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End-of-life dreams and visions and meaning-making in rural India

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DECLARATION

I do hereby affirm that I am the sole author of this dissertation on End-of-life dreams and visions and meaning-making in rural India. The contents in the dissertation are the result of the research that I have done on the topic. The research for the degree of Doctor in Philosophy is thus presented to the Faculty of Psychology Programme at Selinus University is my original work. The material, articles and data referred in the dissertation have been cited in the thesis.

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Abstract

End-of-life dreams and visions (ELDVs) are psychological phenomenon, well documented throughout history and across cultures that manifest while asleep (dreams) or awake(visions), and typically feature deceased family and friends in the months to hours before death. However, they have only recently been subjected to scientific inquiry. This study uniquely examined patient dreams and visions from their personal perspective and reports the qualitative findings from dreams and visions of 12 terminally ill patients. This was the first study of its kind to explore ELDVs in rural communities in India and how meaning making could help, focussing on local religious, cultural and social factors to allay the fear, anxiety and confusion associated with ELDVs. The author believes that such phenomenon could point to the existence of an after-life.

Keywords

end of life, dying, end-of-life experiences, dreams, visions, end-of-life care

Introduction

The progression towards impending death often prompts individuals to engage in spiritual reflection, raising existential questions and concerns (World Health Organisation [WHO], 2002). The past two decades have observed an increased acknowledgement of the psychological and spiritual significance of a range of unexplained phenomena associated with the end of life, which are conceptualised as being “in principle, physically impossible occurrences or beyond the realm of human capabilities” (Barbato, Blunden, Reid, Irwin, & Rodriguez, 1999, p. 30). A broad range of terms have been adopted by researchers to refer to these experiences; “deathbed phenomena”(Brayne, Farnham, & Fenwick, 2006); “deathbed visions” (Fenwick & Brayne, 2011), “deathbed coincidences” (Osis & Haraldsson, 1997); “nearing death awareness” (Callanan & Kelley, 1992);and “End-of-Life Experiences” (Fenwick, Lovelace, & Brayne, 2007). Indeed, the reported prevalence of such phenomena has led some researchers to advocate that such experiences are considered as a natural part of the dying process (Barbato et al., 1999; Brayne & Fenwick, 2008). A recent review of published research within this area suggested a correlation between the occurrence of such phenomena and peaceful death (Mazzarino-Willet, 2010); thus it is proposed that further attention to unusual phenomena at the end of life is warranted.

In ancient Greece dreams were called *oneiros*, a word that originated the adjective *oniric* but that did not mean what was dreamed about and neither the dreaming process, which was not rated as something important, but the *phantasmata*, i.e. the apparitions. Socrates, Plato, Aristotle and Xenophanes, nearly 2,400 years ago, were opposed to the prevailing view of the *phantastikon,* that is, mystic apparitions, and to the premonitory character of dreams as their main characteristics.

The meaning of dreams continues to be an enigmatic issue. Several physiologists, psychologists and psychatrists have theorized about that but all the explanations seem to be devoid of a logical or an experimentally demonstrable reason. Some presently available explanations seem science fiction, rather than true science(*C. Timo-Iaria et al.2009)*. Plato, preceding by twenty four centuries one of the dogmas of psychoanalysis, believed that “forbidden” dreams, such as incestuous or criminal dreams, were only a way of doing incestual sex or killing someone without punishment. Dreams are still taken by a majority of the human kind as premonitory, ascribing them the function of telling us that something important will happen.

Anecdotal evidence suggests that death may be heralded by phenomena which seem to comfort dying persons and prepare them spiritually for death. Medical practitioners have been slow to recognize these ‘end of life experiences’ (ELEs) and there has been little research into the way carers respond when patients try to talk about phenomena they have experienced, and how these ELEs influence the carers’ work.

Professionals working in palliative care who have encountered these phenomena generally feel ill-prepared in managing and discussing these, which could result in unhelpful interactions with patients who have experienced them, and exacerbate negative emotional responses (Brayne, Lovelace, & Fenwick, 2008). It is suggested that palliative-care professionals may mistakenly label such spiritual experiences in patients as “confusion” or “hallucinations” without adequate assessment, and may respond with annoyance, talk to patients in an infantilising manner, or try to treat these experiences with medication (Callanan & Kelley, 1992). A lack of supervision, fear of ridicule from colleagues, and lack of education and training around existential issues have been highlighted as contributing factors to the absence of open discussions about unusual phenomena within palliative-care teams (Fenwick et al., 2010).

Empirical studies have shown that the content of everyday dreams can be related to the dreamer's waking concerns (for a review on the continuity hypothesis between dream content and waking concerns, see Domhoff, 1996, 2002), that the occurrence of specific types of dreams (e.g., recurrent dreams, nightmares) are related to one's psychological well-being (e.g.,Brown & Donderi, 1986; Zadra & Donderi, 2000), and that the dream reports of people suffering from certain psychopathologies (e.g., depression) sometimes differ from those of normal controls (see Kramer,2000, for a review).

The term 'dream appreciation' was proposed (Ullman, 1996), to highlight the active participation and insights provided by the dreamer and to underscore the fact that understanding dream content is possible for professionals and nonprofessionals alike.

Dreams have special significance in many psychological theories—they're the "royal road to the unconscious" according to Sigmund Freud, whereas Carl Jung saw in dreams the expression of mythic archetypes. Throughout history dreams have been closely tied to spirituality across religious lines. From bible stories to eastern religious practices, dreams have held a close tie to religious practice and spirituality throughout most of recorded history. In Biblical times, dreams were often believed to carry prophetic messages, as in the book of Genesis when Joseph's dreams foretold of a coming famine in Egypt, and when Joseph (husband of Mary, the mother of Jesus) was warned of a danger to their baby.

Death bed visions (DBVs) or the recently termed End of life Dreams and Visions (ELDVs) are common phenomena in individuals nearing death. Dreams and visions experienced by the seriously ill have historically been a topic of fascination, and have been observed and documented throughout different cultures (Mazzarino-Willet A, Fenwick and Lovelace). End-of-life dreams and visions (ELDVs) are psychological phenomena that manifest while asleep (dreams) or awake(visions), and typically feature deceased family and friends in the months to hours before death(Mazzarino-Willet A, Kerr CW, Nosek CL). Although ELDVs are common, they have only recently been subjected to scientific inquiry. ELDVs may be inherent to the dying process (Bryan S), serving to help individuals prepare psychologically and/or spiritually for impending death, and may be an effective platform for exploring and addressing existential distress and concerns (Goelitz A, Wright ST). ELDVs are often significant and meaningful to both dying individuals and observers, and should, therefore, be viewed as valuable opportunities for both clinicians and family to connect with dying individuals.

ELDVs may be mistaken for hallucinations or confused states such as delirium (Betty, 2006). However, evidence suggests that these experiences are qualitatively different. Although ELDVs are marked by a sense of realism, peace, comfort, organized thinking, and heightened clarity, and can convey profound meaning, Delirium is characterized by disorganized thinking, altered sensorium, agitation, anxiety, or fearfulness. This is an important distinction, as medical professionals may unnecessarily medicate ELDVs and prevent patients from experiencing potentially meaningful and comforting experiences. Wills-Brandon (2003) suggested that approximately 50–60% of dying individuals who are conscious shortly before their death experience some form of unusual phenomena. Research exploring unusual phenomena at the end of life has generally focused on the frequency/veridicality of these experiences and profiling the defining characteristics of them (Mazzarino-Willet, 2010). Given the high frequency of occurrence of such phenomenon, such experiences are considered as a natural part of the dying process (Barbato et al., 1999; Brayne & Fenwick, 2008).

It is estimated that 50-60% of conscious dying patients experience ELDVs (Mazzarino-Willett, 2010). It is likely this figure is even higher, as research has shown that patients, families and clinicians knowingly under report these experiences for fear of judgement, ridicule and embarrassment (Barbato et al, 1999). The body of research on this topic is limited, and most studies have explored the meaning of patient dreams and visions from the perspective of their hospice clinicians or families (Lawrence and Repede, 2012; Kellehear, 2011; Fenwick et al, 2008; Brayne et al, 2008; 2006).

Given this identified gap in knowledge, the present research aimed to build upon what is known about unusual end-of-life phenomena and furthermore provide an in-depth examination of the meanings and interpretations that are ascribed to these experiences.

It was Victor Frankl, the founder of 'logotherapy', who in 1946, posited in his book, 'Man's search for meaning' that the primary motivation of a person is to discover meaning in life (Frankl, 1962). Frankl insisted that meaning can be discovered under all circumstances, even in the most miserable experiences of loss and tragedy. He said that people could discover meaning through doing a deed, experiencing a value, and experiencing suffering.

The SUPPORT (Study To Understand Prognoses and Preferences for Outcomes and Risks of Treatment) trial on 1995, stimulated a reexamination of systems of care for seriously ill and dying patients. Addressing suffering involves taking care of issues beyond physical symptoms. It thus integrates the psychological and spiritual aspects of patient care. A consensus statement included the assessment and support of spiritual and religious well being and management of spiritual and religious problems as core principles of professional practice and care at the end of life (Cassel CK, Foley KM. 1999).

Palliative care improves the quality of life of patients and their families who are facing problems associated with life-threatening illness, whether physical, psychosocial or spiritual.

According to the World Health Organization (WHO),

“ palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment, and treatment of pain and other problems, physical, psychosocial, and spiritual.”[Connor S, Sepulveda C.]

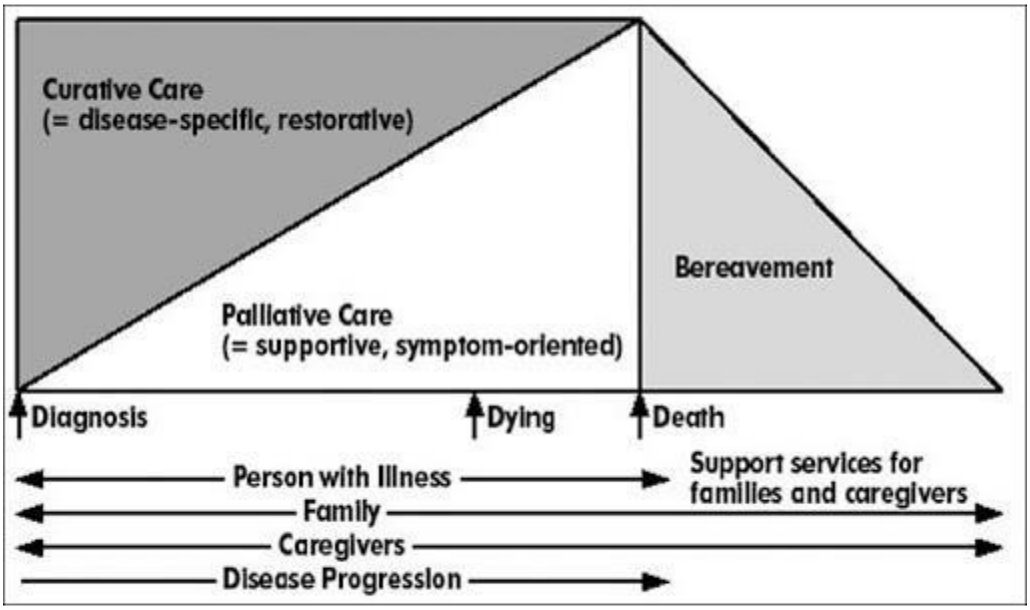
Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is an urgent humanitarian need worldwide for people with cancer and other chronic fatal diseases.

Palliative care is applicable from the time of diagnosis of an incurable or life limiting illness and it helps the patient and family to come in terms with the situation, get good quality of life during the treatment and if do not get cured, during the advanced stages of the disease and death. The family is supported during the bereavement period. A chronic and incurable disease need not be immediately life threatening but can severely affect the quality of life and will benefit from palliative care interventions.

Figure 1.1: —Continuum of Care for Cancer, HIV/AIDS, and other life-limiting diseases.



Source: MoHFW 2012. Strategies for Palliative Care in India [Proposal of Strategies for Palliative Care in India. Ministry of Health and Family Welfare.]

Palliative care considers dying as a normal process. End of life care or terminal care is an important component of palliative care provided to those who are dying but the intention is not to hasten or postpone death. Palliative care helps people with life threatening or life limiting conditions live as actively as possible till the end.

Palliative care is concerned with all aspects of care, namely, disease management, symptom control and psychosocial support. No single sphere of concern is adequate without considering its relationship with the other two.

In order to address sufferings, issues occurring beyond physical domain also need to be taken care of. The psychosocial stress from chronic illnesses adds to the physical suffering. The long-term care required and some of the expensive treatment options can have huge negative financial impacts on patients and their families which push people further in to poverty. Providing supportive care in such complex situations, requires a multidisciplinary approach is required, in which, anyone – health care professionals, social workers, friends or community- who can help improve quality of life of the patient and his/her family can participate. In chronic illnesses needing palliative care most of the care can be provided at the community/primary level and institutions will be required as a back up to handle difficult situations or crises occurring during the course of the illness. This will reduce the stress on the existing health care systems and lead to their optimum use.

Effective palliative care services should be integrated into the existing health system at all levels of care, especially community and home-based care. They involve the public and the private sector and are adapted to the specific cultural, social and economic setting.

