapists. From a similar token, it can be

expected that the significance of positive attitudes towards dreams in the initial analyses might be melted when the theoretical orientation and general dream recall and processing frequency variables were controlled.

All in all, the unique predictor effects of experienced hardships in psychotherapies, psychoanalytical orientation, and the frequency of general dream recall and processing on countertransference dreaming were important findings of the present study that have the potential to provide preliminary empirical supports for the discussions about this specific kind of dreams.

4.3. CLINICAL DREAM PROCESSING

4.3.1. Clinical Dream Processing Frequency

In the present study, clinical dream processing was defined as therapists' working with dreams in clinical settings including their own personal therapies, the therapy processes that they conduct, and professional supervisions. Regarding the descriptive statistics of the component, psychotherapists in the present study reported to clinically process dreams almost at moderate levels. When this frequency is compared with the studies about the extent of utilization of dreams in psychotherapies (Crook & Hill, 2003; Hill et al., 2008; Keller et al., 1995; Schredl et al., 2000), it can be evaluated as slightly more. This can be due to the majority of the present study's sample's having a psychoanalytical orientation (Hill et al., 2008; Schredl et al., 2000) and/or the possible boosting effect of the items that question the frequency of working with dreams in the personal psychotherapies and the supervisions.

4.3.2. Associations of Clinical Dream Processing with Background Characteristics and Study Variables

According to the results of the present study, clinical dream processing was found associated with age, education levels, years of and self-rated experience,

theoretical orientation, client population and number, weekly working hours, their personal therapy processes' orientations and durations, positive attitudes towards dreams as well as general dream recall and processing.

First, in line with the existing literature (Crook, & Hill, 2003; Hill et al., 2008; Schredl et al., 2000; Skrzypińska & Szmigielska, 2018) psychotherapists with psychoanalytical orientation clinically processed dreams more than psychotherapists with other theoretical backgrounds. As for possible explanations about this result, psychoanalytical theories giving more value to the dreams; psychotherapists from other orientations having less training, feeling inadequate and unprepared for utilizing dreams in psychotherapies (Hill & Knox, 2010), and their bias about dreams' falling under the heading of the unconscious (Freeman & White, 2002; Skrzypińska & Szmigielska, 2018) were mentioned in the literature.

As further supports for the above argument, in the current study, age, years of and self-rated professional experience were found positively correlated, and psychotherapists with a degree of expertise were clinically processed dreams more than therapists with lower levels of education. Like the argument for the utilization of dreams by psychoanalytically oriented psychotherapists more than others, these findings may be also related to the confidence and knowledge level of the experienced therapists in working with dreams. A similar finding was found in the study of Lempen and Midgley (2006) with child psychoanalysts that experienced analysts gave more importance to utilize dreams in their therapies, and possible confidence that comes with experience as well as alterations in the analytic technique were discussed regarding this result. Additionally, in Crook and Hill's (2003) survey of 129 therapists, those who had more training about dreams and thus, competence utilized dreams more while working with their patients.

Regarding the working conditions of the participants, significant positive correlations were found with psychotherapists' client number and hours that they spent in conducting psychotherapy. As the questionnaire of the current study asked the frequencies of working with dreams in psychotherapies, it is rational that psychotherapists spending more time in carrying out psychotherapy have an opportunity to work with dreams more. Furthermore, this finding might be related

to the experience levels of the psychotherapists because psychotherapists with more experience might have more clients as well.

Regarding the client population of the participants, it was found that psychotherapists working with adults and/or adolescents utilized dreams more in clinical settings compared to psychotherapists who practice child and/or adolescent psychotherapy. Thus, it can be argued that in general, dreamwork in child psychotherapy might be less compared to adult psychotherapy, and this argument is compatible with the existing literature (Lempen & Midgley, 2006; Spiegel, 1994). Spiegel (1994) explains the possible reason for working with children's dreams infrequently in psychotherapy while telling his way of working with children. He explains his unwillingness of utilizing dreams with children in therapy considering the assumptions that children's dreams, like schizophrenics, being too direct, too close to the surface, and children's not having strong defenses yet to be able to deal with the unconscious material. Also, he claims that children have and/or report dreams more infrequently, and because they can convey their fantasy life or struggles with plays, utilization of dreams is not needed too much (Spiegel, 1994). Furthermore, in the study of Lempen and Midgley (2006) with child analysts in Anna Freud center, most of them reported children's not bringing many dreams to the therapies as well. A lot can be discussed about the dreams of children and the utilization of dreams in child therapy, but this topic exceeds the current paper's aims.

In addition to the above findings, almost at a strong level of positive correlation between clinical dream processing and positive attitudes towards dreams as well as a weak positive association between general dream recall and processing and clinical dream processing were identified in the current study. It is plausible to think that psychotherapists having more positive views about dreams will give importance and utilize dreams more in their practices. A similar finding was also found in the study of Crook and Hill (2003) that therapists' positive attitudes regarding dreams was the unique predictor of the quantity of working with dreams in therapies.

In addition, the positive correlation between general dream recall and processing and clinical dream processing can be thought as compatible with the existing literature. In a former study, Schredl et al. (2000) found that general dream recall was not significantly associated with utilization of dreams in therapies, but personal processing of dreams was. Thus, because of the current questionnaire's containing items about both general dream recall and general dream processing in the same component the correlation in the present study could be affected by the items measuring general dream processing.

Lastly, psychotherapists' clinical dream processing frequencies and the time that they spent in their personal therapies were found strongly positively correlated, therapists who were continuing their therapies or naturally terminated their processes were reported to process dreams clinically significantly more, and psychotherapists having personal therapists who were adhered to psychoanalytical orientation solely had higher clinical dream processing ratings compared to psychotherapists undergoing therapies from other theoretical perspectives.

All these correlations might be affected by the item that questions their frequency of working with the dreams in their personal therapies. Because of this item, the average frequency of clinical dream processing might be higher for psychotherapists who were continuing or naturally terminated their personal therapies as well as therapists whose processes were solely psychoanalytic because it is known that in therapies with psychoanalytical orientation dreams were processed significantly more (Crook, & Hill, 2003; Hill et al., 2008; Schredl et al., 2000; Skrzypińska & Szmigielska, 2018).

Also, there might be the effect of familiarity and training of working with the dreams. Psychotherapists who process their dreams more in their personal therapies may be more interested in or may find easier to utilize dreams in the therapies that they conduct as well. A similar idea also declared in the literature as Altman (1969, as cited in Greenson, 1970) argued that the deficiency in the therapists' personal experiences in analyses of their own dreams in their psychoanalysis led to the decrease in the importance that was given to the utilization of dreams in the therapies that they conducted. Further support is needed with a

questionnaire measuring only the utilization of dreams in conducting psychotherapy like in the study of Hill et al. (2008) to be able to differentiate clinical processing of therapists' own dreams and clinically utilizing dreams while conducting psychotherapy.

4.3.3. Factors That Predict the Extent of Clinical Dream Processing

To be able to identify the unique and comparative impacts of the variables that were found significantly associated with the clinical dream processing and discussed above a stepwise regression analysis was carried out. According to the results of the analysis, professional experience levels, having a psychoanalytical perspective, positive attitudes towards dreams, working solely with adult clients, and general dream recall and processing frequencies were found as unique predictors of clinical dream processing frequency. The predictive powers of these variables were the same with the order of reporting. The possible explanations of and discussions about these factors' associations with clinical dream processing were presented in the previous section.

Contrary to initial analyses of associations, education levels, weekly working hours and variables about psychotherapists' personal therapies did not significantly contribute to the variance in the clinical dream processing. As discussed previously, these variables' significance might be disappeared when the impacts of professional experience and theoretical orientation were controlled. Both the education and professional experience levels' effects on clinical dream processing can be stemmed from training as well as feeling more competent in working with the dreams (Crook & Hill, 2003; Lempen & Midgley, 2006). As again stated formerly, therapists with higher levels of professional experience may also work more in a week. Furthermore, as discussed in the section about countertransference dreaming, psychoanalytically oriented psychotherapists in the current study spent significantly more time in their personal therapies compared to other orientations. At the same time, it can be thought that psychotherapists with a

higher professional experience may be older and thus, spend more time in their personal therapies.

All in all, when the underlying reasons for the impacts of the significant predictor variables on clinical dream processing frequency were examined, several factors such as giving more importance to the dreams, having more training, and feeling more competent in utilizing dreams in psychotherapies come into prominence as in line with the existing literature about the utilization of dreams in psychotherapies (e.g., Crook & Hill, 2003; Hill & Knox, 2010; Lempen & Midgley, 2006), but this analysis gave an assembled and coherent picture about this topic. Nevertheless, the important point to mention is that in this study, clinical dream processing does not solely mean utilization of dreams in psychotherapy but also contains items about therapists' clinically processing dreams in supervisions and their personal therapies. Thus, the results should be evaluated in light of this conceptualization.

4.4. CHARACTERISTICS OF COUNTERTRANSFERENCE DREAMS

4.4.1. Characteristics of and Interpersonal Interactions in the Countertransference Dream

As previously mentioned, the second part of the present study was solely focused on the phenomenon of countertransference dreaming and these dreams' features. 55 countertransference dreams' characteristics were reported and rated by the psychotherapists who had these dreams. In this section, certain characteristics of these dreams and their compatibility with the existing literature will be presented and discussed.

Firstly, the countertransference dreams in the current study were typically recently seen and relatively vivid. These findings supported the result of Spangler et al.'s (2009) qualitative study that was carried out with seven therapists. The possible reason for this result can be that only one dream of the psychotherapists about their clients was asked to be chosen in both studies and thus, therapists'

reporting more salient and recent dreams is rational. However, whether this kind of dream is more notable compared to other dreams because of the presence of a patient should be further investigated via collecting more of this kind of dream and comparing them with other dreams.