As human beings, we all have physical, psychological, social, emotional, spiritual, informational, and practical needs. Each day, we work to fulfil these needs – we rest, sleep, eat, work, play, and develop patterns or ways of coping. However, when an illness strikes, we may not be able to meet our daily needs in the same way. New demands may appear and anxieties and uncertainties emerge. Suddenly, we may feel vulnerable, perceive that things are out of control, and believe we do not know what to do about the situation. We may have to access new information, learn new skills, or seek help from other people before our needs can be met.

Patients experience increased emotional distress if their symptoms are not attended to and will suffer decreased quality of life as a result [Singer, P.A., Martin, D.K., & Kelner, M. (1999)]. Evidence is emerging that elevated emotional distress as a result of poor symptom management is linked to decreased survival, particularly in patients with advanced disease [Edmonds, P., Karlsen, S., Khan, S., & Addington-Hall, J. (2001]. Therefore, one of the key goals in caring for individuals with advanced disease is to provide relief from pain and other distressing symptoms.

Palliative care is aimed at improving quality of life, by employing what is called 'active total care', treating pain and other symptoms, at the same time offering social, emotional and spiritual support. World Health Organisation observes that 'The fundamental responsibility of health profession to ease the suffering of patients cannot be fulfilled unless palliative care has priority status within public health and disease control programme; it is not an optional extra. In countries with limited resources, it is not logical to provide extremely expensive therapies that may benefit only a few patients, while the majority of patients presenting with advance disease and urgently in need of symptom control must suffer without relief' (National Cancer Control Programmes, Policies and Managerial Guidelines. WHO, Geneva 2002)

Palliative care is in its infancy in most parts of India with the result that most patients die painful and undignified deaths with unaddressed symptoms. Barriers include lack of accessibility and availability of care, lack of medications and their affordability and cultural acceptance. Provision of “home care” remains an economically and practically viable option of addressing these symptoms. Assessment of psychosocial and spiritual concerns is also of paramount importance in such resource-poor settings.

Palliative care is now considered as a human right issue [Unbearable Pain: India‘s Obligation to Ensure Palliative Care. Human Rights Watch, (2009)].

People have the right to live with dignity and palliative care aims at helping the chronically and incurably ill people to live with dignity through their disease trajectories and end of life period. Palliative care is gathering momentum worldwide and is now considered as an integral part of universal health coverage.

In the first ever global resolution on palliative care, the 67th World Health Assembly (WHA resolution 67.19) in May 2014, emphasized the need for 'strengthening palliative care as a component of integrated treatment within the continuum of care' and urged the member states to develop palliative care at all levels with emphasis on primary care, community and home based care along with appropriate policies, education and ensuring availability of medicines[9]. Chronic and incurable illnesses are not simple health conditions. They cause tremendous social stress and put great demand on the financial and health resources. A good palliative care programme integrated in to the health care system will ensure continuity of care at all 10 levels and at primary level family and community can get involved to provide basic care, emotional support, spiritual care etc. This will put less stress on the limited health resources in the country. Along with this the awareness among health care professionals, policy makers and the public about palliative care and the benefits it can provide to people with advanced illnesses, has to be improved. The 2017 health policy of the Government of India has identified palliative care as one of the key areas and this is a right step towards providing appropriate care for the millions in the country affected by life limiting illnesses. [National Health Policy. Government of India, 2017.] The 2030 Agenda slogan by United nations „Leave no-one behind‟ means that governments trying to achieve Sustainable Development Goal must develop palliative care policies to cover the 40 million persons (a total that includes at least 20 million carers) who require palliative care support globally[https://sustainabledevelopment.un.org/content/documents/2754713_July_PM_2._Leaving_no_one_behind_Summary_from_UN_Committee_for_Development_Policy.pdf]. Currently, fewer than 10% of patient who need palliative care in low and middle-income countries receive it.

The focus remains on a 'holistic approach' of care and hence, attention to the body, mind and spirit remains of paramount importance.

Spiritual needs are complex. Some of them are really social needs. Others are psychological needs overlaid by religious desire. 'Good spiritual care' may mean a recognition of interdisciplinary understanding that the meaning of wellness in this particular context is dependent on successful ability of all of us to transcend the ordinariness of everyday life & to gather meanings in the unseen world of spirits. Both religion and spirituality include the subjective feelings, thoughts, and behaviors that arise from a search for the sacred.

Life-threatening illness challenges one‘s spirituality. A life threatening diagnosis often evokes questions – Why me? Why now? Why this way?

It threatens hope and motivates a search to find meaning or make sense of the situation. It intensifies yearning to love and belong; threatens core beliefs about the world, how it works and one‘s place in it; and stimulates one to look beyond.

Even though there may no longer be a realistic hope for cure of the disease, there can be hope in wishes for achieving short-term goals (e.g., a night without pain, a good night's sleep, an easy death, the resolution of a conflict). Advancing disease leads people to question what their lives have really meant and to sort through whether they are leaving a legacy. They wonder about what will happen to their families, their lifework, and their life goals.

Positive psychology is the study of the "good life", or the positive aspects of the human experience that make life worth living. As an art, it focuses on both individual and societal well-being(*Seligman, Martin E. P.; Csikszentmihalyi, Mihaly (2000). T*he concepts that form the basis of this field have been present in religious and philosophical discourse for thousands of years.

Psychology of religion consists of the application of psychological methods and interpretive frameworks to the diverse contents of religious traditions as well as to both religious and non-religious individuals. The challenge for the psychology of religion is essentially threefold:

(1) to provide a thoroughgoing description of the objects of investigation, whether they be shared religious content (e.g., a tradition's ritual observances) or individual experiences, attitudes, or conduct;

(2) to account in psychological terms for the rise of such phenomena, whether they be in individual lives; and

(3) to clarify the outcomes—the fruits, as William James put it—of these phenomena, for individuals, and the larger society(*Wulff, D. M. (2010*).

William James argued that religion, in the form of mindcure, leads to contentment and wellbeing, even influencing physical health as well as science does, or even better (*Ryff, C. D., & Singer, B. (2003*). Crystal Park, in her Presidential address at the 111th Annual Convention of the American Psychological Association in 2003, had stated that, "One of the most consistent predictors of positive life change, following the stressors or trauma, is religiousness, measured in various ways, including intrinsic religiousness, religious attributions and religious coping. It has been hypothesized that having a religious framework for understanding, and perhaps also the presence of religious social support, helps individuals to make more meaning from their situation, including identifying positive aspects of the stressful encounter, although this hypothesis awaits empirical examination."

Researchers from psychology of religion and positive psychology have not always shared insights from their respective fields. Moreover, researchers from both fields have neglected to fully engage theological and philosophical perspectives throughout the research process; rather, they attended to them primarily during the development of constructs. Yet scholars in positive psychology and theological studies may have more in common than is normally recognized. Parallel to the development of positive psychology is the field of positive theology, a movement within theological studies that seeks to reorient the field from one that has been largely preoccupied with innate badness and pathology to a focus on well-being and flourishing (*Schnitker SA, Emmons RA. 2017)*.

When we are faced with a threat of dissolution, like a terminal illness such as advanced cancer, we often seek solace in religion and spirituality. These often help in restoring a sense of 'meaning' to our suffering and may also offer a source of hope. In low control situations not amenable to direct repair or problem-solving, such as trauma, loss, and

serious illness, meaning-making is often the most adaptive (*Park, C. L., Folkman, S., & Bostrom, A. (2001)*) . The Meaning Making Model identifies two levels of meaning, global and situational (*Park, C. L., & Folkman, S. (1997)*) . Global meaning plays an essential role in how individuals deal with situations of crisis or serious illness, influencing their adjustment and, some research suggests, even their survival. Meaning making processes help people to change their understanding of their illness (changed appraised meaning, such as its cause or implications for their lives or their ability to handle it). In a study of young to middle-aged cancer survivors, the authors found that meaning making in the form of positive reappraisal led to increases in perceived growth and life meaning, which led to reduced perceptions of the cancer as discrepant from a just world belief. This process was related to better psychological adjustment (*Park, C. L., Edmondson, D., Fenster, J. R., & Blank, T. O.(2008)) .*
Thus, spirituality and religion may help a terminally ill person to enjoy a better quality of life in his/her last days. The goal of a quality comfortable death is achieved by meeting a patient's physical needs and by attending to the social, psychological and the now recognized spiritual and religious dimensions of care (Byock R.,1997) (Emanuel EJ,1998).

Addressing suffering involves taking care of issues beyond physical symptoms. It thus integrates the psychological and spiritual aspects of patient care. A consensus statement included the assessment and support of spiritual and religious well being and management of spiritual and religious problems as core principles of professional practice and care at the end of life (Cassel CK, Foley KM. 1999).

There are three central creative functions of the human spirit, each playing a distinctive, yet complimentary, role in bringing deeply embedded ultimate concern to the surface of our everyday lives, viz., our 'intellectual powers' give it concrete meaning in the here and now so we can ‘know’ it, our ‘moral’ sense provides guidance so we can ‘act’ on it, and our aesthetic sensibility gives it form so we can ‘express’ it purposefully. Religious traditions draw on these creative gifts of the human spirit to develop distinctive world-views (theology), moral values (religious ethics), and aesthetic practices (religious ritual and spirituality) that reflect ultimate concern and address existential questions (O’Connell LJ.1995).

Analysing ELDVs can be challenging. The early psychoanalysts recognized the power of dreams, strongly calling for therapists to work with clients’ dreams in therapy to illuminate both conscious and unconscious conflicts. Perhaps most notably, in his ‘The Interpretation of Dreams (1900/1966)’, Sigmund Freud suggested that the primary purpose of dreams is to satisfy primitive, infantile wishes. Unacceptable to our conscious minds, he proposed that such wishes are repressed during waking life. According to Freud, however, we cannot censor our thoughts during sleep, and thus these wishes emerge in our dreams, often in distorted form (e.g., rather than dreaming of a boss directly, one might dream of a dangerous tiger). According to Freud, then, dreams provide ideal therapeutic fodder, serving as the “royal road” for examining the unconscious. His most powerful approach for working with dreams was free association, in which the dreamer says whatever comes to mind, with as much honesty as possible. Through these associations to dream images, the origins of the dreamer’s intrapsychic conflicts are revealed. In his work with patients, Freud listened to the dream and then to the patient’s associations to specific images, and offered an interpretation using his knowledge of the dreamer and of dreams’ symbolic meanings. Presenting an alternate view, Carl Jung (1964, 1974) believed dreams to be a normal and creative expression of one’s unconscious mind. Asserting that dreams serve a compensatory function, Jung stated that dreams reflect issues that are unexpressed during waking life. He thus believed that dreams can provide a vital means of uniting the conscious and unconscious by making dreamers aware of hidden feelings. Dream interpretation remains one of the central components in Jungian therapy, although Jung did not define specific procedures for dream work. Rather, he supported therapists' working with dreams in whatever way was most useful for the dreamer.

A third notable early dream theorist was Alfred Adler (1936, 1938, 1958). Believing personality to be a unitary construct, Adler asserted that the conscious and unconscious minds are the same, and thus the individual's waking personality is reflected in dreams.

According to Adler, dreams are an expression of the conscious mind and provide the person with reassurance, security, and protection against damage to self-worth (e.g., a dream in which the person is able to fend off an attacker leaves the person feeling a sense of agency). Of primary importance was the emotion stimulated by the dream, which Adler believed allowed the dreamer to find resolutions to problems. Thus, he believed that dreams were a way of preparing for future activities or events and fulfill a problem-solving role. Unfortunately, Adler provided no clear guidelines for working with dreams in therapy.

Emerging in the second half of the 20th century was Aaron Beck's theory of cognitive patterns in dreams (1971). Stating not only that dreams parallel an individual's waking thoughts, Beck also posited that waking cognitions influence dreams. According to Beck, dreams bring automatic, unrealistic thoughts to the dreamer's awareness, and so can be used to help clients recognize their distorted thinking (Hill CE, Knox S, 2010).

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

Arthur Freeman and Beverly White (2004) described a method for using dreams as a standard homework task in cognitive-behavioral therapy (CBT). Here, the dream represents an idiosyncratic dramatization of the dreamer’s view of both self and the world. Freeman and White also provide 15 guidelines for conducting CBT dream work. According to them, dreams should be understood thematically rather than symbolically; thus, the ideas or images present in clients’ dreams should be taken at face value and not as symbolic representations of something or someone else. They also postulate that clients’ affective responses to their dreams parallel affective responses to waking life events. Freeman and White also state that dreams may be particularly useful when clients are “stuck” in therapy, and that clients should be encouraged to establish a system and routine for collecting and logging their dream content. Furthermore, in seeking to understand their dreams, clients should try to discern a “moral” or primary theme from the dreams.

Phenomenologists hold that dreams reflect conscious experiences and can be examined just as experiences in waking life (Boss, 1958, 1963; Craig and Walsh, 1993).

Clara Hill (1996, 2004) integrated many of the previous theories into her cognitive-experiential dream model. Her model rests on the assumptions that

(1) dreams are a continuation of waking thought without immediate input from the external world;

(2) dreams' meaning is personal, and thus standard symbols or dream dictionaries are likely not useful;

(3) working with dreams requires therapist and client collaboration;

(4) dreams are useful for helping people understand themselves more deeply;

(5) dreams consist of cognitive, emotional, and behavioral components; and

(6) therapists must have sound basic helping skills before they can effectively apply the dream model.

Hill's model rests on three stages (exploration, insight, and action).

In the exploration stage, the therapist helps the client deeply and sequentially explores a few dream images by progressing through four steps (description, reexperiencing, association, and waking life triggers). Once several images have been thoroughly explored, the therapist helps the client construct the dream's meaning in terms of the phenomenological experience of the dream, the dream's connection to waking life, or the inner dynamics (i.e., parts of self, conflicts from childhood, spiritual and existential concerns). Once the therapist and client have co-created some meaning for the dream, the therapist helps the client talk about how she or he would like to change the dream. The therapist then bridges from the changes in the dream to changes in waking life (i.e., helps the client apply possible changes in the dream to possible changes in waking life), and then helps the client determine how to go about actually making such changes(Hill CE, Knox S, 2010).

Ullman (1994) presented an experiential group approach for teaching therapists how to make connections between dream images and waking life experiences. He stressed upon the importance of dialogue between the dreamer and therapist, with the therapist listening to and questioning the dreamer to elicit relevant client information.

Meaning making

Meaning-making is the process of how people construe, understand, or make sense of life events, relationships, and the self (Ignelzi, 2000). Meaning-oriented therapies have been used and are widely accepted approaches to aide bereaved individuals in the greiving process. A philosophical tenet of meaning oriented therapies is that people are driven by a need to find or create a sense of purpose, or meaning, in their lives. Meaning making involves “making sense” of or coming to understand the situation in a different way, finding benefit or positives that come from the situation, and changes in identity (Gillies & Neimeyer, 2006; Janoff-Bulman, 1992; Park, 2008). Often, situational meanings must be reconstructed so they fit into an individual’s global meaning system (assimilation), and sometimes global meaning systems are changed to account for a situational meaning (accommodation), and other times both occur. Meaning making is said to be adaptive when an individual successfully constructs or re-constructs meanings that reduce the discrepancies between situational and global meaning (Park, 2008).

Multiple understandings of meaning making exist.

The first conceptualization of meaning making is rooted in attachment theory (see Bowlby, 1980). When an individual loses a significant other to death, the bereaved individual works to re-define their relationship with the deceased through a process of meaning

reconstruction. Therefore, the distress caused by the loss of a significant other leads bereaved individuals to begin a process of searching for meaning in the loss (Gillies & Neimeyer, 2006).

The second conceptualisation of meaning making is rooted in cognitive, trauma and coping theories. ELDVs are akin to a ‘traumatic’ process which can alter a person’s ‘worldview’ and begin cognitive processes that leave them searching for meaning. Finding some benefit, or something positive to come from the negative experience of loss, is seen as a key tenet for successfully creating meaning within cognitive and trauma theories (Gillies & Neimeyer, 2006).

A third conceptualization of meaning making can be seen in Stroebe and Schut's Dual Process Model (DPM; 2001), which takes into account the impact of finding meaning related to the loss of bereaved individuals. Within this model, a bereaved individual alternates between loss-oriented coping and restoration-oriented coping. Loss oriented coping involves dealing with many of the intense emotions that occur after separation from a lost attachment figure due to death. Restoration-oriented coping refers to the ways in which bereaved individuals attempt to re-construct and re-engage in their life without the deceased. It includes spiritual and symbolic identity changes that occur as the bereaved individual attempts to re-define themselves and their attachment with the deceased. Meaning making is seen as the task that drives these alternating forces in the DPM (Gillies & Neimeyer, 2006; Stroebe & Schut, 2001).

Neimeyer (2001) suggested that the idea of meaning making in grief was a central construct linking these theories together, thus beginning a shift to a more constructivist framework for understanding grief and bereavement within the field (Neimeyer, 2001). The constructivist framework emphasizes how individuals construct meanings about the self and about the world through relationships and narratives. Meaning making in response to loss can be said to include the ideas of sense making (the process of finding or creating a sense of understanding regarding a loss), benefit finding (the creation of meaning structures that underscore positives resulting from a loss), and identity change (the positive or negative reconstruction of self). Benefit finding is understood as "positive reappraisal" in cognitive and coping theories. Furthermore, individuals experiencing "posttraumatic growth" express many positive identity changes, including feeling more resilient, having more awareness about the fragility of life, and having more empathy for others (Gillies & Neimeyer, 2006). However, there is much inconsistency in the field regarding how meaning making is defined, conceptualized, and measured (Gillies & Neimeyer, 2006; Neimeyer, 2001). Three such meaning oriented approaches include Park’s (2008) general meaning making model, Neimeyer’s (2001)/Neimeyer, Burke, Mackay, and van Dyke Stringer’s (2010) meaning reconstruction theory, and Armour’s (2006) meaning making grounded in action approach.

Based on these multiple understandings of meaning making, there is much inconsistency in the field regarding how meaning making is defined, conceptualized, and measured (Gillies & Neimeyer, 2006; Neimeyer, 2001). Many researchers, in an attempt to create more consistency in meaning oriented approaches, have created meaning making models or theories for working with bereaved individuals. Three such meaning oriented approaches include Park’s (2008) general meaning making model, Neimeyer’s (2001)/Neimeyer, Burke, Mackay, and van Dyke Stringer’s (2010) meaning reconstruction theory, and Armour’s (2006) meaning making grounded in action approach.

Within the general meaning making model proposed by Park (2008), the general beliefs through which individuals view and interpret their world are known as global beliefs. When an event happens, such as the death of a loved one, an individual assigns some meaning to that event (appraised meaning). Based on worldview theory, individuals are said to hold certain assumptions or beliefs about the world that give them a sense of meaning or purpose in their lives (global beliefs). The loss of a loved one can challenge some of these core assumptions and lead bereaved individuals to experience distress, which occurs to the extent that the appraised meaning differs from the individual’s global meaning. This can challenge an individual’s worldview or personal narrative, which is said to initiate meaning making efforts, as individuals attempt to bring their global and situational meanings into alignment. Meaning making involves “making sense” of or coming to understand the situation in a different way, finding benefit or positives that come from the situation, and changes in identity (Gillies & Neimeyer, 2006; Janoff-Bulman, 1992; Park, 2008). Often, situational meanings must be reconstructed so they fit into an individual’s global meaning system (assimilation), and sometimes global meaning systems are changed to account for a situational meaning (accommodation), and other times both occur. Meaning making is said to be adaptive when an individual successfully constructs or re-constructs meanings that reduce the discrepancies between situational and global meaning (Park, 2008).

Neimeyer (2001) proposed a constructivist model of grief therapy which is rooted in contemporary constructivist approaches in psychology that emphasize an individual’s desire to create meaning in their life experiences. Humans create a narrative that includes their underlying assumptions and beliefs both about the world and about themselves. The death of a loved one challenges some of these assumptions and beliefs and disrupts an individual’s self narrative, moving them to either assimilate the loss experience into their previously held assumptions and beliefs or accommodate to the loss by reconstructing, creating, or expanding their assumptions and beliefs about the world and about themselves in order to incorporate their loss experience into their self narrative (Neimeyer et al., 2010). The process of searching for significance or meaning involves constructing or re-constructing a new orientation in the world, both practically and existentially (Neimeyer, 2001). Failure to integrate the loss into one’s self narrative can lead to difficulties in the grieving process, leaving these individuals feeling a sense of meaninglessness, confusion, and feeling lost as their self narrative no longer makes sense (Neimeyer et al., 2010).

Within this framework, grief is seen as a process, wherein the loss changes the bereaved individual permanently as they begin a search to make sense out of the death.

Context, culture, and relationships are taken into account as bereaved individuals attempt to face an often overwhelming sense of meaninglessness that results from the loss of a loved one. Some of the core goals of Neimeyer’s (2001) meaning reconstruction theory include:

(a) helping the bereaved find or create meaning both in the death of their loved one and in their current life,

(b) exploring ongoing emotional attachment or relationship with the deceased and how this connection can serve as positive and healing,

(c) attending to explicit meanings discussed by clients as well as implicit meanings observed,

(d) encouraging the construction of meaning, along with integration of meaning into a newly constructed life narrative,

(e) facilitating the construction of meaning on both a personal and interpersonal level,

(f) discussing meaning in terms of individual contexts, as well as broader cultural contexts, and

(g) using the narrative approach as a guiding concept to facilitate re-authoring of an individual’s story of life after loss.

Armour (2006) proposed a model of meaning reconstruction grounded in action for survivors of traumatic bereavement. In this model, the central tenet of meaning making is the pursuit of what matters now, which is expressed by bereaved individuals through action. Meaning making tasks are often cited as more difficult for survivors of traumatic bereavement because the trauma or violence surrounding the death does not fit in with most people’s basic assumptions about the way in which the world operates

(Armour, 2006; Neimeyer, 2001).

One of the ways in which traumatically bereaved individuals find meaning is through a process of “letting go,” which involves focusing on something that transcends their pain. For some individuals this is done through religion, spirituality, or faith which can lead to an increased sense of control. Another important way in which traumatically bereaved individuals find meaning is by accepting that some of their questions will never be answered. Then, they can begin to accept new realities including a reconstructed view of the self and reconstructed beliefs or assumptions about the world and how it operates.

Meanings made regarding basic assumptions about the world may include the idea that death can happen at any time and the world is unpredictable. Individuals will attempt to reintegrate changed understandings of themselves and their worlds in order to create a “new normal.” The pursuit of what matters now is an important way in which traumatically bereaved individuals make meaning out of their loss. This method of meaning making is more performance based and involves engaging in their current life through acts that have symbolic meaning, in order to increase their sense of control and power. It is understood that meaning in these cases is often created as a by-product of focusing on what is significant in their life now, perhaps by helping discover resilience, benefits in the loss, and opportunities for self-development. Through these actions, individuals can begin to reconstruct a more coherent self-narrative and a new reality of meaning (Armour, 2006).

Construals are the process by which individuals perceive, comprehend and interpret the world around them, particularly the behaviour or action of others towards themselves. Meaning-making can help people feel less distressed, and allows people to become more resilient in the face of loss (Calhoun & Lawrence, 2006). Highly negative or traumatic experiences are an unfortunate part of life, and individuals’ ability to cope with these events is a critical contributor to overall psychological well-being. In particular, recent research has focused on individuals' abilities to create meaning from stressful events in the form of more coherent, emotionally expressive, and reflective narratives (Fivush & Baker-Ward, 2005; McLean, Pasupathi, & Pals, 2007). The presence of meaning and social support have been implicated as the strongest predictors of post-traumatic growth in individuals living with chronic illnesses (Zeligman et al., 2018). Post-traumatic growth has been conceptualized as a process by which individuals find new meaning and use the injury/illness as the opportunity to re-evaluate core priorities and anticipated goals (Hawley and Joseph, 2008).

Narratives are socially and culturally conventional mechanisms by which individuals organize and represent their past experiences (Bruner, 1987; McAdams, 1992).

Research on autobiographical narratives with adults has consistently indicated that narrative indicators of meaning-making are related to increased well-being. Coherent, reflective and emotionally expressive narratives about specific stressful life events are related to higher levels of well-being (Frattaroli, 2006; King, Scollon, Ramsey, & Williams, 2000; Pennebaker & Chung, 2007).

Rural India

67 per cent of Indian population live in rural areas and depend mostly on agriculture and petty businesses. Reddy (1985) has stated the following as the characteristic of Indian Rural Society.

1. The village is the unit of the rural society. Its people carry on the business of living together within a distinctive framework of caste and social custom. Caste is a dominant social institution permeating social and economic relations. Traditional caste occupation mostly prevails. Co-operative labour of different castes is required not only for agro-economic activities but also for socio-religious life. The large villages have within its population all the occupational castes, have a comparatively more integrated and self sufficient economic as well as socio-religious life than smaller villages.

2. The village as a social and cultural unit possesses a basically uniform organisation and structure of values all over India. Many problems are common to the entire Indian country side.

3. The ethnic, linguistic, religious and caste composition of a village largely determine its character and structure. Some villages of hamlets are inhabited almost exclusively by certain castes as in the case of Agraharams for Brahmins. Even in a village with mixed population the different castes usually live in different sections of the same village. Inter caste rivalries are present.

4. Women do not have full equality with men in several aspects of life.

5. Indian rural society is predominantly based on agriculture. Possession of land carries with it social and prestige value, besides being considered as an economic asset. In many villages,

the land is mostly distributed between two or more castes, or among a few families, or between one big land owner and the rest of the community. Landless labourers and tenants constitute a considerable part of the population depending on agriculture.

6. Every village has its own organisational set up, authority and sanctions. It has its growing body, the panchayat, based on local tradition since long, but now constituted on a regular basis according to provisions of Panchayat Raj.

7. Social distance or isolation has a bearing on the nature of the organisation of a village and of its view on the world. Availability of or nearness to modern means of transport or communications also modifies the setting and fabric of a village.

8. Village settlements are generally governed by certain regional and local traditions. The layout of the village, construction of the house, the dress, the speech, and manners follow the set pattern of the cultural area. Each village possesses an individual of its own. Some have a reputation for generosity, hospitality and fair play, while others are notorious for their meanness and corruption. Some villages are known for their co-operatives, while some are noted for their litigations and factions.