Furthermore, more than half of the reported countertransference dreams coincided with the middle of the psychotherapies, and this result is compatible with the study of Hill et al. (2014) in which a total of 19 dreams were collected. It can be argued as a possible reason for this finding that during this period of the psychotherapies, both the conflicts and relationship between the psychotherapist and the client might be more intense. From this perspective, this result can be meaningful regarding the existing literature that links countertransference dreams with conflictual times of therapies (e.g., Cohen, 1952; Heenen-Wolf, 2005; Spangler et al. 2009), intense transference reactions (Lester et al., 1989), and/or with the synchronization, relationship or intersubjectivity among the counterparts of the therapeutic process (e.g., Ferguson, 2020; Lester et al., 1989; Sánchez-Medina, 2018; Wilner, 1996).

In terms of the content of these dreams, in the majority of dreams, both the client and the psychotherapist could be identified in the manifest content according to the evaluations of the dreaming psychotherapists. This exploration is in line with and supports Kron and Avny (2003) about their emphasis on the interpersonal aspect of countertransference dreams due to these dreams' mostly containing both the patient and the therapist in interpersonal interaction. Congruent with the study of Spangler et al. (2009) and contrary to the study of Kron and Avny (2003) the locations in the dreams were outside of the therapy room in more than half of the dreams. In addition to dreams' exceeding the traditional borders of the therapeutic frame by themselves, dreams' settings' not containing therapeutical references may be evaluated additionally as a continuation of the views about countertransference dreams' being a part of an extra-analytic dialogue (Pollack-Gomolin, 2002) and evidence of the continuation of intersubjectivity beyond the classical frame (Rachmani, 2018).

Furthermore, when the social interactions in the dreams were considered, most of the dreams contained friendly interactions as well as boundary violations whereas verbal aggression was found in almost half of the dreams and the presence of psychical aggression and sexual interactions were comparatively less. Also, the average intensities of certain interactions, namely sexual interactions, verbal and physical aggression were low. The possible reason for these low averages is because of these interactions' total absence in most of the reported dreams.

The presence of friendly interactions in most of the dreams was in line with the previous literature about dream contents in general. In the study of Bernstein and Roberts (1995) about general dream contents, friendly interactions were reported substantially more than aggressive and sexual interactions. Also, in the study of Rohde et al. (1992) on the transference dreams of 67 therapists about their own personal therapists, friendly interactions were identified more compared to aggressive and sexual. Nonetheless, in the content analysis of the studies specifically about countertransference dreams (Hill et al., 2014; Kron & Avny, 2003; Spangler et al., 2009), friendly interactions were not mentioned. One of the reasons for these partly conflicting results might be the self-coding technique in the present study. In the questionnaire that was used in the present study, rather than asking to choose one of the interactional patterns and determining the dominant theme, the presence and intensity of each were asked separately. Thus, elements of friendliness in dreams might become more visible with this reporting.

On top of what is discussed above, one of the most commonly reported interpersonal interactions in these dreams was a type of aggression, namely boundary violations. A similar common presence of intrusions of boundaries was also found in the qualitative study of Spangler et al. (2009) and the study of Kron and Avny (2003). As Brown (2007) stated, in essence dreaming about a patient and/or patients entering the dream lives of therapists can be evaluated as a violation of boundary by itself. Also, when these dreams were linked to some extent with the difficult therapeutic processes and/or patients (e.g., Heenen-Wolf, 2005; Hill et al., 2014; Spangler et al., 2009), one of the most common difficulties in therapies, namely violations of boundaries' reflecting to the dreams can be expectable.

Furthermore, in the qualitative investigation of Spangler (2007) some therapists associated these dreams with excessive identification or empathy with the patient. This can also echo in the dreams as transcending of boundaries. Associations between dream content and experiences in the actual therapeutic relationship will be discussed in further sections as well.

4.4.2. Emotions in the Countertransference Dream

In the second part of the study, participants were also asked to report and rate the intensities of certain emotions that they experienced in the specific dream that one of their patients appeared. A total of 13 emotions were presented to the participants to be rated. The more prominent feelings of countertransference dreams regarding the evaluations of participant psychotherapists can be identified as anxiety, surprise, guilt, fear, anger, shame, and sadness. In contrast, happiness, relief, disgust, jealously, contempt, and envy were reported significantly less. Thus, as in line with the existing literature (Hill et al., 2014; Kron and Avny, 2003; Lester et al., 1989), the dominant feelings in the countertransference dreams that were reported in the present study were negatively toned as well.

Even though in the previous empirical studies the existence of shame, fear, and guilt were reported (Hill et al., 2014; Lester et al.,1989, Spangler, 2007), the dominance of feeling anxiety in the dreams in the present study can be considered as an important finding that may provide support for the perspectives that links countertransference dreams with therapists' anxiety (Cohen, 1952; Heenen-Wolf, 2005; Lester et al., 1989; Zwiebel, 1985). In line with the continuity hypothesis of dreaming that claims dreams' mirroring experiences of waking life (Hall and Nodrby, 1972; Schredl, 2003; Schredl, 2010) and also with Freud's (1900/1955) views about dreams' containing day residues, psychotherapist's anxiety about the patient and/or therapeutic process may be showing itself in the dreams as well. Furthermore, the prevalence of violations of boundaries in the content of the dreams that was discussed in the previous section and the intensity of feeling anxious in the dreams might be interrelated.

In addition, surprise' being the second intensely experienced emotion can be mentioned. The possible reason for this emotion might be related to feeling surprised because of patients' appearing in the dreams of psychotherapists like in the study of Hill et al. (2014) as well as in the dream settings apart from the therapy room. Also, the prevalence of negativity in these dreams may be considered due to psychotherapists' processing the hardships of the psychotherapy via these dreams, similar to the arguments of Kron and Avny (2003) and Hill et al. (2014).

4.4.3. Characteristics of the Dreamt About Client

In addition to the characteristics of countertransference dreams, the characteristics of the clients who were seen in the dreams were also investigated with three questions asking the gender, age, and diagnosis/formulation of the client. Even though the dreamt about clients' characteristics is an extensive topic all by itself, in the present study collecting preliminary information about these clients were aimed without a direct focus. According to the results, most clients' genders were declared as female, and their age had a quite range from seven to 60. The dominance of female clients can be thought of as in line with their seeking more psychological assistance and thus, going more to psychotherapy compared to men (Yousaf et al., 2015).

In terms of the reported diagnosis/formulations of the clients, two categories can be identified as more prevalent, namely narcissistic and borderline. Because this was an open-ended question, the answers of the participants differed regarding their conceptualizations. Nevertheless, the answers containing narcissistic or borderline specifications constituted approximately half of the answers. The important characteristics of borderline patients in general according to McWilliams (2011) and those can be associated with the views of countertransference dreaming that were reviewed previously are their having strong and solid transferences (Lester et al., 1989), evoking intense negative countertransference reactions in therapists (Cohen, 1952; Spangler et al., 2009; Zwiebel, 1985), using primitive defense mechanisms like projective identification extensively as a way of

communication (Brown, 2007; Ferguson; 2020; Sánchez-Medina, 2018; Sedlak; 1997; Zwiebel, 1985), and mostly causing conflicts about boundaries in the therapeutic frame (Cohen, 1952).

According to the classification of Kernberg (1975) narcissism at a pathological end resides within the developmental level of borderline organization. Thus, the qualities that were mentioned above and associated with countertransference dreaming theories can also be thought regarding most of narcissistic patients. Also, specifically about narcissistic patients, McWilliams (2011) mentions their intense ego-syntonic idealizations and devaluations of the therapist, projecting part of their selves to the therapists as transference, and their leading extensive countertransference reactions in therapists such as nervousness and boredom. These qualities can also be thought of regarding the aforementioned perspectives about countertransference dreams.

In addition, according to DSM – V (American Psychiatric Association, 2013) classification both borderline and narcissistic personality disorders are grouped under cluster B which were found in the study of Betan et al. (2005) as associated with countertransference reactions of overwhelmed, inadequate, overinvolved as well as sexualized. As discussed many times until this point, there are significant views that link therapists' competency concerns (e.g., Cohen, 1952; Lester et al., 1989; Zwiebel, 1985) and overinvolvement (e.g., Heenen-Wolf, 2005; Spangler et al., 2009) to the countertransference dreams.

All in all, both borderline and narcissistic patients regardless of the way of conceptualization can be considered as compelling for psychotherapists most of the time, which in turn may pave the way for psychotherapists' experiencing countertransference dreams about them regarding the results of the current study and literature about countertransference dreaming (e.g., Heenen-Wolf, 2005; Hill et al., 2014; Spangler et al., 2009).

4.4.4. Countertransference Dream Characteristics and Therapeutic Relationship

To be able to explore the possible links between factors related to the therapeutic relationship and countertransference dreams' characteristics, namely interpersonal interactions in the dreams and experienced feelings in relation to these dreams several correlational analyses were carried out. Due to other interactions' not dispersing in the data, only friendly interactions and boundary violations were included in the analysis in terms of interpersonal interactions. Also, regarding the same issue, several emotions such as jealousy, envy, and relief were not utilized in the analyses as well.

In general, continuity between the awake feelings of psychotherapists as well as the relationship between psychotherapist and client and characteristics of countertransference dreams were observed, compatibly with the continuity hypothesis (Hall and Nodrby, 1972; Schredl, 2003; Schredl, 2010) and Freud's (1900/1955) day residue perspective that were discussed in the former sections. First, when the associations of the therapeutical bond were inspected, positive correlations with friendly interactions, happiness as well as negative correlations with boundary violations, sadness, anxiety, anger, and fear were obtained.

Furthermore, countertransference reactions that were grouped under dislike and insufficiency headings were identified as positively correlated with boundary violations in the dreams. They were also positively correlated with most of the negative emotions and negatively correlated with happiness in the dream. Especially, statistically strong level associations of dislike countertransference with boundary violations and anger as well as of insufficiency countertransference with feeling anxious in the dreams can be evaluated as striking.

Lastly, parenting countertransference was found associated with feeling shame and guilt in the dreams. These self-conscious emotions that can be other based were associated with parenting in the literature in terms of parents' feeling shame and guilt because of their children's wrongdoings due to their sensing to have a joint identity and feeling interdependent with their children (Lickel et al., 2005;

Scarnier et al., 2009). Thus, the associations between parenting countertransference and experiencing shame and guilt in the dreams can be considered compatible with the existing literature.