The important characteristics of the Indian villager was summarised by Reddy (1985) as hospitality, feminist traditionalism, fatalism, religiousness often combined with superstitious beliefs, leisure attitude to life, and low standard of living. However, the classic picture of rural India as earlier described by Reddy (1985), has been changing in a consistent manner. Both micro-environmental issues like water and land availability, suitability to crop growth, literacy rate, caste composition and availability of transport facilities and macro factors like economic growth, infrastructure and rural–urban linkages play an important role in shaping rural transformation. India’s rural sector is transforming predominantly from an agrarian to an industrial and service sector oriented one and the process of transformation started in the 1980s and gained momentum after the 1990s. The religious practices and beliefs of the rural population vary from region to region in India. Rural religion explains the meaning and direction of human existence. Admittedly, religion is a belief of a person towards the supernatural. But it is also a moral code for its followers. The moral code gives social order to the society. The fear or the wrath of the god compels a man to live a moral life, follow the sacred and avoid the profane. Rural religion gives an outlook to the rural people about their survival in the world. The rural Hindu people believe more in the Karma theory. This theory guides the day-to-day activities of the rural people. Every individual in the rural society is aware that if he does not behave properly in this birth, his next birth will be full of sorrows and miseries. Thus, the theory of transmigration of soul controls and regulates the lives of the rural people. Rural sociologists have stressed on some of the social functions of rural religion. Sociological thinkers have also stressed on the positive functions of religion in maintaining the unity of village.

Purpose of this study

This study was undertaken with a view to assess the incidence and nature of ELDVs in rural India, with its rich cultural, spiritual, and religious heritage, and to help the patients make a sense of meaning out of their ELDVs.

Aims and objectives

1. To enquire into the nature of dreams experienced by the terminally ill in rural India.
2. To determine any pattern of consistency in such dreams.
3. To determine the association of mortality, if any, with such dreams.
4. To determine what effect the discussion of ELDVs had on the patients.
5. To help the subjects attribute a sense of ‘meaning’ to their ELDVs through the use of narration.

Review of literature

The Roman writer Lucretius, the first popularizer of science, in his book *De Rerum Natura* (1978) credited these Greek philosophers for the discovery of the characteristics of sleep and dreams (Lucrece. Rerum Natura, I et II. Les Belles Lettres, Paris 1978.) During the second century of the present era, Galen, a Greek physician who practiced Medicine in Rome and was a great anatomist and clinician, knew that temperature, heart rate and respiration exhibited cyclic changes at night, which he attributed to dreaming (Rothschuch KR. Geschichte der Physiologie. Springer Verlag, Frankfurt 1953). De Sanctis, in 1899, in his book *I Sogni, Studi Clinici ed Psicologici di un Alienista* (*Dreams, Clinical and Psychological Studies of a Psychiatrist*), cites no less than 323 articles and books dealing with dreams, which proves that the objective study of dreams did not start during the middle of the 20th century, as is usually taken for granted(De Sanctis S. I Sogni e il Sonno. Studi Psicologici e Clinici di un Alienista. Fratelli Bocca Editori, Torino 1899). Charles Darwin, in his landmarking book *Emotions in Man and Animals*, published in 1872 and reedited several times in the twentieth century (Darwin C. The Expression of Emotions in Man and Animals. University of Chicago Press, Chicago & London edition 1985), states that "*at least* birds and mammals do dream", a concept that still remains unchallenged, despite which most researchers that carry out studies on sleep still hold that dreaming is specifically human. With Darwin (1965), we are fully convinced that "*at least birds* and mammals do dream". As a matter of fact, manifestations of dreaming have been identified in many species, including chickens, chimpanzees, cats, rats and in some birds. The American psychologist Mary Whiton Calkins published in 1893 an important, although entirely unkwnown, article under the title *Statistics of Dreams*, wherein she introduced the technique of arousing people when they moved parts of the body during sleep and asking them to report their dreams (Timo-Iaria C.1997). Calkins thus discovered that most dreams occur during the second half of the night and that around 89% of them are closely related to the events occurring the day before, confirming the thoughts of Aristotle. The correlation between dream content and the oniric movements was first studied by Aristotle, who *identified lip, eye and limb movements and correctly related them to what was being dreamed of.* Many studies performed during the eighteenth century confirmed such statement (Timo-Iaria C.1997). In 1896 Weed & Halam (De Sanctis.1899) published the first quantification of dreams content as related to their sensory content. Eye movements in humans predominate because vision is our main sensory channel and our visual memory is overwhelmingly predominant, resulting in preponderance of visual dreams. Vision is our predominant sensory channel, so much so that if we hear a sound we immediately convey the eyes to the source of the sound, trying to identify its origin, even if vision is absent. No wonder that most dreams in humans have a visual component, explaining the reason why eye movements occur in any kind of dream, alone or as part of non-visual dreams. Comparing the dream content in humans with events of the previous day, Calkins found in 1876 that nearly 89% of the reported dreams were closely related to such events. The reason why when we dream we are walking we do not get out of the bed and really walk, or when we dream we are talking to someone we do not really talk, is that neural circuits located in the neighborhood of locus coeruleus, in the pontine tegmentum, inhibit the motoneurons and do not allow the real movements to occur (*C. Timo-Iaria et al.2009)*.

Generation of sleep is reasonably well known but not that of dreaming. Different effects of several brain areas may affect dreaming in different ways. In an extensive review on this subject, Solms(2000) describes a complete cessation of dreaming in patients with posterior cortical or deep bilateral frontal lesions. A popular theory is the one that connects dreams, in particular, desynchronized sleep in general, with memory consolidation. An acceptable evidence in favor of the consolidation hypothesis arises from the study of a gene involved in neuronal activation (Christy B, Nathans D.1989). Foulkes (1982) considered that dreams are so easily forgotten because the brain in desynchronized sleep is in a "reflective state". It may well be that dreams are forgotten because the reticular activating system is highly deactivated during desynchronized sleep and thus the memory of the dreams cannot be consolidated. Jouvet, one of the most important researchers on sleep, suggests that dreaming is "a guardian and programmer of the hereditary part of our personality" and as such it plays a role in our general behavior. He postulates that dreaming activity plays a key role during the earliest years of life and thus may be involved in continuously programming some of the most subtle reactions of our consciousness during wakefulness. Whereas Freud was convinced that dream forgetting was an active function of repression, Hobson, Pace-Schott & Stickgold(2000) attribute the failure to recall a dream to a state-dependent amnesia caused by aminergic demodulation of the sleeping brain. It has been proposed (Hobson JA,2000) that presleep mentation is infrequently incorporated in top dreams and that "naturalistic" day time events rarely enter dream content, but several authors correlated dream content to the previous day events, starting with Aristotle 2,400 years ago and with Calkins in 1893. Winson (1990) believes that dreams "reflect an individual strategy for survival. The subjects of dreams are broad-ranging and complex, incorporating self-image, fears, insecurities, strengths, grandiose ideas, sexual orientation, desire, jealousy and love". According to Mancia (1995), the brain "produces dreams" as "a symbolic process of elaborating, interpreting and reorganizing in narrative sequences all the material accumulated in the memory during waking hours". This author "thus proposes a psychoanalytical model of dreaming, in which dreams constitute a way of representing the individual’s inner world with internal objects related with one another and with the self”. Hernandez-Peon (1966) considered dreams to be hallucinations and theorized that they are possible because the system responsible for wakefulness is inactivated during sleep, releasing memory tracings which are brought to consciousness. The meaning of dreams is therefore still an unsolved problem. Many hypotheses have been advanced but so far they do not explain why and what for we do dream. Despite the fact that many studies have found that mental activity during wakefulness differs from that during dreaming, the mechanisms involved in both may differ as to the degree of control over the release and combination of memorized information in wakefulness and in desynchronized sleep (*C. Timo-Iaria et al.2009)*.

Sigmund Freud, in his The Interpretation of Dreams (1900/1966), suggested that the primary purpose of dreams is to satisfy primitive, infantile wishes. Being unacceptable to our conscious minds, he proposed that such wishes are repressed during waking life. He further suggested that we cannot censor our thoughts during sleep, and thus these wishes emerge in our dreams, often in distorted form. According to Freud, then, dreams provide ideal therapeutic fodder, serving as the “royal road” for examining the unconscious. His most powerful approach for working with dreams was free association, in which the dreamer says whatever comes to mind, with as much honesty as possible. In his work with patients, Freud listened to the dream and then to the patient’s associations to specific images, and offered an interpretation using his knowledge of the dreamer and of dreams’ symbolic meanings. Freud (1953) proposed that dreams had two interrelated functions. One function was to give expression to previously repressed wishes from the id, thereby allowing the release of psychic tension. A second function of dreams was to protect sleep from being disturbed. In essence, the dream was seen as a compromise between unacceptable unconscious wishes, often sexual in nature and dating from early childhood, and the desire to remain asleep. Because of their antimoral and antisocial characteristics, these wishes needed to be distorted to be acceptable to the dreamer, thereby allowing their partial expression (dreams as 'wish-fulfillment') while assuring the continuation of sleep (dreams as 'the guardians of sleep'). This task is accomplished by the dream censor (or dream work) through the defense mechanisms of condensation, displacement, symbolization, and secondary elaboration. He thus made an important distinction between the manifest and the latent content of dreams. The former refers to the actual dream as experienced and reported, whereas the latter refers to the true meaning of the dream. According to his theory, dream interpretation involves retracing the various distortions that produced the manifest dream back to their sources in the latent dream thoughts (i.e., the unconscious conflicts and desires). Free association was considered by Freud to be the fundamental tool for deciphering a dream's underlying meaning. To reverse the dream work, the client is asked to provide an uncensored description of the feelings and thoughts evoked by each element of the dream's manifest content. These associations form an associative chain that allows the therapist to uncover the latent dream content. Since the dreamer's initial associations to the dream images are followed by associations to those associations, and so on, the manifest content is quickly abandoned. The analyst plays a crucial role by offering the client his or her own interpretation of the dream based on an understanding of the client's dynamics. This approach thus requires the mastery of various psychoanalytic concepts. Free association has remained at the heart of most psychoanalytically inspired dream interpretation. Despite some agreements, psychoanalysts from different orientations tend to obtain very different interpretations for the same dream series (Fosshage & Loew, 1987). Freud may thus have developed a widely used tool for exploring the significance of dreams; but what one finds depends, in part, on the one's views and theoretical inclinations.

Carl Jung (1964, 1974) believed dreams to be a normal and creative expression of one's unconscious mind. Asserting that dreams serve a compensatory function, Jung stated that dreams reflect issues that are unexpressed during waking life. He thus believed that dreams can provide a vital means of uniting the conscious and unconscious by making dreamers aware of hidden feelings. Dream interpretation remains one of the central components in Jungian therapy, although Jung did not define specific procedures for dream work. Rather, he supported therapists' working with dreams in whatever way was most useful for the dreamer. Jung himself frequently used associations, portrayal of dreams through artistic expressions, and interpretation of dreams via archetypes and myths. Jung viewed unconscious processes as being in opposition to conscious ones. Within this context, Jungian dream theory sees the dream as serving a compensatory function by presenting the ego viewpoints that are complementary to its dominant waking attitudes (Jung, 1974). Jung's theory emphasizes the transparent and creative nature of dreams, which are viewed as a direct, natural expression of the psyche's current state. The manifest content of dreams is not a facade intended to deceive, and there is no need to posit a latent content as described by Freud. Jung (1969) distinguished between objective dream interpretations (i.e., relating dream elements to something or someone who is part of the dreamer's external reality) and subjective ones (i.e., relating dream elements to the dreamer himself, including his personality). Jungians believe that a dream image can be interpreted both ways, but tend to emphasize their subjective meaning (Hall, 1983; Jung, 1969;Mattoon, 1984). The first step in Jungian dream interpretation is to examine the dream's context in the individual's waking life. By describing his or her waking life in relation to the dream, the dreamer provides information that helps guide the therapist towards an accurate interpretation. The therapist then seeks amplifications of the dream images. Hall (1983) describes three levels of amplifications: personal, cultural, and archetypal. Personal amplifications consist in obtaining the dreamer's personal dream related associations (thoughts, feelings, and recollections) to explore links to the dreamer's life. Cultural amplifications seek to enrich dream images with the transpersonal meaning that they might convey in a given culture. Archetypal amplification consists in drawing parallels between a dream image and, for instance, a myth, a fairy tale, a literary, historical, or religious reference that connects the dreamer to what Jung called the collective unconscious. In all three cases, the goal of amplification is to uncover deeper elements of the dream's potential meaning for the individual while remaining rather close to the dream's manifest content and by bringing the client back to other images in the dream. Active imagination is another method devised by Jung to explore a dream's significance that involves using one's imagination to recreate all or part of a recalled dream. This method, well described by Shafton (1995), consists of having an individual enter a quiet state, deliberately invoke and focus on dream images, and then observe the imagery evolve. This requires active participation with the images rather than mere passive observation of them.

Alfred Adler (1936,1938, 1958) believed personality to be a unitary construct, and asserted that the conscious and unconscious minds are the same, and thus the individual's waking personality is reflected in dreams. According to Adler, dreams are an expression of the conscious mind and provide the person with reassurance, security, and protection against damage to self-worth. Of primary importance, as well, is the emotion stimulated by the dream, which Adler believed allowed the dreamer to find resolutions to problems. Thus, dreams are a way of preparing for future activities or events and fulfill a problem-solving role. Alfred Adler postulated continuity between the manifest content of dreams and the dreamer's waking concerns and lifestyle. This view greatly influenced the existential–phenomenological, cultural, and Gestalt approaches to dream interpretation.