As a conclusion, these reported associations provide further support for the continuity hypothesis (Hall and Nodrby, 1972; Schredl, 2003; Schredl, 2010) as well as the contemporary understanding of dream interpretation that underlines the significance of manifest content in providing valuable information (e.g., Aron, 1989; Glucksman, 2001; Lane et al., 1995; Rohde et al., 1992; Stolorow, 1978).

4.5. PROCESSING OF THE COUNTERTRANSFERENCE DREAM

As being the last section that the results of the present study were discussed, in this section reports of the participant psychotherapists about how they processed these dreams, what they gained from processing them as well as from which theoretical perspective that they understood these dreams will be presented and discussed.

First, most of the psychotherapists in the present study were stated to work on these dreams in the clinical settings which include their personal therapies, supervisions, and/or therapies that they carry out. These methods of processing were also reported in the previous literature (Degani, 2001; Spangler et al., 2009). Compatibly with the previous research (e.g., Hill et al., 2014; Lester et al., 1989; Myers, 1987), in the current study, except for one participant all therapists were claimed to gain new and/or increased insights mostly about themselves and therapeutic processes at the same time.

In terms of understanding specific dreams that were reported, none of the participants thought that they are meaningless or do not have any function. When the agreements of participants to each statement regarding the reported countertransference dream were examined, almost half of the participants shared the contemporary notion of these dreams' being an aspect of unconscious communication between the counterparts of the therapeutic relationship (e.g., Brown, 2007; Sánchez-Medina, 2018; Wilner, 1996) and the function of these

dreams of resolving and processing the unconscious conflicts as well as unprocessed emotions of the patients (Citivarese, 2006; Ferguson, 2020; Sedlak, 1997).

When the understandings were grouped under two headings as contemporary two-person, relational views and one-person, intrapsychic perspectives the majority of the sample's views were identified as adhering to the relational or mixed perspectives. In contrast, psychotherapists who gave meaning to their specific dream based on the intrapsychic views about dreams, namely wish fulfillment and projection of their own internal worlds solely (Freud, 1900/1955) were in the minority. Lastly, the majority of the participant psychotherapists believed that these dreams were shared products of both the therapist and patient in line with the contemporary relational understanding (e.g., Brown, 2007; Ferguson, 2020; Sánchez-Medina, 2018; Wilner, 1996) while only one-fifth of the psychotherapists saw the dreams as only belonging to themselves.

Nonetheless, the important point that should be considered while evaluating these results is that these collected opinions may not represent the global views of participants regarding countertransference dreams as in the instructions their evaluating these perspectives based on one of their countertransference dreams that they reported was asked. Hence, it might be better to think these understandings regarding the interpretation of the specific dream rather than making inferences about the general point of views of the psychotherapists. As it might be the case that for instance, even though psychotherapists believe countertransference dreams' being a product of two subjectivities of the therapy, the specific dream that was reported might be dominantly related to the dynamics of the therapist with a minimal impact of the patient despite differentiating these aspects cannot be absolute.

4.6. CLINICAL IMPLICATIONS

As widely reviewed in the literature section, utilizations of dreams in psychotherapy offer significant advantages such as understanding the client or

therapeutic relationship better, enhancing insight, and facilitating the involvement of the clients in the processes (Eudell-Simmon & Hilsenroth, 2005; Peasant & Zadra, 2004; Schredl et al., 2000). Also, from a more psychoanalytic perspective, these dreams' providing valuable information about transference and countertransference in the therapeutic process were underlined as well (Blechner, 1995; Glucksman, 2001; Lane, 1997). Thus, there is no doubt about the significance of clinically processing dreams in terms of therapeutic processes. In the present study, further identifying the factors that have an impact on therapists' processing dreams in clinical settings may extend the research about this topic as well as underline once again the importance of it for clinical practices.

In addition, as also extensively put emphasis on the former sections, while there are a wide variety of studies about dreams of patients, literature about the psychotherapists' dreams about patients is limited (Abramovitch & Lange, 1994; Lester et al., 1989, Spangler et al., 2009; Watson, 1994; Zwiebel, 1985). With the present study, preliminary empirical supports were provided regarding the causes, characteristics, understandings, and gains of the countertransference dreams. As previously mentioned in the literature review, regarding the new and/or increased insights that come with the processing of countertransference dreams, these dreams are considered as significant tools that can be utilized in the therapeutic process for gaining a deeper understanding of the patient, therapist, therapy process and thus, guiding psychotherapists in the hard roads of psychotherapy (e.g., Spangler et al., 2009; Rudge, 1998; Zwiebel, 1985). Furthermore, their function of enabling psychotherapists for assisting patients in containing and processing the unthinkable conflicts and emotional material was discussed as well (e.g., Citivarese, 2006; Ferguson, 2020; Sedlak, 1997). Thus, regarding these benefits, the current study' extending the topic provides valuable information, emphasizes again the importance of utilization of these dreams, and further encourages psychotherapists to pay attention to them.

Especially the significant associations of countertransference dream characteristics and psychotherapists' conscious feelings, countertransference reactions towards the dreamt about client can be considered as an important finding

to not dismiss these dreams. As Betan et al. (2005) puts, all therapists regardless of their theoretical background should behold their countertransference and try to understand them regarding the patient and therapeutic relationship because they bear valuable information. From a similar token, as mentioned above exploring the countertransference dreams have significant therapeutic potential as well. Specifically, regarding the significant associations in the present study, psychotherapists can consider thinking through the client whom they dreamt about and the therapeutic process with this client due to these dreams' having a possibility of signaling a difficulty in the therapeutic process.

4.7. LIMITATIONS AND FUTURE DIRECTIONS

The first limitation of the study that can be discussed is regarding the method that was used in collecting information about dreams. The advantages and disadvantages of different methods of measuring dream content and frequency have been already discussed in detail at the beginning of the discussion section. Shortly, the limitations of utilizing retrospective dream questionnaires can be mentioned as their bearing risks of being affected by autobiographical, faulty memory (Schredl, 2002; Zadra & Domhoff, 2011) and by participants' self-concepts (Bernstein & Roberts, 1995) or attitudes (Hill et al., 2008; Hill & Knox, 2010). In addition, by nature, the self-report scales can impact each other.

On the other hand, the effects of these limitations can be thought to be less in the present study because factors such as general dream recall and processing frequency and attitudes towards dreams were controlled during regression analyses. Nevertheless, the results of the present study can be supported by using different dream collecting methods like asking therapists to keep dream journals as well, like in the study of Hill et al. (2014). Also, with this methodology more specific associations between the psychotherapists' dreams about patients and the qualities of specific psychotherapy sessions that coincided with the time of these dreams or the immediate countertransference feelings of psychotherapists can be collected.

In terms of the sample of the study, there was a dominance of female psychotherapists and therapists with a psychoanalytic background. Also, the sample might be biased to some extent because psychotherapists who have more positive attitudes regarding dreams might choose to participate more in the studies about dreams (Crook & Hill, 2003). Thus, in future research, the variety of sample characteristics can be extended to grasp a more generalizable picture.

Furthermore, in the second part of the present study only the information about the characteristics of the specific countertransference dream, the dreamt about client, and the therapy process was collected. Thus, to be able to compare the characteristics of countertransference dreams with other dreams of the participants as well as dreamt about clients with clients who did not enter the dream spaces of psychotherapists, information about other dreams and clients of the psychotherapists are also needed. To be able to grasp the unique qualities of these dreams and clients, future studies can make mentioned comparisons.

Lastly, during the discussions of the results, the possible mediator effects of psychotherapists' anxiety and/or having thin boundaries on the correlation between experienced difficulties in therapies and countertransference dreaming frequency were considered. Hence, in future research, these mediations can be examined to be able to understand the association better.

CONCLUSION

The current study is one of the most inclusive empirical studies that explore the phenomenon of countertransference dreaming. It aimed to broaden the knowledge about countertransference dreams and provide empirical support for the views about countertransference dreams in the previous literature. Also, additional information about psychotherapists' clinical dream processing was aimed to be gathered. Regarding these aims, statistical analyses were carried out to identify factors that uniquely predict countertransference dreaming as well as clinical dream processing. Furthermore, in the second part of the study more specific information about countertransference dreams was collected, reported, and associated with certain therapeutic relationship measures.

Because this was an exploratory study, a great number of findings were found. Nevertheless, several important results of the study can be summarized as psychotherapists' experienced difficulties in therapies, their theoretical orientations, and general dream recall and processing frequencies' uniquely predicting countertransference dreaming frequency and the continuity between the qualities of the actual therapeutic relationship and the interactions as well as emotions in the countertransference dreams. Also, clinical dream processing was found to be significantly predicted by certain professional characteristics of the psychotherapists, attitudes towards dreams, and general dreaming and processing frequencies.

In general, the study provided preliminary empirical information about countertransference dreams and these findings were needed to be further supported as well as this topic was needed to be further explored with extending empirical research.

References

Abramovitch, H., & Lange, T. (1994). Dreaming about my patient: A case illustration of a therapist's initial dream. *Dreaming*, *4*(2), 105. https://doi.org/10.1037/h0094405

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Angel, E. (1979). The resolution of a countertransference through a dream of the analyst. *Psychoanalytic review*, *66*(1), 9-17.

Anzieu, D. (1986). *Freud's self-analysis: Translated from the French by Peter Graham. With a preface by M. Masud R. Khan*. The International Psycho-Analytical Library, 118:1-596. London: The Hogarth Press and the Institute of Psycho-Analysis.

Aron, L. (1989). Dreams, narrative and the psychoanalytic method. *Contemporary Psychoanalysis*, *25*(1), 108-127. https://doi.org/10.1080/00107530.1989.10746284

Aron, L. (1996). *A meeting of minds*. Hillsdale: NJ: The Analytic Press.

Aserinsky, E., & Kleitman, N. (1953). Regularly occurring periods of eye motility, and concomitant phenomena, during sleep. *Science*, *118*(3062), 273-274. Doi: 10.1126/science.118.3062.273.

Atlas, G. (2013). Eat, pray, dream: Contemporary use of dreams in psychoanalysis. *Contemporary Psychoanalysis*, *49*(2), 239-246. https://doi.org/10.1080/00107530.2013.10746550

Beck, A. (2002). Cognitive patterns in dreams and daydreams. *Journal of Cognitive Psychotherapy*, *16*(1), 23-27. doi: 10.1891/jcop.16.1.23.63703 (Original work published in 1971).

Bergmann, M. S. (1966). The intrapsychic and communicative aspects of the dream: Their role in psycho-analysis and psychotherapy. *The International Journal of Psychoanalysis, 47*(2-3), 356-363.

Bernstein, A. E., & Katz, S. C. (1987). When supervisor and therapist dream: the use of an unusual countertransference phenomenon. *Journal of the American Academy of Psychoanalysis, 15*(2), 261-271. https://doi.org/10.1521/jaap.1.1987.15.2.261

Bernstein, D. M., & Belicki, K. (1996). On the psychometric properties of retrospective dream content questionnaires. *Imagination, Cognition and Personality*, *15*(4), 351-364. doi: 10.2190/R1FR-YHF7-EVG9-UDJT

Bernstein, D. M., & Roberts, B. (1995). Assessing dreams through self-report questionnaires: Relations with past research and personality. *Dreaming, 5*(1), 13. doi: 10.1037/h0094420

Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, *162*(5), 890-898. doi: 10.1176/appi.ajp.162.5.890

Bilican, F. I., & Soygüt, G. (2015). Professional development processes of trainee and experienced psychotherapists in Turkey. *Turkish Journal of Psychiatry*, *26*(4). doi: 10.5080/u8024

Bion W. R. (1962). *Learning from experience. In seven servants.* New York: Aronson, 1977.

Blechner, M. J. (1995). The patient's dreams and the countertransference. *Psychoanalytic Dialogues, 5*(1), 1-25. doi: 10.1080/10481889509539047

Brown, L. J. (2007). On dreaming one's patient: Reflections on an aspect of countertransference dreams. *The Psychoanalytic Quarterly*, *76*(3), 835-861. https://doi.org/10.1002/j.2167-4086.2007.tb00281.x

Cartwright, R. D. (1993). Who needs their dreams? The usefulness of dreams in psychotherapy. *Journal of the American Academy of Psychoanalysis, 21*(4), 539-547. doi: 10.1521/jaap.1.1993.21.4.539

Cartwright, R. D., Tipton, L. W., & Wicklund, J. (1980). Focusing on dreams: A preparation program for psychotherapy. *Archives of General Psychiatry, 37*(3), 275-277. doi: 10.1001/archpsyc.1980.01780160045004

Cavdar, A. (2020). Psikodinamik Psikoterapide Duygular ve Belirtisel Değişim: Boylamsal bir Çalışma, *Türk Psikoloji Dergisi*.

Civitarese, G. (2006). Dreams that mirror the session. *The International Journal of Psychoanalysis*, *87*(3), 703-723. doi: 10.1516/CQUL-BUPN-30QQ-XQ88

Cohen, D. B. (1969). Frequency of dream recall estimated by three methods and related to defense preference and anxiety. *Journal of Consulting and Clinical Psychology*, *33*(6), 661. https://doi.org/10.1037/h0028438

Cohen, M. B. (1952). Countertransference and anxiety. *Psychiatry, 15*(3), 231-243. https://doi.org/10.1080/00332747.1952.11022877

Crook, R. E., & Hill, C. E. (2003). Working with dreams in psychotherapy: The therapists' perspective. *Dreaming*, *13*(2), 83-93. doi:10.1023/A:1023350025033

Degani, H. (2001). Therapists' dreams about patients and supervisors. [Doctoral dissertation, California School of Professional Psychology - Berkeley/ Alameda]. *Dissertation Abstracts International, 62*(3-B), 1570.

Domhoff, G. W. (1996). *Emotions, personality, and psychotherapy. Finding meaning in dreams: A quantitative approach*. Plenum Press. https://doi.org/10.1007/978-1-4899-0298-6

Dosamantes-Beaudry, I. (2007). Somatic transference and countertransference in psychoanalytic intersubjective dance/movement therapy. *American Journal of Dance Therapy*, *29*(2), 73-89. doi: 10.1007/s10465-007-9035-6

Doweiko, H. E. (2002). Dreams as an unappreciated therapeutic avenue for cognitive-behavioral therapists. *Journal of Cognitive Psychotherapy, 16*(1), 29. doi: 10.1891/jcop.16.1.29.63700

Eudell-Simmons, E., & Hilsenroth, M. (2005). A review of empirical research supporting four conceptual uses of dreams in psychotherapy. *Clinical Psychology & Psychotherapy*, *12*(4), 255-269. doi: 10.1002/cpp.445

Favero, M., & Ross, D. R. (2002). Complementary dreams: a window to the subconscious processes of countertransference and subjectivity. *American Journal of Psychotherapy, 56*(2), 211-224. doi: 10.1176/appi.psychotherapy.2002.56.2.211

Ferenczi, S. (1913). To whom does one relate one's dreams. *Further Contributions to the Theory and Technique of Psycho-Analysis*, 349.

Ferguson, H. (2020). Dreaming the Field: The Analyst's Dreams as a Co-Creative Act. *Psychoanalytic Inquiry, 40*(4), 243-252. https://doi.org/10.1080/07351690.2020.1742538

Freeman, A., & White, B. (2002). Dreams and the dream image: Using dreams in cognitive therapy. *Journal of Cognitive Psychotherapy, 16*(1), 39. doi: 10.1891/jcop.16.1.39.63706

Freud, S. (1955). *The Interpretation of Dreams* (J.Strachey, Trans.). New York, NY: Basic Books. (Original work published 1900).

Freud, S. (1957). The future prospects of psycho-analytic therapy. *In the Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XI (1910): Five Lectures on Psycho-Analysis, Leonardo da Vinci and Other Works*, 139-152. (Original work published 1910).

Friedman, R. (2000). The interpersonal containment of dreams in group psychotherapy: A contribution to the work with dreams in a group. *Group Analysis, 33*(2), 221-233. doi: 10.1177/0533316400332004

Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology, 57*(8), 983-991. doi: 10.1002/jclp.1065

Gitelson, M. (1952). The emotional position of the analyst in the psycho-analytic situation. *International Journal of Psycho-Analysis, 33*, 1-10.

Glucksman, M. L. (2001). The dream: A psychodynamically informative instrument. *The journal of psychotherapy practice and research, 10*(4), 223.

Greenson, R. R. (1970). The exceptional position of the dream in psychoanalytic practice. *The Psychoanalytic Quarterly*, *39*(4), 519-549. https://doi.org/10.1080/21674086.1970.11926541

Gubb, K. (2014). Craving interpretation: A case of somatic countertransference. *British Journal of Psychotherapy*, *30*(1), 51-67. https://doi.org/10.1111/bjp.12062

Guneri-Minton G (2006) *The Psychotherapeutic relationship among psychotherapists in Turkey and the United States* [Unpublished doctoral dissertation]. The Illinois School of Professional Psychology of Argosy University, Chicago.

Hall, J. A. (1983). *Jungian dream interpretation*. Toronto: Inner City Books.

Hall, C. S., & Nordby, V. J. (1972). *The individual and his dreams*. Signet Book.

Harrison, R. H., Hartmann, E., & Bevis, J. (2006). The Boundary Questionnaire: Its preliminary reliability and validity. *Imagination, Cognition and Personality*, *25*(4), 355-382. https://doi.org/10.2190/8120-6340-T808-7001

Hartmann, E., & Kunzendorf, R. G. (2006). Boundaries and dreams. *Imagination, Cognition and Personality*, *26*(1), 101-115. https://doi.org/10.2190/HK76-038K-407M-8670

Heenen-Wolff, S. (2005). The countertransference dream. *The International Journal of Psychoanalysis*, *86*(6), 1543-1558. doi: 10.1516/fngk-ph5n-lg6l-400t

Heimann, P. (1950). On counter-transference. *The International Journal of Psychoanalysis*. *31*, 81-84.

Hill, C. E. (1996). *Working with dreams in psychotherapy*. New York: Guilford Press.

Hill, C. E., Kelley, F. A., Davis, T. L., Crook, R. E., Maldonado, L. E., Turkson, M. A., Wonnell, T.L., Suthakaran, V., Zack, J.S., Rochlen, A.B., Kolchakian, M.R., & Codrington, J. N. (2001). Predictors of outcome of dream interpretation sessions: Volunteer client characteristics, dream

characteristics, and type of interpretation. *Dreaming, 11*, 53–72. doi:10.1023/A:1009420619940

Hill, C. E., & Knox, S. (2010). The use of dreams in modern psychotherapy. *International review of neurobiology*, 92, 291-317. doi: 10.1016/S0074-7742(10)92013-8

Hill, C. E., Knox, S., Crook-Lyon, R. E., Hess, S. A., Miles, J., Spangler, P. T., & Pudasaini, S. (2014). Dreaming of you: Client and therapist dreams about each other during psychodynamic psychotherapy. *Psychotherapy Research*, *24*(5), 523-537. doi: 10.1080/10503307.2013.867461

Hill, C. E., Liu, J., Spangler, P., Sim, W., & Schottenbauer, M. (2008). Working with dreams in psychotherapy: What do psychoanalytic therapists report that they do?. *Psychoanalytic Psychology*, *25*(4), 565. doi: 10.1037/a0013539

Hill, C. E., & Rochlen, A. B. (2002). The Hill cognitive-experiential model of dream interpretation. *Journal of Cognitive Psychotherapy*, *16*(1), 75-89. doi: 10.1891/jcop.16.1.75.63705

Hill, C. E., Zack, J. S., Wonnell, T. L., Hoffman, M. A., Rochlen, A. B., Goldberg, J. L., Nakayama, E.Y., Heaton, K.J., Kelley, F.A., Eiche, K., Tomlinson, M. J., & Hess, S. (2000). Structured brief therapy with a focus on dreams or loss for clients with troubling dreams and recent loss. *Journal of Counseling Psychology*, *47*(1), 90. doi: 10.1037/0022-0167.47.1.90

Hobson, J. A., & McCarley, R. W. (1977). The brain as a dream state generator: an activation-synthesis hypothesis of the dream process. *The American journal of psychiatry*. doi: 10.1176/ajp.134.12.1335

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223–233. https://doi.org/10.1037/0022-0167.36.2.223

Johnson, B., & Flores Mosri, D. (2016). The Neuropsychoanalytic Approach: Using Neuroscience as the Basic Science of Psychoanalysis. *Frontiers in Psychology, 7*. doi: 10.3389/fpsyg.2016.01459

Jung, C. G. (1974). *Dreams*. Princeton, NJ: Princeton University Press.