The existential–phenomenological perspective seeks to describe things as they are (Boss, 1977). Dreams are thus conceptualized as an authentic mode of existence in continuity with waking experiences(Boss & Kenny, 1987). Existentialists let the dream unfold as it is by suspending all preconceived beliefs or ideas, and without trying to analyze or interpret its content (Craig, 1990; Craig & Walsh, 1993). The therapist encourages the dreamer to relate even the smallest detail of the dream and emphasizes emotions as to allow the client to relive the dream here and now (Boss & Kenny, 1987; Craig, 1990). Rather than trying to decipher a dream's hidden meaning, existentialists help the client identify what is happening in the dream and focus on what this dream, considered as an experience of being-in-the-world as real as any waking experience, expresses in and of itself (Boss & Kenny, 1987; Craig & Walsh, 1993). If focusing on the manifest dream content yields a spontaneous emergence of memories or insights (Boss, 1977), then clients might be encouraged to establish parallels between the dream experience and their waking life (Craig, 1990).

Bonime (1962) described the 'culturalist approach' to dream interpretation in which he emphasized that, it was essential that the therapist and the client develop a collaborative alliance because the dreamer is viewed as the only person who can judge the value of the meaning ascribed to the dream. Along with Boss and Craig, Bonime greatly contributed to popularize the notion that it is ultimately up to the dreamer to interpret his or her own dreams and that the role of the therapist resides in being a helpful guide rather than an expert. The approach of Bonime (1962, 1989) focuses on emotions in dreams, whether they are truly experienced or expressed through symbols. Emotions are deemed important because ‘‘when detected and fully understood, [they] are probably the most subtle, precise and comprehensible indicators of personality’’(Bonime, 1962, p. 49).

Perls (1992) described the Gestalt approach, all dream elements are understood as projections of the accepted or unwanted aspects of the dreamer’s personality. Dream work aims at integrating the rejected and disowned parts of the self. The Gestalt approach is regarded as a somatic approach, in which the dreams are explored through the dreamer’s bodily sensations during a session. In this approach, the client is first asked to recount the dream in the present tense and in first person as to reexperience the dream (Fantz, 1987). The dreamer then identifies with different dream elements and describes his emotions, thoughts, and actions as if he actually was those elements.

The dreamer then enacts the dream components and characters. A dialogue between the various dream elements is then initiated, a process which may highlight tensions and polarities between different aspects of the dreamer’s personality. Perls postulates that clinical progress arises from the awareness and insights that emerge when the client reexperiences the dream and not from intellectual interpretation alone.

Gendlin (1986) described another experiential and body-oriented approach, which he named the ‘focussing technique’ in which the client reflects on the dream’s content while paying attention to bodily sensations. This helps the dreamer develop a felt sense of the dream experience, which, in turn, can result in a visceral ‘‘Eureka’’ of the dream’s meaning.

The dreamer is also encouraged to obtain information from the dream that does not merely restate what the client usually says about himself.

Hall and Van de Castle (1966) described an approach to dream interpretation which rests on the assumption that the frequency with which a dream element or theme appears reveals the dreamer's preoccupations and interests. They developed a coding system to quantitatively analyze the content of dreams on a number of dimensions (e.g., characters, emotions, social interactions). This system is applied to a series of dreams from the same individual but does not require any other information about the dreamer. Content analysis on a dream series can be used in various ways. These include obtaining unique information about the dreamer by comparing the resulting scores and patterns to normative data, exploring the significance of specific dream elements (e.g., animal figures), establishing gender differences, and exploring developmental patterns of dream content. Although this approach has been used primarily in research settings rather than for therapeutic endeavors, it can yield insightful clinical information.

Delaney(1991) elaborated The Dream Interview Method (DIM), which rests on the basic assumption that dream images are symbols or metaphors representing aspects of waking life. Therapists using the DIM pretend to come from another planet to establish a client–therapist relationship in which the latter is not an expert and has no preconceived ideas regarding the potential meaning of dream elements (e.g.,characters, objects, locations). In Phase 1, the interviewer (or therapist) asks the client some questions to encourage her to formulate, in her own words, a subjective description of each major dream element. In

Phase 2, called bridging, the interviewer asks the client questions to help her recognize how the dream might be a metaphor of a current waking life situation. Dream characters may be seen as projections of some aspects of the dreamer's personality. At the end, the dreamer is asked to think about changes that she could make in her life based on what was learned, and the therapist encourages the dreamer to consider different options for changes as a function of the meaning attributed to the dream.

Hill (1996, 2003) developed an integrative approach, which relies on the interactive collaboration between therapist and client. This model includes three stages: exploration, insight, and action. During the exploration stage, clients must recount their dream in the present tense, while concentrating on felt emotions to better immerse themselves in the dream experience. The most important dream images are then explored by describing them in detail, by re-experiencing the feelings linked to them, by providing associations, and by identifying potential waking life triggers of these images. The acronym DRAW (description, re-experiencing, association, and waking life triggers) summarizes the steps of the exploration stage. At the insight stage, the therapist helps the client find a meaning to the dream by integrating what has been learned from the exploration stage. A dream can be understood from several perspectives or levels of interpretation. First, one can link dream images and emotions to current life situations, experiences, concerns, emotions, thoughts, or to past memories (waking life level). Second, one can consider certain dream elements as projections of the self (parts of self-level). Third, the dream experience can be explored as it is, in the here and now of the therapy session, without considering the dream as a metaphorical representation of something else (experience in and of itself level). Fourth, clients can explore how the dream reflects the spiritual and existential stakes of their own life. Finally, a dream can be understood as reflecting the state of a given relationship (relationship level). The action stage is when possible changes in the dreamer's life are considered based on the new understanding of the dream. In most cases, the therapist introduces this stage by asking clients in what way they would change the dream if they could. This question serves as a starting point to reflect on how changes could be brought about in waking life.

Cognitively and psychoanalytically oriented therapists use many activities to work with dreams. Cognitively oriented therapists reported that they most often listened if clients brought in dreams, explored connections between dream images and waking life, asked for a description of the images, and collaborated with clients to construct interpretations of dreams (Crook and Hill,2003). On the other hand, psychoanalytically oriented therapists also frequently engaged in these four activities, but in addition often encouraged clients to associate to dream images, worked with conflicts represented in dreams, interpreted dreams in terms of waking life and past experiences, invited clients to tell dreams, encouraged clients to re-experience feelings in dreams, used dream images as metaphors later in therapy, and mentioned to clients that they were willing to work with dreams (Hill et al., 2008).

Clinical reports suggest that using dreams in therapy can enhance a client's active involvement in the therapeutic process (Bonime, 1987; Derr & Zimpfer, 1996). Studies have shown that clinical use of dreams enhances clients' insights, or what others have called a better self-knowledge, self-understanding, or self-awareness (Bonime, 1962). However, in some cases, clients may be less reluctant to discuss disturbing issues when these are approached through dream exploration, partly because dreams are often seen as not being real, and a safer distance exists between the client and the material evoked by a dream. However, dream work can also be beneficial in building a trusting relationship, even when clients are initially distrustful of the therapeutic process.

Hill et al. (2000) compared the effects of dream- and loss-centered therapy in clients suffering from psychological distress caused by troubling dreams and a recent loss. Seven participants were assigned to each form of therapy for 8 to 11 weekly sessions, and both quantitative and qualitative data were collected. Both types of therapies decreased the psychological impact of the loss and led to new insights and changes in the clients' lives. When compared with the loss-centered group, clients in the dream-centered group gained a better understanding of their dreams and interpersonal relationships and rated the therapeutic process higher in terms of working alliance, depth, insight, and action gains.

By contrast, clients in the loss-centered group gained greater insight concerning the loss and the effects of the past on their present situation and had a greater appreciation for their therapist's advice. The authors conclude that dream interpretation makes a unique contribution to therapy by enhancing clients' involvement in the therapeutic process.

Diemer et al. (1996), however, were unable to replicate and extend the results of Hill et al. (1993) in the context of brief psychotherapy. Twenty-five distressed clients took part in 12 weekly sessions of a therapy program. Two sessions were devoted to dream interpretation based on the Hill model, 2 to the interpretation of a recent disturbing event using the same three stages of Hill's model, and the remaining 8 sessions were unstructured. The overall treatment reduced clients' symptoms, improved their interpersonal functioning, and helped them achieve greater insight into troubling events. Nevertheless, dream interpretation sessions were not found to be more effective than the other types of sessions on

Post session measures of depth, working alliance, understanding, mastery, and insight. The authors conclude that both the interpretation of dreams and waking life events were equally effective in identifying clients' most central issues.

Webb and Fagan (1993) tested the impact of a dream interpretation session on the frequency of recurrent dreams using a technique based on psychological kinesiology (PK). Instead of verbally exploring their dream content, participants answered the experimenter's questions with a yes or a no using different types of muscular pressure. Participants were often surprised by their physical answers, and a single 45-min PK session was found to significantly reduce the frequency of recurrent dreams. These results led the authors to suggest that understanding a troubling recurrent dream can reduce its occurrence and its associated distress.

Very few scientific studies have been done to classify the phenomenon of deathbed visions. The largest survey was carried out by Osis and Haraldsson (1997) over 20 years ago. In a cross cultural survey they reported that over 70% of death bed visions were 'take away.' Several groups of phenomena are reported in the 24 hours before death. The most often reported phenomena are 'take-away' visions - the so-called deathbed visions. These are visions seen by the person who is dying, in which figures are apparently seen who have the express purpose of collecting the dying person and taking them on a journey through physical death (Fenwick P. Dying: a spiritual experience as shown by Near Death Experiences and Deathbed Visions).

In a Western culture dead parents or relatives are most commonly seen; strangers are occasionally seen and children may report seeing living friends. People who have a strong religious faith may see religious figures, and in Eastern cultures the take-away figure is often a 'Yamdoot', the messenger of the God of death. Usually the dying person's response to the vision is one of interest or joy, the figures are welcome and the person is usually ready to leave with them. More rarely the response may be one of fear or a refusal to go.

Typical is this case quoted by Osis and Haraldsson (1977) of a dying 16 year old girl who had just come out of coma.

(She said)… 'I can't get up', and she opened her eyes. I raised her up a little and she said 'I see him, I see him, I am coming'. She died immediately afterwards with a radiant face, exulted, elated.

In an Italian study, Giovetti (1999) reports that 40% of the deathbed visions she collected were 'take-away'. In one such case a wife describes the moment of her husband's death.

The gauze over his face moved. I ran to him. 'Adriana my dear, your mother (who had died 3 years before) is helping me to break out of this disgusting body. There is so much light here, so much peace'.

Carers also report that the dying person may tell them that they can move between the room in which they lie and a transcendent world in which they meet those awaiting them after death. Many features of this transcendent state are similar to those of the NDE and contain the light, feelings of love and a wonderful brightly coloured realm.

The similarity of deathbed visions to NDEs is striking. The peace, love and light are common to both, as is the experience of a journey and an entry into a world dominated by beauty and colour (Fenwick P. Dying: a spiritual experience as shown by Near Death Experiences and Deathbed Visions) .

End-of-life dreams and visions (ELDVs) are not uncommon and are experienced by many near the time of death. It is estimated that 50–60% of conscious dying patients experience ELDVs. The most prevalent ELDVs reported are those in which the dying patients describe seeing deceased family, friends, or religious figures. These visions can occur months, weeks, days, or hours before death (Barbato M, Blunden C, Reid K, Irwin H, Rodriguez P.)

People nearing the end of life often experience increasingly vivid and memorable dreams which have been well documented and reported across different cultures (Bulkley P, Bulkeley K.). The ELDVs are often described as existential phenomena, associated with a strong spiritual connection and sensitivity, which allows the patient to experience images of previously dead friends and relatives Fenwick P, Brayne S.)

Dr. Osis and Dr. Haraldsson have evaluated data from a 4-year study involving 50,000 deathbed observations by 1000 doctors and nurses. The study was cross-cultural with comparisons between the United States and India. Dr. Osis and Dr. Haraldsson made a careful characterization of the apparition experience in these terminal patients and separated hallucinations from experiences of reality. They conclude, “this evidence strongly suggests life after death – more strongly than any alternative hypothesis can explain the data.”(Osis K, Haraldsson E.).

L Stafford Betty had in 2006, penned an article on the Spirituality of Deathbed and Near-death visions and had put up the following arguments.... Are they visions of real people who live in an afterlife environment or are they hallucinations? Most social scientists assume they are hallucinations, but a thorough and careful analysis of the evidence does not point to this conclusion. The argument for the reality of such visions is muddied, however, by aspects of the visions that are dependent on the personal histories of the percipients and suggest, in some cases, illusory content. A theory that makes sense of all aspects of these visions is developed and defended, then tied into our theme: the spirituality of death.

Muthumana SP, Kumari M, et al had in 2010 published an interview-based study of 104 families and their observations of the last weeks and days of a dying family member. Forty families reported "unusual experiences and behaviors" from the dying person in their last period of life. Thirty of these dying persons displayed behavior consistent with deathbed visions-interacting or speaking with deceased relatives, mostly their dead parents. There were six cases of reported premonitions of death and five possible confusional states with one patient reported to have had both a deathbed vision and confusional experiences. Socio-demographic factors such as gender, age, occupation, or cause and place of death were not found to be significant. Hindu patients appeared to be more likely than Muslim patients to report these experiences. Use of opiates (or not) did not appear to influence reports. The findings are discussed with reference to past studies of deathbed visions as well as their implications for the future pastoral care of dying people and their families.