Kanzer, M. (1955). The communicative function of the dream. *International Journal of Psycho-Analysis*, *36*, 260-266.

Karcher, J. E. (1999). Countertransference dreams in supervision. [Doctoral dissertation, California School of Professional Psychology – Berkeley/Alameda] *Dissertation Abstracts International, 59*(9-B), 5090.

Kassaw, K., & Gabbard, G. O. (2002). Creating a psychodynamic formulation from a clinical evaluation. *American Journal of Psychiatry, 159*(5), 721-726. doi: 10.1176/appi.ajp.159.5.721

Keller, J. W., Brown, G., Maier, K., Steinfurth, K., Hall, S., & Piotrowski, C. (1995). Use of dreams in therapy: A survey of clinicians in private practice. *Psychological Reports, 76*(3 Pt 2), 1288-1290. doi: 10.2466/pr0.1995.76.3c.1288

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. Rowman & Littlefield.

Kron, T. (1991). The dialogical dimension in therapists' dreams about their patients. *The Israel Journal of Psychiatry and Related Sciences, 28*(2), 1-12.

Kron, T., & Avny, N. (2003). Psychotherapists' dreams about their patients. *Journal of Analytical Psychology, 48*(3), 317-339. https://doi.org/10.1111/1465-5922.t01-3-00003

Lane, R. C. (1997). Dream Controversies. *Psychotherapy in Private Practice, 16*(1), 39-68. doi: 10.1300/j294v16n01_04

Lane, R. C., Daniels, M., & Barber, S. (1995). Configurational approach to manifest dream analysis: Possible acceleration of the patient's communication in psychoanalytic psychotherapy. *Journal of Contemporary Psychotherapy, 25*(4), 331-365. https://doi.org/10.1007/BF02306568

Lempen, O., & Midgley, N. (2006). Exploring the role of children's dreams in psychoanalytic practice today: A pilot study. *The Psychoanalytic study of the child, 61*(1), 228-253. doi: 10.1080/00797308.2006.11800772

Lester, E. P., Jodoin, R. M., & Robertson, B. M. (1989). Countertransference dreams reconsidered: A survey. *International Review of Psycho-Analysis, 16*, 305-314.

Lickel, B., Schmader, T., Curtis, M., Scarnier, M., & Ames, D. R. (2005). Vicarious shame and guilt. *Group Processes & Intergroup Relations, 8*(2), 145-157. https://doi.org/10.1177/1368430205051064

Mancia, M. (2004). The dream between neuroscience and psychoanalysis. *Archives italiennes de biologie, 142*(4), 525-531. doi: 10.4449/AIB.V142I4.423

McWilliams, N. (2011). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process*. Guilford Press.

Myers, W. A. (1987). Chapter 3: Work on Countertransference Facilitated by Self-Analysis of the Analyst's Dreams. In *The Interpretations of Dreams in Clinical Work*, 37-46.

Myers, W. A., & Solomon, M. (1989). Dream frequency in psychoanalysis and psychoanalytic psychotherapy. *Journal of the American Psychoanalytic Association, 37*(3), 715-725. doi: 10.1177/000306518903700306

Ogden, T. H. (1994). The analytical third: working with intersubjective clinical facts. *International Journal of Psycho-Analysis, 75*(1), 3–20.

Ogden, T. H. (2004). This art of psychoanalysis: Dreaming undreamt dreams and interrupted cries. *The International Journal of Psychoanalysis, 85*(4), 857-877. doi: 10.1516/0020757041557575

Ogden, T. H. (2005). On psychoanalytic supervision. *The International Journal of Psychoanalysis, 86*(5), 1265-1280. doi: 10.1516/dcqv-k4t9-8rw7-4ke0

Orlinsky, D., & Rønnestad, M. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. American Psychological Association. doi: 10.1037/11157-000

Pagel, J., Blagrove, M., Levin, R., States, B., Stickgold, B., & White, S. (2001). Definitions of dream: A paradigm for comparing field descriptive specific studies of dream. *Dreaming, 11*(4), 195-202. doi: 10.1023/a:1012240307661

Pesant, N., & Zadra, A. (2004). Working with dreams in therapy: What do we know and what should we do?. *Clinical Psychology Review*, *24*(5), 489-512. doi: 10.1016/j.cpr.2004.05.002

Pollack-Gomolin, R. (2002). The countertransference dream. *Modern Psychoanalysis*, *27*(1), 51-73.

Rachmani, V. (2018). Countertransference dreaming: Life in the intersubjective third. *The American Journal of Psychoanalysis*, *78*(3), 247-266. doi: 10.1057/s11231-018-9146-5

Robertson, B. M., & Yack, M. E. (1993). A candidate dreams of her patient: A report and some observations on the supervisory process. *International Journal of Psycho-analysis, 74*, 993-1003.

Rochlen, A., & Hill, C. (2005). Gender role conflict and the process and outcome of dream work with men. *Dreaming, 15*(4), 227-239. doi: 10.1037/1053-0797.15.4.227

Rohde, A. B., Geller, J. D., & Farber, B. A. (1992). Dreams about the therapist: Mood, interactions, and themes. *Psychotherapy: Theory, Research, Practice, Training*, *29*(4), 536. https://doi.org/10.1037/0033-3204.29.4.536

Rosenbaum, M. (1965). Dreams in which the analyst appears undisguised—a clinical and statistical study. *International Journal of Psycho-Analysis, 46*, 429-437.

Rudge, A. (1998). A Countertransference dream: An instrument to deal with a difficult transference situation. *International Forum of Psychoanalysis*, *7*(2), 105-111. doi: 10.1080/080370698436187

Sabini, M. (1981). Dreams as an aid in determining diagnosis, prognosis, and attitude towards treatment. *Psychotherapy and Psychosomatics, 36*(1), 24-36. doi: 10.1159/000287523

Samsa, A. (2017). *Perceived Impact of Personal Therapy and Clinical Supervision on Clinical Practice: An Exploratory Study* [Unpublished master's dissertation]. Istanbul Bilgi University.

Sánchez-Medina, A. (2018). Projective identification and “telepathic dreams”. *The International Journal Of Psychoanalysis*, *99*(2), 380-390. doi: 10.1080/00207578.2018.1425091

Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psycho-analysis*, *3*(1), 43-47.

Scarnier, M., Schmader, T., & Lickel, B. (2009). Parental shame and guilt: Distinguishing emotional responses to a child's wrongdoings. *Personal Relationships*, *16*(2), 205-220. https://doi.org/10.1111/j.1475-6811.2009.01219.x

Schneider, J. A. (2010). From Freud’s dream-work to Bion’s work of dreaming: The changing conception of dreaming in psychoanalytic theory. *The International Journal of Psychoanalysis*, *91*(3), 521-540. doi: 10.1111/j.1745-8315.2010.00263.x

Schredl, M. (1999). Dream recall: research, clinical implications and future directions. *Sleep and Hypnosis*, *1*(2), 72-81.

Schredl, M. (2002). Questionnaires and diaries as research instruments in dream research: Methodological issues. *Dreaming*, *12*(1), 17.

Schredl, M. (2003). Continuity between waking and dreaming: A proposal for a mathematical model. *Sleep and Hypnosis*, *5*, 38-52.

Schredl, M. (2004). Reliability and stability of a dream recall frequency scale. *Perceptual and motor skills*, *98*(3 Pt 2), 1422-1426. doi: 10.2466/pms.98.3c.1422-1426

Schredl, M. (2008). Laboratory references in dreams: Methodological problem and/or evidence for the continuity hypothesis of dreaming?. *International Journal of Dream Research*, *1*(1). https://doi.org/10.11588/ijodr.2008.1.19

Schredl, M. (2010). Characteristics and contents of dreams. *International review of neurobiology*, 92, 135-154. https://doi.org/10.1016/S0074-7742(10)92007-2

Schredl, M., Berres, S., Klingauf, A., Schellhaas, S., & Göritz, A. S. (2014). The Mannheim Dream questionnaire (MADRE): Retest reliability, age and gender effects. *International Journal of Dream Research, 7*(2), 141–147. https://doi.org/10.11588/ijodr.2014.2.16675

Schredl, M., Bohusch, C., Kahl, J., Mader, A., & Somesan, A. (2000). The use of dreams in psychotherapy: A survey of psychotherapists in private practice. *The Journal of psychotherapy practice and research, 9*(2), 81.

Schredl, M., Braband, M., Gödde, J., Kreicker, S., & Göritz, A. S. (2019a). Dream recall frequency and attitude toward dreams: Stability over a 5-year period. *Dreaming, 29*(4), 303. doi: 10.1037/drm0000116

Schredl, M., Burau, N., Kunkel, R., & Lanzl, J. (2019b). Are Negative Attitudes Toward Dreams Just the Inverse of Positive Attitudes Toward Dreams? An Empirical Investigation. *Imagination, Cognition and Personality, 40*(1), 8-19. doi: 10.1177/0276236619889553

Schredl, M., & Doll, E. (1998). Emotions in diary dreams. *Consciousness and cognition, 7*(4), 634-646. https://doi.org/10.1006/ccog.1998.0356

Schredl, M., & Erlacher, D. (2003). The problem of dream content analysis validity as shown by a bizarreness scale. *Sleep and Hypnosis, 5*, 129-135.

Schredl, M., & Göritz, A. S. (2017). Dream recall frequency, attitude toward dreams, and the Big Five personality factors. *Dreaming, 27*(1), 49. doi: 10.1037/drm0000046

Schwaber, E. A. (1992). Countertransference: The analyst's retreat from the patient's vantage point. *The International Journal of Psycho-analysis, 73*(2), 349-361.

Schwartz, W. (1993). The manifest problem as the psychoanalytic unit in the interpretation of dreams. *International journal of psychosomatics: official publication of the International Psychosomatics Institute, 40*(1-4), 11-3.

Sedlak, V. (1997). The dream space and countertransference. *International journal of psycho-analysis, 78*, 295-305.

Seward, E. (2018). Words, images, dreams and metaphors: The analyst's embodied imagination in the service of therapeutic engagement. *Psychoanalysis, Self and Context*, *13*(1), 29-36. doi: 10.1080/24720038.2018.1388078

Sharpe, E. F. (1938). *Dream analysis: A practical handbook of psychoanalysis.* Routledge.

Shaw, B. (2016). Developments in the Neuroscience of Dreams. *Activitas Nervosa Superior*, *58*(1-2), 45-50. doi: 10.1007/bf03379951

Shedler, J. (2006). That was then, this is now: An introduction to contemporary psychodynamic therapy. *University of Colorado School of Medicine*.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American psychologist*, *65*(2), 98. doi: 10.1037/a0018378

Skrzypińska, D., & Szmigielska, B. (2018). Dreams in cognitive-behavioral therapy. In *Cognitive behavioral therapy and clinical applications, chap. 6*, 97-115. doi: 10.5772/intechopen.70893

Solms, M. L. (2018). The neurobiological underpinnings of psychoanalytic theory and therapy. *Frontiers in Behavioral Neuroscience*, *12*, 294. doi: 10.3389/fnbeh.2018.00294

Soygüt, G., & Işıklı, S. (2008). Terapötik ittifakın değerlendirilmesi: Terapötik İttifak Ölçeği'nin güvenilirlik ve geçerlik çalışması. *Turk Psikiyatri Dergisi*, *19*(4).

Spangler, P. (2007). *Therapist Dreams about Clients: A Qualitative Investigation of Themes, Exploration, and Use* [Doctoral dissertation]. University of Maryland, College Park.

Spangler, P., Hill, C. E., Mettus, C., Guo, A. H., & Heymsfield, L. (2009). Therapist perspectives on their dreams about clients: A qualitative investigation. *Psychotherapy Research*, *19*(1), 81-95. https://doi.org/10.1080/10503300802430665

Spero, M. (1984). A psychotherapist's reflections on a countertransference dream. *The American Journal of Psychoanalysis*, *44*(2), 191-196. doi: 10.1007/bf01248298

Spiegel, S. (1994). An alternative to dream interpretation with children. *Contemporary psychoanalysis*, *30*(2), 384-395. https://doi.org/10.1080/00107530.1994.10746859

Stolorow, R. D. (1978). Themes in dreams: A brief contribution to therapeutic technique. *International Journal of Psycho-Analysis*, *59*, 473-475.

Watson Jr, R. I. (1994). The clinical use of the analyst's dreams of the patient. *Contemporary psychoanalysis*, *30*(3), 510-521

Whitman, R. M. (1963). Remembering and forgetting dreams in psychoanalysis. *Journal of the American Psychoanalytic Association*, *11*(4), 752-774. doi: 10.1177/000306516301100404

Whitman, R. M., Kramer, M., & Baldridge, B. J. (1963). Which dream does the patient tell?. *Archives of General Psychiatry*, *8*(3), 277-282. doi: 10.1001/archpsyc.1963.01720090065007

Whitman, R. M., Kramer, M., & Baldridge, B. J. (1969). Dreams about the patient: An approach to the problem of countertransference. *Journal of the American Psychoanalytic Association*, *17*(3), 702-727. doi: 10.1177/000306516901700302

Wilner, W. (1996). Dreams and the holistic nature of interpersonal psychoanalytic experience. *Psychoanalytic Dialogues*, *6*(6), 813-829. https://doi.org/10.1080/10481889609539154

Yousaf, O., Popat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men & Masculinity*, *16*(2), 234. https://doi.org/10.1037/a0036241

Zachrisson, A. (2009). Countertransference and changes in the conception of the psychoanalytic relationship. *International Forum of Psychoanalysis*, *18*(3), 177-188. doi:10.1080/08037060902727761

Zadra, A., & Domhoff, G. W. (2011). Dream content: Quantitative findings. *Principles and practice of sleep medicine*, *5*, 585-94. doi: 10.1016/B978-1-4160-6645-3.00050-5

Zwiebel, R. (1985). The dynamics of the countertransference dream. *International review of psycho-analysis*, *12*, 87-99.

APPENDICES

Appendix A: Demographic Information and Professional Background Form

1. Mesleki Durum (Size uygun olan birden fazla seçeneği işaretleyebilirsiniz).

1. Psikolog 2. Psikoterapist 3. Psikolojik Danışman
4. Psikanalist 5.Psikiyatrist

2. Eğitim Durumu:

1. Lisans mezunu 2. Yüksek lisans öğrencisi 3. Yüksek lisans mezunu
4. Doktora öğrencisi 5. Doktora mezunu

3. Cinsiyetiniz: ( ) Kadın ( ) Erkek ( ) Diğer ( ) Belirtmek istemiyorum

4. Lütfen yaşınızı belirtiniz: _____

5. Şu anda aktif olarak danışan görüyor musunuz? ( ) Evet ( ) Hayır

6. Ne kadar süredir psikoterapi uyguluyorsunuz? _____

7. Haftada kaç saat terapi uyguluyorsunuz? _____

8. Aktif olarak terapi sürecini sürdürdüğünüz kaç danışanınız bulunmaktadır? ___

9. Şu sıralar deneyimlediğiniz mesleki iş yükünü en iyi tanımlayan seçeneği lütfen işaretleyiniz.

Çok az Oldukça fazla

1 2 3 4 5

10. Şu anda sürdürdüğünüz terapi çalışmalarınız aşağıdaki teorik görüşlerin hangisinden etkileniyor? (Size uygun birden fazla seçeneği işaretleyebilirsiniz).

1. Psikodinamik/Psikanalitik
2. Bilişsel – Davranışçı
3. Hümanistik/ Varoluşçu
4. Sistemik
5. Diğer (Lütfen belirtiniz): _____

11. Şu anda sürdürdüğünüz terapi çalışmalarında hangi popülasyonla çalışmaktasınız? (Size uygun birden fazla seçeneği işaretleyebilirsiniz)

1. Çocuk
2. Ergen
3. Yetişkin
4. Çift ve aileler

12. Mesleki deneyim düzeyinizi en iyi tanımlayan seçeneği lütfen işaretleyiniz:

Çok Deneyimsiz Oldukça deneyimli

1 2 3 4 5

13. Kişisel terapi, analiz ya da danışmanlık hizmeti aldınız mı ve/veya şu an alıyor musunuz?

1. Hiç almadım.
2. Şu an sürecime devam ediyorum.
3. Aldım, süreci yarıda bıraktım.
4. Aldım, sürecim bitti.

14. Şu ana kadar bulunduğunuz terapi süreci/süreçlerinin toplam süresi ne kadardır? _____

15. Bireysel terapi sürecinizin yönelimi aşağıdaki teorik görüşlerden hangisidir? (Size uygun olan birden fazla seçeneği işaretleyebilirsiniz. Hiç terapi hizmeti almadıysanız bu soruyu boş bırakabilirsiniz.)

1. Psikodinamik/Psikanalitik
2. Bilişsel – Davranışçı
3. Hümanistik/ Varoluşçu
4. Sistemik
5. Diğer (Lütfen belirtiniz): _____

Appendix B: Therapists' Experienced Difficulties Questionnaire

Danışanlarınızla yürüttüğünüz terapi süreçlerinde bir terapist olarak aşağıdaki duyguları ne sıklıkla hissediyorsunuz? Lütfen 1 ile 5 arasında bir sayı vererek değerlendirin. (1: Asla 2: Çok seyrek 3: Bazen 4: Sık 5: Çok Sık).

		Asla	Çok seyrek	Bazen	Sık	Çok Sık
1	Danışana yararlı olmak konusunda kendine güven duymamak	(1)	(2)	(3)	(4)	(5)
2	Danışanın tedavisinde yarardan çok zarar verdiğinden korkmak	(1)	(2)	(3)	(4)	(5)
3	Bir danışana yardım etmede en iyi yolun ne olduğu konusunda emin olmamak	(1)	(2)	(3)	(4)	(5)
4	Terapi üzerindeki kontrolü danışana bırakma tehlikesi	(1)	(2)	(3)	(4)	(5)
5	Danışanın deneyimleriyle gerçek bir empati kurmakta zorlanmak	(1)	(2)	(3)	(4)	(5)
6	Kişisel değerlerinizin danışana karşı uygun bir tavır takınmanızda engel oluşturmasından dolayı huzursuzluk duymak	(1)	(2)	(3)	(4)	(5)
7	Danışanın trajik yaşam şartlarını değiştirme konusunda güçsüzlüğünüze üzülmek	(1)	(2)	(3)	(4)	(5)
8	Bir danışanla çalışmanız sırasında ortaya çıkan etik meselelere sıkılmak	(1)	(2)	(3)	(4)	(5)

9	Bir danışan ile olan terapiyi yapıcı bir yola yönlendirecek ivmeyi kazandırmakta zorlanmak	(1)	(2)	(3)	(4)	(5)
10	Sizin çabalarınızı bilfiil engelleyen danışandan rahatsızlık duymak	(1)	(2)	(3)	(4)	(5)
11	Bir danışana yardım etmek için yol bulmakta zorlandığınızdan moral bozukluğu yaşamak	(1)	(2)	(3)	(4)	(5)
12	Danışanın sorunlarını derinlemesine anlamakta zorlanmak	(1)	(2)	(3)	(4)	(5)
13	Danışanın duygusal açlığına dayanamamak	(1)	(2)	(3)	(4)	(5)
14	Bir danışanda hoşlanacak ya da saygı duyulacak bir yan bulmakta zorlanmak	(1)	(2)	(3)	(4)	(5)
15	Danışanın yarar görmesini engelleyen yaşam şartlarına karşı kızgınlık duymak	(1)	(2)	(3)	(4)	(5)
16	Bir danışana olan sorumluluklarla diğerlerine olan benzer sorumluluklar arasında bir denge kurmakta zorlanmak	(1)	(2)	(3)	(4)	(5)
17	Bir danışan ile geleceği olmayan bir ilişkiye saplanmak	(1)	(2)	(3)	(4)	(5)
18	Danışana zamanınızı harcadığı için kızmak	(1)	(2)	(3)	(4)	(5)