James Houran and Rense Lange had in 1997 published an article of a sample of 49 accounts of deathbed visions from Barrett's 1926 classic collection which were analyzed using the classification scheme for contextual variables proposed recently by Lange, Houran, Harte, and Havens. Consistent with previous research, the contents of the contextual variables operating during these deathbed visions were consistent with the contents of the percipients' experiences. In addition, contextual variables were related to the modalities of the experiences, e.g., visual, auditory, and sensed presences, as well as the number of contents, e.g., deceased relatives, angelic beings, and the perception of symbolic borders or limits including water and heavenly gates, as perceived during the dying process. These findings are consistent with the interpretation that deathbed visions are comforting hallucinations and that contextual variables serve to structure these otherwise ambiguous experiences.

Peter Fenwick argues that a reductionist explanation of deathbed visions would be that they are simply hallucinations interpretable in terms of a change in brain chemistry, or psychologically derived, confirming expectations or providing comfort as the dying approach their death. A point against this is that occasionally visions of a dead relative appear who the dying person does not know is dead. However, some phenomena surrounding the deathbed are witnessed by carers, and the mechanism for these is clearly different. A reductionist view would be that they are in response to the stress that the carer has had in the months leading up to the death and are probably mediated by a change in affect. Expectation could also play a part, as death always occurs within a culture and in Western culture the concept of soul and a departure to heaven of peace and love is common. However, as we now move towards post-modern science, together with the recognition that as yet neuroscience has no explanation of consciousness (subjective experience), the possibility of transcendent phenomena around the time of death should also be considered.

Madelaine Laurence and Elizabeth Repede had in 2013 published a study with the purpose of determining the incidence of deathbed communications (DBCs) during the 30 days before death and their impact on the dying process. A total of 60 hospice chart audits and 75 survey responses by hospice nurses across the United States were analyzed. Chart audits revealed 5 (8.33%) of the 60 included descriptions of DBCs. The survey of 75 hospice nurses identified 363 incidences of DBCs, with an average of 4.8 patient occurrences per nurse per 30 days. In all, 89% of the hospice nurses reported patients who experienced a DBC had a peaceful and calm death, with only 40.5% reporting a peaceful and calm death without the

DBC. They concluded that these DBCs had a positive impact on the dying process but were underreported in patient records and under described in textbooks.

Angela M Either calls ELDV as death related sensory experiences. A death-related sensory experience (DRSE) is a spiritually transforming experience occurring with the appearance of a messenger beyond the visible observable universe to guide a dying person through the dying process. DRSEs have been reported to occur among those who are dying, most commonly individuals with terminal illness. Known dead family members are most commonly seen, followed by religious beings. Communication takes place between the dying individual and the apparition. Feelings of peace and comfort are reported by the majority of individuals experiencing DRSEs. DRSEs can occur over a period of hours to months before death. They have been referred to as veridical hallucinations, visions of the dying, deathbed visions, and predeath visions. Reported throughout time, among people of all cultures, religions, races, ages, genders, socioeconomic status, and educational levels, DRSEs are intense spiritual experiences. She argues that validating a child's DRSE provides a way to start a dialogue regarding death and concludes that further research is needed to more fully understand DRSEs from the perspective of the dying child.

Grant P et al in 2014 had researched into the significance of ELDV. The results of their study suggested that fear of death often diminishes as a direct result of ELDVs, and what arises is a new insight into mortality (Bulkley and Bulkeley, 2006). The emotional impact was frequently positive, comforting and, paradoxically, life affirming. The person was physically dying, but their emotional and spiritual identity remained present as manifested by dreams and visions. In this way, ELDVs did not deny death but transcended the dying experience and presented a therapeutic opportunity for clinicians to assist patients and their families in the transition from life to death, providing comfort and closure.

Christopher Kerr et al(2014) had conducted a longitudinal study on Hospice patients experiencing ELDV. It was a mixed-methods study which surveyed patients in a hospice inpatient unit using a semi-structured interview. Fifty-nine participants comprised the final sample. Most participants reported experiencing at least one dream/vision. Almost half of the dreams/visions occurred while asleep, and nearly all patients indicated that they felt real. The most common dreams/visions included deceased friends/relatives and living friends/relatives. Dreams/visions featuring the deceased (friends, relatives, and animals/pets) were significantly more comforting than those of the living, living and deceased combined, and other people and experiences. As participants approached death, comforting dreams/visions of the deceased became more prevalent. They concluded by stating that ELDVs are commonly experienced phenomena during the dying process, characterized by a consistent sense of realism and marked emotional significance. These dreams/visions may be a profound source of potential meaning and comfort for the dying, and therefore warrant clinical attention and further research.

Cerebral localisation studies have indicated that complex subjective experiences are mediated through the activation of a number of different cortical areas, rather than any single area of the brain. A globally disordered brain would not be expected to support lucid thought processes or the ability to ‘see’, ‘hear’, and remember details of the experience. Any acute alteration in cerebral physiology leads to confusion and impaired higher cerebral function (Marshall et al 2001).

Keesee et al. (2008) conducted a study on the ability of bereaved parents to find meaning after the loss of a child. Meaning making ability in this study was defined as sense making (understanding the loss) and benefit finding (finding some positive to stem from the loss). Bereaved parents who attempted or struggled to make meaning after the loss of their child, but failed to do so, seemed to be particularly at risk for experiencing symptoms that met criteria for complicated grief.

In exploring the role of meaning making among bereaved parents, the study done by Lichtenthal et al. (2010) supports the idea that ability to make meaning (as defined by sense making and benefit finding) is related to experiencing less intense symptoms of grief and less symptoms of complicated grief. Lichtenthal et al. conducted a mixed methods study with bereaved parents in order to identify the role of meaning making as it relates to symptoms of complicated grief. While a majority of bereaved parents in this study (44.9%) expressed that they were not able to make any sense out of the loss of their child, the remaining bereaved parents identified at least one way in which they made meaning out of the loss.

Danforth and Glass (2001) conducted a qualitative study of middle aged bereaved widows in an attempt to examine their meaning making processes. Rather than simply asking, "What sense have you made from your loss?" these authors realized that meaning construction is something done on both an intra- and inter- personal level, including through dialogue with the interviewer. Interview questions were guided by a reflective process and the authors attempted to explore assumptions widows held that shaped their view of the death, how these assumptions changed during and after the loss, and new insights of the bereaved which may be reflected in behaviors, attitudes, or feelings. The authors concluded that the loss of a spouse triggered a desire to make meaning of the experience.

Study design

This is a prospective, cohort-based study conducted in consenting, adult terminally ill patients having a perception of their disease prognosis and who are mentally competent.

A 'Qualitative' approach has been used in my research. It focuses upon drawing meaning from the experiences and opinions of the participants – it pinpoints "…meaning, purpose or reality" (paraphrase of Hiatt, 1986; in Hardwell, N.D., p.148; Cohen et al., 2011; Merriam, 2009). Qualitative research places emphasis upon exploring and understanding "…the measuring individuals or groups ascribe to a social or human problem". It is an inductive method of reconnoitering the experiences of human beings towards social phenomena to discover the essence of such occurrences (Creswell, J.W., 2014) .

Although the origins of phenomenology can be traced back to Kant and Hegel, Vandenberg (*Vandenberg,D. (1997)*) regards Edmund Husserl (1859-1938), a German philosopher, as "the fountainhead of phenomenology in the twentieth century".

Husserl rejected the belief that objects in the external world exist independently and that the information about objects is reliable. He argued that people can be certain about how things appear in, or present themselves to, their consciousness (*Eagleton, T. (1983)*) (*Fouche, F. (1993)*). To arrive at certainty, anything outside immediate experience must be ignored, and in this way the external world is reduced to the contents of personal consciousness. Realities are thus treated as pure "phenomena" and the only absolute data from where to begin. Husserl named his philosophical method "phenomenology", the science of pure "phenomena" (*Eagleton, T. (1983)*). The aim of phenomenology is the return to the concrete, captured by the slogan “Back to the things themselves!” (*Eagleton, T. (1983)*) (*Moustakas, C. (1994)*).

According to Welman and Kruger “the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved”. Husserl’s philosophical phenomenology provided a point of departure for Alfred Schultz who turned it “toward the ways in which ordinary members of society attend to their everyday lives” (*Gubrium, J. F., & Holstein, J. A. (2000)*. A researcher applying phenomenology is concerned with the lived experiences of the people (*Greene, M. (1997)) (Holloway, I. (1997)*) (*Robinson, D., & Reed, V. (Eds.). (1998).) (Maypole, J., & Davies, T. G. (2001*)) involved, or who were involved, with the issue that is being researched.

A researcher’s epistemology according to Holloway*, Mason* and Creswell is literally his theory of knowledge, which serves to decide how the social phenomena will be studied. My epistemological position in my proposed study is based on the following facts:

1. The ‘lived experience’ of the terminally ill patients experiencing end of life dreams and visions will formulate the data that I seek.
2. It is on the interpretation of these data, that I hope to make a sense of meaning
3. This will lead me to engage with the subjects to collect the data.

I also undertook this research with the pre-supposition that end of life dreams and visions in the terminally ill convey meaningful information and may even provide the missing link to after-life. Hammersley (*Hammersley, M. (2000).*) believed that the phenomenological researcher, in contrast to positivists, cannot detach his own presuppositions and that the researcher should not pretend otherwise.

A ‘phenomenological’ methodology was used as my goal is to answer a specific research question about the experiences of the participants in terms of ‘lived experiences’, meaning subjective understandings of their own experiences. It focuses on human experience as lived by the individuals of the topic being explored. It also allows for in-depth examination, interpretation, and development of an understanding that leads to greater self-understanding, a greater moral awareness and an appreciation of the views of others.

A Grounded theory approach on the other hand, looks at experiences and other data sources to develop a more objective understanding of the subject of study. Thus, Phenomenology is a philosophical approach to a study, while Grounded Theory is a sociological approach.

Considering end of life dreams and visions to be a unique state of consciousness, interpretative phenomenological analysis(IPA) was used to get a detailed picture of subjective experiences of the individuals during these experiences. This method was considered ideal because of its ability to tap the essence of the subjective experience and to analyze these experiences by interpretation of the story told by an individual in his own words. It is a unique qualitative method, founded on the principles of *critical realism* (Bhaskar, 1978) and the *social cognition paradigm (*Fiske 1991). *Critical realism* is based on the premise that there are states of reality, which are independent of human conceptualization and which can be given different meanings by different individuals. *The social cognition paradigm* underscores the importance of the abilities of speech and behaviour in reflecting these differences in meanings directly or indirectly. As evident, this method underscores the importance phenomenology as an important methodology of science.

Data were collected via semi-structured interviews and interpretative phenomenological analysis (IPA; Smith, 1996) was used to analyse the data. IPA is a phenomenological approach which attempts to explore participants' lived experiences and furthermore attempts to make meaning out of these (Smith, Flowers, & Larkin, 2009). IPA, unlike most of traditional psychology, offers the psychologist the chance to engage with a research question at an idiographic (particular) level. The participant's 'lived experience' is coupled with a subjective and reflective process of interpretation, in which the analyst explicitly enters into the research process. IPA seeks to understand an individual's personal perceptions of an event, rather than attempting to produce an objective statement of the event itself (Smith & Osborn, 2008). Here, the participant's 'lived experience' is coupled with a subjective and reflective process of interpretation. Inferences that can be made from 'data'(often interview transcripts) to 'persons'(embodied and encultured beings). IPA makes these inferences cautiously, and with an awareness of the contextual and cultural ground against which data are generated, but it is willing to make interpretations that discuss meaning, cognition, affect and action. IPA's increasing popularity within health psychology may well stem from its ability to contribute to biopsychosocial perspectives. It also provides a viable alternative to the top-down (deductive and derivative) assumptions of main stream health psychology(Reid et al, 2005). Palliative medicine, being a 'holistic' model of care, focuses on the biopsychosocial approach in order to improve the quality of life of the patients and their care givers.

Locating the subjects

The idiographic nature of IPA involves a commitment to understanding how a particular phenomenon has been understood from the perspective of particular people, within a specific context, through an in-depth and time-intensive analysis (Smith et al., 2009). As such, IPA studies commonly recruit small, purposively selected homogenous samples and this approach was adopted within this research (Smith & Osborn, 2003). IPA challenges the traditional linear relationship between 'number of participants' and value of research. It retains an idiographic focus, with 10 participants at the higher end of most recommendations for sample sizes (Smith et al.,1999). Looking at the IPA literature base collectively, the mean number of participants involved in IPA research to date is 15 (Reid et al, 2005).

Inclusion criteria

Participants were eligible for inclusion if they were terminally ill and had experienced and/or currently experiencing dreams and visions.

I used ‘purposive sampling’ to locate the subjects for my study. They were primarily drawn out from my current practice, after fulfilling the desired criteria for participation based on my judgment and the purpose of the research (*Babbie, E. (1995).*) (*Greig, A., & Taylor, J. (1999)*).

Purposive sampling was described by Welman and Kruger (*Welman, J. C., & Kruger, S. J. (1999)*) as the most important kind of non-probability sampling to identify primary participants.