Appendix C: Attitudes Towards Dreams Scale

Aşağıda rüyalarla ilgili düşünce ve tutumlara dair ifadeler yer almaktadır. Lütfen her ifadeyi okuyun ve her bir maddeye ne kadar katıldığınızı 0 ile 4 arasında bir sayı vererek değerlendirin. (0: Hiç, 1: Pek değil, 2: Kısmen, 3: Oldukça, 4: Tamamen)

		Hiç	Pek değil	Kısmen	Oldukça	Tamamen
1	Rüyalara olan ilginiz ne kadar güçlüdür?	(0)	(1)	(2)	(3)	(4)
2	Rüyaların anlamlı olduğunu düşünüyorum.	(0)	(1)	(2)	(3)	(4)
3	Rüyalar hakkında daha çok şey bilmek istiyorum.	(0)	(1)	(2)	(3)	(4)
4	Eğer biri rüyalarını hatırlayabilir ve yorumlayabilirse hayatı zenginleşir.	(0)	(1)	(2)	(3)	(4)
5	Rüya görmenin genel olarak çok ilginç bir olgu olduğunu düşünüyorum.	(0)	(1)	(2)	(3)	(4)
6	Rüyaları üzerine düşünen kişi, kesinlikle kendisi hakkında daha çok şey öğrenebilir.	(0)	(1)	(2)	(3)	(4)
7	Rüyalar hakkında konuşmayı severim.	(0)	(1)	(2)	(3)	(4)
8	Kişinin rüyalarını hatırlamaması daha iyidir.	(0)	(1)	(2)	(3)	(4)
9	Rüyaları eğlendirici bulurum.	(0)	(1)	(2)	(3)	(4)
10	Rüyalar anlamsızdır.	(0)	(1)	(2)	(3)	(4)
11	Rüyalar benim için sıkıcıdır.	(0)	(1)	(2)	(3)	(4)

12	Rüyalar hakkında düşünmek zaman kaybıdır.	(0)	(1)	(2)	(3)	(4)
13	Rüyaları hatırlamak faydalıdır.	(0)	(1)	(2)	(3)	(4)
14	Rüyaların yorumlanması anlamsızdır.	(0)	(1)	(2)	(3)	(4)
15	Rüyaların uyanık hayat üzerinde olumlu bir etkisi vardır.	(0)	(1)	(2)	(3)	(4)
16	Rüyaların dilekleri açığa çıkardığına inanıyorum.	(0)	(1)	(2)	(3)	(4)
17	Rüyalar uykuda gereksiz yere devam eden düşünmedir.	(0)	(1)	(2)	(3)	(4)
18	Rüyalar problemleri çözmeye yardım edebilir.	(0)	(1)	(2)	(3)	(4)
19	Her kim rüyaları hakkında başkalarıyla konuşursa kendini daha iyi tanır.	(0)	(1)	(2)	(3)	(4)
20	Rüyaların günü işlemeye yardım ettiğine inanıyorum.	(0)	(1)	(2)	(3)	(4)
21	Rüyalar önemli mesajlar içerebilir.	(0)	(1)	(2)	(3)	(4)
22	Rüyalar beynin fuzuli bir ürünüdür.	(0)	(1)	(2)	(3)	(4)

Appendix D: Dream Recall and Processing Frequency Scale

Rüya Hatırlama ve İşleme Sıklığı Ölçeği:

Aşağıda çeşitli rüya görme/hatırlama ve rüyaları çalışma sıklıklarınızı soran ifadeler bulunmaktadır. Lütfen her bir maddeyi ne sıklıkta deneyimlemiş olduğunuzu en iyi tanımlayan seçeneği işaretleyiniz. (Hiç süpervizyon almadıysanız veya terapiye gitmediyseniz lütfen ilgili soruları boş bırakınız.) (0: Hiç, 3: Bazen, 6: Çok sık)

		Hiç			Bazen			Çok sık
1	Rüyanın içeriğini hatırlayıp hatırlamadığınıza bakmaksızın, genel olarak ne sıklıkta rüya görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
2	Ne sıklıkta gördüğünüz rüyaları uyandığınızda hatırlarsınız?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
3	Ne sıklıkta kendi kendinize rüyalarınızı anlamlandırmaya çalışırsınız?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
4	Bireysel terapi sürecinizde, gördüğünüz rüyaları ne sıklıkta çalışırsınız/çalışırdınız?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
5	Rüyalarınızı ne sıklıkta terapistiniz dışında başkalarına anlatırsınız?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
6	Ne sıklıkta arkadaşça etkileşimlerin olduğu rüyalar görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)

7	Ne sıklıkta saldırgan/agresif etkileşimlerin olduğu rüyalar görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
8	Ne sıklıkta cinsel etkileşimlerin olduğu rüyalar görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
9	Ne sıklıkta kâbus görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
10	Danışanlarınızı ne sıklıkta oldukları gibi (şu andaki görünümlerinde / kendileri olarak) rüyanızda görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
11	Rüyalarınızda ne sıklıkta doğrudan danışanlarınız gibi görünmeseler de danışanlarınızı temsil ettiğini düşündüğünüz imgeler görürsünüz?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
12	Seanslarınızda yaşadığınız olumlu duygu ve deneyimler ne sıklıkta rüyalarınıza yansır?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
13	Seanslarınızda yaşadığınız olumsuz duygu ve deneyimler ne sıklıkta rüyalarınıza yansır?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
14	Danışanlarınız yürüttüğünüz terapilerde ne sıklıkta rüyalarını anlatırlar?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
15	Danışanlarınız ne sıklıkta sizi gördükleri rüyalardan bahsederler?	(0)	(1)	(2)	(3)	(4)	(5)	(6)
16	Sürdürdüğünüz terapilerde danışanlarınızın rüyalarını ne sıklıkta çalışırsınız?	(0)	(1)	(2)	(3)	(4)	(5)	(6)

17	Aldığınız süpervizyonlarda danışanlarınızın ve/veya sizin rüyalarınızı ne sıklıkla çalışırsınız/çalışırdınız?	(0)	(1)	(2)	(3)	(4)	(5)	(6)

Appendix E: Questions about Specific Dream Characteristics and Processing

Çalışmanın bundan sonraki aşaması danışanlarını rüyasında gören ve bunlardan en az birini hatırlayan katılımcılarla devam edecektir. Eğer danışanınızı gördüğünüz en az bir rüyayı hatırlıyorsanız lütfen sonraki aşamalara devam edin. Görmediyseniz ve/veya hatırlamıyorsanız çalışmayı burada sonlandırabilirsiniz, katılımınız için teşekkür ederiz.

1. Danışanlarımı rüyamda hiç görmedim/hatırlamıyorum.
2. Danışanımı gördüğüm en az bir rüyayı hatırlıyorum.

Bu aşamadan sonra sizden danışanınızı gördüğünüz ilk aklınıza gelen rüyayla ilgili birtakım soruları yanıtlamanız istenmektedir. Lütfen aşağıdaki soruları şu anda aklınızdan geçmiş olan tek bir rüyayı düşünerek cevaplandırın:

1. Bu rüyayı ne zaman gördünüz? Tam olarak hatırlamıyorsanız lütfen en yakın gelen seçeneği işaretleyin.
    1. Bu hafta içinde
    2. Bu ay içinde
    3. Geçtiğimiz birkaç ay içinde
    4. Bu yıl içinde
    5. Geçtiğimiz birkaç yıl içinde
    6. Daha eski

2. Bu rüyayı danışanınızla terapi sürecinizin hangi aşamasında gördünüz?
    1. Başlangıç seansları sırasında
    2. Sürecin ortalarında
    3. Süreci bitirme seanslarında
    4. Süreç bittikten sonra

3. Bu rüyayı ne kadar canlı hatırlıyorsunuz?

İmgeler çok silik, belirsiz İmgeler çok canlı, net

1	2	3	4	5	6	7	8	9

4. Bu rüyanın görünen içeriğinde hangi karakterler açık olarak bulunmaktadır?
    1. Sadece danışan
    2. Danışan ve terapist
    3. Danışan ve başka kişiler
    4. Danışan, terapist ve başka kişiler
    5. Diğer _____
    6. Hatırlamıyorum / belirsiz

5. Bu rüya hangi mekân/mekanlarda geçmektedir?
    1. Terapi odası
    2. Terapi odasının dışı
    3. İkisi birden
    4. Diğer _____
    5. Hatırlamıyorum / belirsiz

6. Bu rüyada kişilerarası etkileşimler yer alıyorsa öznel değerlendirmenize göre bu etkileşimlerin yoğunluğunu 0 ile 4 arasında bir rakam vererek lütfen derecelendiriniz.

		Hiç	Oldukça Az	Biraz	Çok	Oldukça Çok
Arkadaşça etkileşimler		(0)	(1)	(2)	(3)	(4)
Saldırgan etkileşimler	Sınır Aşımları	(0)	(1)	(2)	(3)	(4)
	Sözlü Saldırılar	(0)	(1)	(2)	(3)	(4)
	Fiziksel Saldırılar	(0)	(1)	(2)	(3)	(4)
Cinsel etkileşimler		(0)	(1)	(2)	(3)	(4)
Diğer (Varsa Belirtiniz)		(0)	(1)	(2)	(3)	(4)

7. Bu rüyanın sizde uyandırdığı duyguları lütfen değerlendiriniz. (1: Hiç hissetmedim; 7: Çok hissettim)

	Hiç						Çok
Mutluluk	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Üzüntü	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Rahatlama	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Utanç	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Endişe	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Suçluluk	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Öfke	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Şaşkınlık	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Korku	(1)	(2)	(3)	(4)	(5)	(6)	(7)
İğrenme	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Kıskançlık	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Küçümseme	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Haset	(1)	(2)	(3)	(4)	(5)	(6)	(7)

8. Gördüğünüz bu rüyayı anlamlandırmak için hangi yöntemleri kullandınız? (Birden fazla seçenek işaretleyebilirsiniz.)
    1. Süpervizörümle paylaştım.
    2. Terapistimle paylaştım.
    3. Meslektaşlarımla paylaştım.
    4. Meslek dışı yakınlarımla paylaştım.
    5. Rüyamda gördüğüm danışanla paylaştım.
    6. Tek başıma üzerinde düşündüm.
    7. Anlamlandırmaya çalışmadım.
    8. Diğer (Lütfen belirtiniz) …….

9. Gördüğünüz bu rüyanın size kazanımları neler oldu? (Birden fazla seçenek işaretleyebilirsiniz)

1. Tamamen yeni iç görüler kazandım.
    1. Danışanım hakkında
    2. Kendim hakkında
    3. Danışana yönelik duygu ve düşüncelerim hakkında
    4. Terapi süreci hakkında
2. Var olan iç görülerim derinleşti/arttı.
    1. Danışanım hakkında
    2. Kendim hakkında
    3. Danışana yönelik duygu ve düşüncelerim hakkında
    4. Terapi süreci hakkında
3. Diğer (Lütfen belirtiniz) ……..
4. Hiçbir kazanımım olmadı.

10. Sizce neden bu rüyayı gördünüz? (Birden fazla seçenek işaretleyebilirsiniz.)
    1. Danışanımla bilinçdışı iletişimimizin bir parçasıydı.
    2. Danışanıma karşı hissettiğim yoğun duyguların boşaltımını sağlayan iyileştirici bir rüyaydı.
    3. Bilinçaltı arzularımı doyurucu bir niteliği vardı.
    4. Danışanımla ilgili bilinçaltımdaki çatışmaların çalışılmasını/çözümlenmesini sağladı.
    5. Danışanımdan bağımsız kendi iç çatışmalarımın yansımasıydı.
    6. Özel bir anlamı ve işlevi yoktu.
    7. Diğer (Lütfen belirtiniz) ……

11. Sizce bu rüya kime aitti?
    1. Sadece danışanımın iç dünyasının ve/veya çatışmalarının bir yansımasıydı.
    2. Sadece benim iç dünyamın ve/veya çatışmalarımın bir yansımasıydı.
    3. Hem danışanımın hem de benim iç dünyalarımızın ortak bir ürünüydü.
    4. Rüyaların bir anlamı olmadığı için hiç kimseye ait değildi.

Appendix F: Questions about the Dreamt about Client

Aşağıda bu rüyanızda gördüğünüz danışanınızla ilgili kimliğini açığa çıkarmayacak ve gizliliğini ihlal etmeyecek birkaç soru bulunmaktadır. Rahat hissediyorsanız yanıtlamanızı rica ederiz.

1. Danışanınızın cinsiyeti: (K) (E) (Diğer) (Belirtmek istemiyorum)

2. Lütfen danışanınızı gördüğünüz rüyanın zamanında danışanınızın kaç yaşında olduğunu belirtiniz (Emin değilseniz yaklaşık bir rakam verebilirsiniz) …… (Belirtmek istemiyorum)

3. Paylaşmak isterseniz danışanın tanısı/kişilik örgütlenmesi sizce nedir? ……..

Appendix G: Working Alliance Inventory Therapist Form (WAI-TF) Affective Bonding Subscale

Aşağıda terapi ilişkisi ile ilgili ifadeler bulunmaktadır. Aşağıdaki her cümleyi okuduktan sonra rüyanızda gördüğünüz danışanınızla ilgili sürecinizi düşünerek her bir maddeyi ne sıklıkla yaşadığınızı 0 ile 6 arasında bir rakam vererek değerlendiriniz. (0: Hiçbir zaman, 6: Her zaman)

		Hiçbir zaman			Bazen			Her zaman
1	Danışanımla kendimi rahat hissetmiyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
2	Danışanımı anladığımı düşünüyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
3	Danışanımın bana yakın hissettiğine inanıyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
4	Danışanımın iyiliğini gerçekten düşünüyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
5	Danışanım ve ben birbirimize saygı duyuyoruz.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
6	Danışanıma gösterdiğim duygularımda tam olarak dürüst olmadığımı hissediyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
7	Danışanıma yardım edebileceğime inanıyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)

8	Danışanımı takdir ediyorum.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
9	Danışanım ve ben birbirimize güveniyoruz.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
10	İlişkimiz danışanım için çok önemli.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
11	Danışanımın, eğer yanlış şeyler söyler ya da yaparsa, benim terapiye devam etmeyeceğime dair korkuları var.	(0)	(1)	(2)	(3)	(4)	(5)	(6)
12	Onaylamadığım şeyler yapsa da danışanıma olan saygım devam eder.	(0)	(1)	(2)	(3)	(4)	(5)	(6)

Appendix H: Countertransference Questionnaire Short Form (CTQ-SF)

Son olarak, aşağıda danışanlarınızla terapi sürecinde hissedebileceğiniz duygu, düşünce ve tutumlara dair ifadeler bulunmaktadır. Lütfen her ifadeyi okuyun ve bu rüyanızda gördüğünüz danışanınızla terapi süreçlerinizde her bir maddeyi **ne sıklıkta deneyimlediğinizi** en iyi tanımlayan seçeneği işaretleyin. (0: Hiç 1: Nadiren 2: Bazen 3: Sıklıkla 4: Çok Sık)

		Hiç	Nadiren	Bazen	Sıklıkla	Çok Sık
1	Seanslarda kopmuş, sıkılmış, içine dönmüş ve/veya angaje olamamış hissediyorum.	(1)	(2)	(3)	(4)	(5)
2	Ona yardım etmek konusunda çaresiz ve/veya ümitsiz hissediyorum.	(1)	(2)	(3)	(4)	(5)
3	Terapisti olarak kendimi eksik ve/veya yetersiz hissediyorum.	(1)	(2)	(3)	(4)	(5)
4	Seanslarda ona sinir oluyorum ve/veya öfkeleniyorum.	(1)	(2)	(3)	(4)	(5)
5	Onun beni kullandığını, takdir etmediğini ve/veya küçümsediğini hissediyorum.	(1)	(2)	(3)	(4)	(5)
6	Onun ihtiyaçlarının beni aştığını ve/veya boğduğunu hissediyorum.	(1)	(2)	(3)	(4)	(5)
7	Terapisti olarak korkmuş ve dağılmış hissediyorum.	(1)	(2)	(3)	(4)	(5)
8	Onun ebeveyniymiş gibi hissediyorum; ona bakım vermek ve onu beslemek istiyorum.	(1)	(2)	(3)	(4)	(5)
9	Onu korumak istiyorum; onu kıran, üzen kişilere öfke duyuyorum.	(1)	(2)	(3)	(4)	(5)

10	Onu sevdiğimi, iyi bir ilişkimiz olduğunu hissediyorum.	(1)	(2)	(3)	(4)	(5)
11	Seanslardan sonra terapist olarak kendimden hoşnut ve terapötik kazanımlardan memnun oluyorum.	(1)	(2)	(3)	(4)	(5)
12	Ona karşı cinsel hisler duyuyorum ve/veya aramızda cinsel bir gerilim hissediyorum.	(1)	(2)	(3)	(4)	(5)
13	Onunlayken kendimi açtığım, seansları bitirmekte zorluk çektiğim, fazladan çaba gösterdiğim oluyor.	(1)	(2)	(3)	(4)	(5)
14	Onun diğer danışanlarıma kıyasla benim için daha özel olduğunu düşünüyorum.	(1)	(2)	(3)	(4)	(5)

Appendix I: Informed Consent Form

Sayın Katılımcı,

Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı bünyesinde Dr. Öğr. Üyesi Alev Çavdar Sideris danışmanlığında, Sezgi Ermergen tarafından bir tez çalışması kapsamında yürütülmektedir. Bu çalışmanın amacı, terapistlerin danışanlarını gördükleri rüyalar başta olmak üzere rüya görme deneyimlerini ve rüyaların yürütülen terapi süreçleriyle ilişkisini araştırmaktır. Bu amaç doğrultusunda, katılımcılara rüyalar ve terapi süreçleri ile ilgili duygu, tutum ve görüşleriyle ilgili birtakım sorular sorulacaktır. Anket birbirini izleyen iki kısımdan oluşmaktadır. Anketin ilk kısmına rüya görmüyor/hatırlamıyor olsanız dahi katılabilirsiniz.

Bu araştırmaya katılım tamamen gönüllülük esasına dayalıdır. Çalışmanın amacına ulaşması için sizden ricamız, rahat hissettiğiniz sürece, bütün sorulara eksiksiz ve içtenlikle cevap vermenizdir.

Anketin her bir kısmını tamamlamanız yaklaşık 15 dakika, iki kısmın tamamlanması yaklaşık 30 dakika sürmektedir. Araştırmanın herhangi bir noktasında **hiçbir gerekçe belirtmeden** çalışmaya katılmaktan vazgeçebilirsiniz. Bu durumda verileriniz kaydedilmeyecek ve/veya kapsam dışında bırakılacaktır.

Araştırmanın hiçbir aşamasında kimlik bilgileriniz sorulmayacak ve verdiğiniz yanıtlar araştırmacılar dışında üçüncü kişilerle paylaşılmayacaktır. Yanıtlar toplu halde değerlendirilecek ve sadece bilimsel araştırma/yayın amacıyla kullanılacaktır.

Çalışmaya bulunduğunuz değerli katkılar için teşekkür ederiz.

☐ Yukarıda verilen bilgiler doğrultusunda bu çalışmaya katılmayı kabul ediyorum.

ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.