A detailed and duly informed consent was taken from the willing participants, as deception can be counter-productive (*Bailey, C.A. (1996).*) by preventing insights, while honesty coupled with confidentiality reduces suspicion and promotes sincere responses. The ‘informed consent form’ was then designed using the following criteria:

1. That they are participating in research
2. The purpose of the research
3. The procedures of the research
4. The risk and benefits of the research
5. The voluntary nature of research participation
6. The procedures used to protect confidentiality (*Arksey, H., & Knight, P. (1999)) (Bless, C., & Higson-Smith, C. (2000))*

The Eastern Cooperative Oncology Group (ECOG) functional status was evaluated for every subject. This is a health tool that evaluates the functional status of patients suffering from cancer. The ECOG status quantifies the functional status of malignant patients and is used as a prognostic tool in several types of cancers. As a performance status scale it describes the need for care and or ambulatory status.

The original study by the Eastern Cooperative Oncology Group (ECOG) now part of the ECOG-ACRIN Cancer Research Group, published in 1960, comprised of only 5 points and also known as the Zubrod score (after C. Gordon Zubrod), while the second version, published in 1982, represents a performance status evaluation on a scale from 0 to 6, 0 indicating a normal patient and 6 indicating death. The ECOG comes after several other models such as the Karnofsky score and the pediatric Lansky score. It is actually considered to be a more simplified version of the KPS. The evaluation is simple, with the clinician trying to assign the current situation of the patient to one of the following stages.

- 0 – Asymptomatic (Fully active, able to carry on all pre-disease activities without restriction);

- 1 – Symptomatic but completely ambulatory (Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. For example, light housework, office work);

- 2 – Symptomatic, <50% in bed during the day (Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours);

- 3 – Symptomatic, >50% in bed, but not bedbound (Capable of only limited self-care, confined to bed or chair 50% or more of waking hours);

■ 4 – Bedbound (Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair);

■ 5 – Death.

Being put under question in an inter-observer variability study on a population of 100 patients with 3 oncologists, the ECOG score performed sensibly with:

■ Total unanimity observed in 40 cases;

■ Unanimity between 2 observers in 53 cases;

■ Total disagreement in the other 7 cases.

Often, clinical trials employ scores such as the ECOG or the KPS in evaluating the general health of prospective participants and trial protocols state exactly the stages they are interested to receive. By comparison to the KPS, the stages are similar with one stage of the ECOG being similar to two consecutive stages of the Karnofsky, i.e 0 with 0 and 1, 1 with 2 and 3 of the latter.

All our subjects had a ECOG status between 3 and 4.

Exclusion criteria

1. Refusal to participate in the study
2. Patients having delirium. Delirium is an acute onset potentially reversible organic brain syndrome. It is considered as an altered mental state, which is somewhere on the continuum between coma and stupor at one extreme and normal wakefulness and alertness at the other (Mattoo SK et al,2010). Cognitive disturbances are part and parcel of delirium. Due to this, many of the instruments which have been primarily designed to assess disturbances in cognitive functions have been used for screening for delirium. The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings (Inouye SK et al, 1990). All our participants were screened for the presence of delirium using the CAM tool.
3. Patients with pre-existing dementia. Dementia is a term for a clinical syndrome characterized by progressive acquired global impairments of cognitive skills and ability to function independently. Many patients show varying levels of behaviour disturbance at some point in the illness. The syndrome is caused by many diseases, with Alzheimer's disease, vascular dementia and dementia with Lewy bodies together accounting for around 90% of cases. Incidence and prevalence of dementia are strongly age dependent (NICE 2006). In clinical practice and in research, cognition is considered the key change we want to observe in people with dementia. Diagnostic criteria for dementia depend on the presence of cognitive impairment [APA, 2000], and other aspects of the clinical picture in dementia (behaviour,

impairment in function, increased costs, carer stress) ultimately derive from impaired cognition. The Clock drawing test was used to screen for cognitive impairment in dementia in our study. We used the pre-drawn method in which the subject was presented with a circular contour and is expected to draw in the numbers on the clock face. It is fast, requires no training and most scoring methods are fairly simple. It shows fairly good sensitivity and specificity as a screening test (Brodaty H., Moore C. (1997).

Ethical Issues :

- This particular study was completely academic in nature and all the data provided by the participants was kept confidential.
- After explaining this, informed written consent was taken from the study participant.
- Useful health advices and information were given to all study participants to alleviate the symptom and agony.
- Principle of confidentiality: This particular study was completely academic in nature and all the data provided by the participants was kept confidential.
- Principle of consent: Appropriate informed consent Performa was developed and translated into local language (Hindi) and appropriate form was used as per language of the participants. After explaining this, informed written consent was taken from the study participants.
- Principle of autonomy: The participants have every right either to participate or not in the study and also can anytime refuse to participate in the middle of the study without giving any reason for it.
- Principle of beneficence: Any morbidity detected among the study population during the study was managed by proper referral.
- Principle of non-maleficence: They were assured that in case of any injury if at all occurs will be managed accordingly. Apparently, there was no risk of injury in the study

- Principle of justice: No discrimination in any form was done in selecting the study population.
- Principle of essentiality: This study was essential and without human participation this study cannot be done.

Methodology

A total of 12 subjects were interviewed.

Demographic profile of subjects is given in Table 1.

Face-to-face interviews were conducted with all of the participants. Interviews were often paused, when necessary, when the participant became emotional or tired. Interviews were conducted in the participant's homes as they felt comfortable and secure in their home environment and because most of them were too sick to travel to our Hospice. Interviews were recorded using a digital audio recorder and subsequently transcribed verbatim. Closed-ended questions were asked regarding the presence or absence of dreams and visions, whether these experiences occurred during sleep or wakefulness, content and frequency, degree of realism, and comfort versus discomfort. The interviews also consisted of a number of broad open-ended questions and a small number of prompts to facilitate a flexible exploration of participants' experiences.

The interviews allowed for sensitivity, reflexivity and flexibility for 'participants to think, speak and be heard' (Reid et al., 2005, p. 22).

The interviewees were allowed to speak as much as they wanted at a stretch. Further statements/questions were prompted in the following circumstances:

1. When the interviewees wanted some clarification regarding the questions being asked.
2. When the interviewer wanted some clarification about the statements made by them.

These questions were non-leading, and no options were provided. They usually had the following framework:

'We were unable to follow you when you mentioned / said that "…."

Can you explain the topic a bit more so that we can understand your statements better?'

The principles of 'good communication' were adhered to during the interviews, but as the topic of discussion was very unusual and at times statements were emotionally-laden, special additional considerations were made for enhancing the empathic bonding between the interviewer and interviewee: Mostly, head nodding was used as a non-verbal affirmation along with low-pitched sounds (mmm, hmmm, yes, ok, that's interesting.etc.) for the statements made by the patients to facilitate the flow of speech of the interviewee.

Encouraging statements like 'Please proceed, you are describing nicely,' 'Thank you very much for that great description' were used occasionally at places where the individual was found fumbling or at loss of words for describing his experiences. Non-judgmental and neutral answers were provided to the patients whenever they asked for the interviewers views about supernatural elements like God, spirits, after-death life, and so on. Interviewers mostly answered by statements like "I really don't know about that you know, so I really cannot give you an answer in favour or against your belief," "It is really very difficult to answer your question at this point of time, maybe I could speak more after we have acquired enough data," or "We are still searching for answers to these questions."

The length of the interviews ranged from 30 minutes to 60 minutes. Each interview was audio-taped and subsequently fully transcribed by the researcher. The occasional questions were put by researchers so as to cover the following areas in the descriptions:

a. Description of the experiences of their dreams and visions.

b. Description and identification of the person/s or other animate objects in ELDVs

c. Individual interpretations of the ELDVs.

d. Impact of the ELDVs on the individuals.

TABLE 1

Male subjects	7
Female subjects	5
Average age (in years)	55.33
Literacy levels	6 subjects literate
Religious beliefs	All Hindus, believers in God, following the *Shakta* & *Shaivaite* traditions. Followers of ritualistic practices.
Cultural background	Rural, with a farming background
Socio-economic status	Poor, with a monthly income of less than Rs.10,000
Primary Care-givers	Immediate family members
ECOG status	All subjects between stage 3 and 4.

Data analysis

The analysis was performed with the ‘idiographic approach,’ one of the original two outlined by Smith(2003). This method involved a detailed initial analysis of a single interview transcript prior to analyzing the others. During this initial stage, any issues and ideas emerging from the transcript, understood by the individual researcher as important from the viewpoint of study, were recorded in the left-hand margin. The transcript was reread a number of times, and existing ideas and concepts were given more abstract keywords that were recorded in the right-hand column and provided a synopsis of the text. Examination of this one interview provided a list of preliminary themes. Subsequently, the remaining transcripts were examined keeping these themes in mind, using the same procedure in which the researcher continued to search for descriptions with meanings of existing themes but also identified novel emergent themes. Using this method, a list of themes for each interview was produced, together with transcript extracts that supported and illustrated them. The list of themes (and corresponding transcript extracts) for each interview were read together to identify connecting themes and parallels between the interviews. Once the preliminary themes that pervaded the interviews (i.e. common themes across the interviews) had been established, several were grouped together based on their conceptual similarity, allowing master, and subordinate themes to be identified. The transcript extracts that had been paired with the preliminary themes were reread, and instances that supported the master and subordinate themes were assigned accordingly. Each transcript was then reread to ensure that the final master and subordinate themes were characteristic of the original material. This was all done in accord with the description of interpretative phenomenological analysis method originally described by Smith(2003) along with guidance taken from other studies, which have used this method so far.

In order to ensure rigour and enhance the credibility of the analysis, a selection of individual transcripts (n = 3), summary notes, and theme narratives were audited within the research team. This process was undertaken as a means of ensuring the credibility of the analytic approach, rather than to produce an analysis which is objectively “true” (Yardley, 2008).

The experience occurred while awake (n=2) or asleep (n=8) or both (n=10), the dreams and visions ‘felt real’. Many of their dreams and visions were of past meaningful experiences (n=3) and reunions with deceased loved ones (n=11) .Many reported dreams of preparing to go somewhere (n=7). As seen with previous research with American patients, there was a noted absence of dreams featuring religious figures (Fenwick et al, 2010; Osis and Haraldsson, 1997).

After repeated and comparative reading of the transcripts, we were able to extract the following themes from the transcripts:

The dream content mostly had explicit recall with clarity

“Everything was very clear… as if it was happening for real” (Interview 5).

I can clearly recall most of their faces (Interview 6)

I recognise all of them...(Interview 2)

Yes, most of the faces are known to me...(Interview 8)

ELDVs could occur at any time of the day

"They come mostly at night, but then there is no fixed time… I have seen him in day time as well" (Interview 7).

Mostly I see them when I am lying down at night, not fully asleep (Interview 5)

I see them at daytime too (Interview 2)

ELDVs are mostly disturbing

"I was scared and confused… she had died 6 months back… how could she be sitting next to me and smiling at me?" (Interview 3).

I am frightened...I cannot understand why though... (Interview 5)

I cannot understand why they keep coming...it scares me. (Interview 1)

There are some dark figures at times whom I do not recognise...it is scary...but they do not harm me (Interview 6)

The persons visualized in ELDVs do not threaten or scare the patient

They never harm or frighten me. They are always smiling…" (Interview 4).

They do not harm or threaten me...(Interview 3)

They do not speak to me or threaten me...they just move all around my bed, mostly talking amongst themselves...(Interview 1)

The known persons visualized are seen as they were in their prime of health

“My mother died of cancer. But, when I see her at night, she looks fresh, healthy, and wearing nice clothes” (Interview 1)

...(haltingly)...they all seem in good health, wearing nice clothes...(Interview 4)

They seem happy & healthy (Interview 5)

They are wearing good clothing & look good (Interview 6)

ELDVs seem very “real”

“I feel confused… I can't understand if it is a dream… it is so real… I see them, they sit next to me, walk about, talk to me…” (Interview 3).

It seems so real...they are all around me, next to me, talking...(Interview 2)

Most patients have ELDVs when they become very sick and essentially bed-bound

“I have been seeing him (my deceased husband) since I have been bed-bound” (Interview 8).

They have been coming since last 3 weeks now...they never came before...(Interview 5)

They are coming almost daily since last 2 weeks now (Interview 2)

With improvement of symptom burden, ELDVs decrease in frequency or disappear

“I feel much better now after the medications (for pain, constipation, nausea). The dreams do not come anymore… (Interview 1).

They no longer come...(Interview 3)

They have stopped coming since 1 week now... (Interview 5)

Most patients were clueless about the significance of their dreams

“I don't understand why I see them… I have never seen them before, so why now?” (Interview 3).

I see weird dreams, many ‘old’(meaning departed) people... (Interview 1)

My dreams seem meaningless...why do they come? All those people who are long dead...(Interview 6)

Meaning making of the ELDV

After a compassionate listening to the experiences of the subjects, reasoning & suggestions were offered to help the subjects to ‘normalise’ and make a ‘sense of meaning’ of their dreams and visions. We used a constructivist framework as the process of meaning making in which meaning construction was done using information gathered both from an inter-personal and intra-personal level. The questions by the interviewer were guided by a reflective process as the doubts, fears or any other assumptions regarding the EDLVs were heard by a process of ‘active listening’. The majority of the subjects could not make any sense of ‘meaning’ out of their ELDVs. Also the ‘benefit finding’ component of meaning making was absent. However, by a process of reasoning & suggestions, we could help the subjects arrive at a suitable ‘sense making’ and ‘benefit finding’.

We thus used a ‘cognitive therapy model’ in our ‘dream work’, which primarily had four major activities viz.,

1. Active listening
2. Exploring connections, if any, between dream images and waking life
3. Description of the images/visions
4. Collaboration with the subjects to construct an interpretation of the dream.

As per the Jungian interpretation model of dreams, we sought to correlate the dream’s context in the individual’s waking life. By describing his or her waking life in relation to the dream, the dreamer provides information that helps guide the therapist towards an accurate interpretation. The therapist then seeks amplifications of the dream images.We were also influenced by Hall (1983) for his work on the amplification process of dream images for the dream interpretation and meaning making process. He describes three levels of amplifications: personal, cultural, and archetypal. Personal amplifications consist in obtaining the dreamer’s personal dream related associations (thoughts, feelings, and recollections) to explore links to the dreamer’s life. Cultural amplifications seek to enrich dream images with the transpersonal meaning that they might convey in a given culture. Archetypal amplification consists in drawing parallels between a dream image and, for instance, a myth, a fairy tale, a literary, historical, or religious reference that connects the dreamer to what Jung called the collective unconscious. In all three cases, the goal of amplification is to uncover deeper elements of the dream’s potential meaning for the individual while remaining rather close to the dream’s manifest content and by bringing the client back to other images in the dream.

We also used the principles laid down by Neimeyer for meaning making in bereavement therapy. Some of the core goals of Neimeyer’s (2001) meaning reconstruction theory include:

(a) helping the bereaved find or create meaning both in the death of their loved one and in their current life,

(b) exploring ongoing emotional attachment or relationship with the deceased and how this connection can serve as positive and healing,

(c) attending to explicit meanings discussed by clients as well as implicit meanings observed,

(d) encouraging the construction of meaning, along with integration of meaning into a newly constructed life narrative,

(e) facilitating the construction of meaning on both a personal and interpersonal level,

(f) discussing meaning in terms of individual contexts, as well as broader cultural contexts, and

(g) using the narrative approach as a guiding concept to facilitate re-authoring of an individual’s story of life after loss.

Interview 3:

“I don't understand why I see them… I have never seen them before, so why now?”

“I feel confused… I can't understand if it is a dream… it is so real… I see them, they sit next to me, walk about, talk to me…”

“I was scared and confused… she had died 6 months back… how could she be sitting next to me and smiling at me?”

They do not harm or threaten me...

Why is this happening...

(They are your relatives, your loved ones. Do you think that they want to harm you?)

No.

(And you said that they want to take you to a better place...where there is no suffering...)

Yes, and I too have tried to follow them back, but can't...I seem unable to get up...

(So what do you think?)

(Pauses)...I don't think that they mean harm...but why can't I follow them when they ask me to accompany them...

(Do you think that they want to see you safe & not suffer, for after all they are your parents, etc.)

Yes, they will not harm me(with renewed confidence)

(So maybe they come to protect you)

Yes, I guess so (nodding)...(pauses) but there are some dark figures whom I do not recognise...they scare me.

(Have those dark figures ever threatened you?)

(Haltingly)...no, never.

(So you see, perhaps they do not mean harm)

(Nods in agreement)

(So do you still think that they come to harm you?)

(Confidently)...I do not think so now. I was afraid and confused before.

(So what do you think now?)

They do not mean harm. They want me safe and hence want to take me to a 'better' place.

Discussion

ELDVs were very common although most participants did not volunteer the information till specifically enquired upon with the use of ‘closed’ questions. Also, it was found that ELDVs were frequently so intense that the dream crossed from the sleep state to waking reality. Almost all participants reported that their ELDVs seemed to feel real. The ELDVs were memorable and were recalled with clarity and our findings are consistent with those reported by Mazzarino-Willet 2010 and Kellehear et al, 2008. This realism is consistent with prior research suggesting that, during stages of transition or crisis, dreams become more vivid, intense and memorable (Barrett, 1996). There was hardly any dialogue exchange in the ELDVs. Most of the participants had expressed fear after experiencing the ELDVs. This was in direct contradiction to other studies which found end-of-life dreams and visions (ELDVs) to be deeply comforting and profoundly meaningful for patients and their families (Fenwick et al, 2007; Brayne et al, 2006; Lawlor et al, 2000; Barbato et al, 1999). We found that ELDVs can occur months, weeks, days or hours before death, which is consistent with the findings of other studies (Mazzarino-Willett, 2010). Lawrence and Repede, 2012 and Wills-Brandon, 2000, in their studies had concluded that ELDVs typically reduce fear of dying, making transition from life to death easier for those experiencing them. However, in our findings, our participants had experienced fear, confusion and anxiety till the ‘meaning making’ process was done. The participants, prior to being involved in the ‘meaning making’ process were mostly nonplussed, disturbed and even fearful and none of the participants reported their ELDVs to be comforting. Another unique finding in our study was that ELDVs were related inversely with the symptom burden of the patient, where relief of distressing physical symptoms were associated with cessation of ELDVs. Also, ELDVs were more common as the patient approached death, which is consistent with the findings of other studies, which reported participants who experienced ELDVs had peaceful and calm deaths (Lawrence and Repede, 2012). This suggests that ELDVs may be prognostically significant based on changes in dream/vision content and increased frequency as death nears(Grant P et al ,2014).

There is much inconsistency in the field regarding how meaning making is defined, conceptualized, and measured (Gillies & Neimeyer, 2006; Neimeyer, 2001). We used the constructivist framework, where emphasis was given on the ‘process’ of meaning making using reasonings and suggestions based on the subject’s phenomenological experience.

Wheeler (2001) conducted a study using qualitative methodologies to attempt to

have a better understanding about parental meaning making after the death of a child. In this study, meaning making was defined as a “search for cognitive mastery,” which included a search for understanding, sense-making, and coherence, and a “search for renewed purpose,” which includes finding a new sense of purpose in current life and new life goals/plans after the loss (p. 52). The search for cognitive mastery stems from the cognitive perspective for coping with traumatic life events. It involves a search to attempt to answer the “how” and “why” questions. The authors found that this search often leads bereaved parents to want details surrounding the death, including an understanding of the sequence of events leading to the death. In our study too, we asked the “why” and “how” questions, albeit not in a direct fashion, as a part of the meaning making process, to arrive at a coherence. We too, like Wheeler’s study, have difficulties in answering the “why” questions and we agree that it does lead to a deeper spiritual & religious search about meaning of life and death and more importantly, the presence of an ‘after-life’.

Previous studies have reported consistent and positive changes in session quality and on outcomes that are specifically focused on dream work (e.g., insight, action ideas, target problems, and attitudes toward dreams). Less clear evidence has been reported on outcomes not specifically targeted in dream work (e.g., depression, anxiety, and self-esteem).Previous researchers have also found decreases in general symptoms (Diemer *et al*.,1996; Hill *et al*., 2000; Wonnell and Hill, 2005) and in depression (Falk and Hill, 1995), as well as increases in existential well-being when spiritual insight was the focus of the dream work (Davis and Hill,2005).

Research on autobiographical narratives with adults has consistently indicated that narrative indicators of meaning-making are related to increased well-being. Coherent, reflective and emotionally expressive narratives about specific stressful life events are related to higher levels of well-being (Frattaroli, 2006; King, Scollon, Ramsey, & Williams, 2000; Pennebaker & Chung, 2007). The findings of our study were in congruence with the above studies.

Limitations of this study

This study focused on only Hindu patients based in a rural setting. A larger study involving the inclusiveness of various religions, both rural and urban settings, multi-centric and involving different socio-economic strata of the society is warranted. Many participants were already experiencing ELDVs at the time of enrolment, which made it difficult to analyse the time course of this phenomenon.

Conclusions

This study was the first of its kind in evaluating ELDVs and 'meaning making' in rural India. What made this study unique that it focussed on the rural population, with its 'preserved' social, cultural and religious traditions (as compared to urban population), to have a better understanding on the nature of ELDVs experienced in this population and the resultant meaning making process in this community.

ELDVs are common and can often result in a sense of fear and confusion until they are counselled and they are helped to bring about a 'sense of meaning' to them. People are usually uncomfortable discussing ELDVs for fear of judgement and ridicule and this can bring about a sense of anxiety, fear and confusion. ELDVs can occur in wakeful or sleep states and typically manifest with clear consciousness, possessing a level of clarity, detail and organisation when reported. However, in contradiction to other studies, our participants had experienced fear, confusion and anxiety as a result of ELDVs till the 'meaning making' process was done. The participants, prior to being involved in the 'meaning making' process were mostly nonplussed, disturbed and even fearful and none of the participants reported their ELDVs to be comforting.

Another unique finding in our study was that ELDVs were related inversely with the symptom burden of the patient, where relief of distressing physical symptoms were associated with cessation of ELDVs. Also, ELDVs were more common as the patient approached death, which is consistent with the findings of other studies. Also, the deceased 'apparitions' visualised in the dreams appeared to be in the very best of their health, were well dressed and did not seem to threaten or harm the subjects.

Also, the 'meaning making' process of the EOLDVs provided a great sense of relief from the fear, confusion and anxiety which had been associated with the ELDVs. Also, the process of meaning making used in our study strongly focussed on the local cultural and social views and traditions that are common in Hindu, Sikh and Buddhist practices focussing on the presence of an after-life. The author too is convinced that the ELDVs point to the existence of an after-life. The author also is convinced that ELDVs presents a therapeutic opportunity for palliative care physicians and death duolas to assist patients and their families in the transition from life to death and even beyond, thus providing comfort and closure.

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Appendix Consent Form

CONSENT FORM

Title of project:

End-of-life dreams and visions and meaning-making in rural India

Name of Researcher: Dr. Abhijit Dam

Please
initial box

1. I confirm that I have read and understand the information sheet or the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I consent to use of recording of the interview with possible use of anonymysed verbatim quotation in reports or publications arising from the study ☐

4. I agree to take part in the above study ☐

______________________	___________	______________
Name of Participant	Date	Signature
______________________	____________	______________
Name of person Taking consent	Date	Signature

Appendix : Field Journal Notes

Bracketing Journal*:

Date: (List date of interview)

Location:

Pre-Interview Thoughts:

Question 1: How are you feeling?

Question 2: What pre-conceived thoughts and beliefs do you have regarding this phenomena, interview, and co-researcher?

Researcher’s Post-Interview Notes:

**The purpose of the bracketing interview/notes is to identify any preconceived ideas the researcher has about the topic in order to assist in identifying and acknowledging the researchers own ideas (i.e., emotions, thoughts, feelings, and beliefs) about the end-of-life dreams & visions (EOLDVs) process and their interpretation. In addition, this assists the researcher in his/her efforts to not impose his/her own personal views on the co-researchers’ descriptions and responses.*

Lay person’s understanding

What is the purpose of this study?

The proposed study intends to

1. To explore the personal experiences as well as the internally interpreted meanings of those experiences in terminally ill patients experiencing ELDVs.
2. To understand if the ‘meaning making process’ of the ELDVs could help in improving the quality of life of these individuals.

Why have I been invited?

We are inviting you to better understand your lived experiences of your ELDVs experienced and to determine if the ‘meaning making’ process had any effect on your overall quality of life . We are hoping to interview between 6 and 12 participants.

It is up to you to decide whether you wish to participate. If you are interested in participating we will describe the study and go through this information sheet. If you then decide to take part we will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen if I take part?

The researcher will discuss the study with you and answer any questions you may have, if you are then happy to be involved they will arrange a convenient time to interview you about your experiences.

The researcher will be asking some ‘closed ended’, ‘open ended’ and semi-structured questions to you about your experiences of ELDVs. The researcher will be recording the interview so it can be transcribed (typed out) afterwards but it will anonymised once it has been transcribed into a written copy. Nothing within the written copy will be included that could identify you in any way. The researcher will offer to telephone you one week later to check that you were happy with the interview and that no problems or issues have arisen as a result. They will give you their contact details in case you feel you need to speak to them again after the interview has taken place.

Do I have to take part?

No. Taking part is entirely voluntary. If you decide not to take part, or to withdraw at any time, you may do so without explanation.

What are the possible benefits of taking part?

There is currently a paucity of information on the potential benefits that ‘meaning making’ can offer to come to terms with the ELDVs experienced in terms of improving their Spiritual quality of life and positively affecting their psychology. Participating in this study can potentially boost you both psychologically and spiritually and help you in improving your holistic quality of life.

What are the possible disadvantages in taking part?

There are no physical risks as this study will only involve an interview and a psychological counselling offered on a voluntary basis in concurrence with the local culture. Talking about issues in end of life care may potentially be a distressing topic. You can stop the interview and/or withdraw from taking part in the study at any time without giving an explanation. The researcher will talk to you after the interview to check that it has not caused any particular problems and will offer to telephone you a week later to make sure no problems have arisen.

What if there is a problem?

If you have a concern about any specific aspect of this study, you could speak to the researcher who will do their best to answer your questions (Dr.Abhijit Kanti Dam).

Will my taking part in this study be kept confidential?

Yes. All information that is collected about you will be kept confidential. Only authorized persons such as the researchers or regulatory authorities (if the conduct of the study is audited for monitoring of the quality of the research) will have access to your identifiable data. All will have a duty of confidentiality to you as a research participant. Any information from the study which leaves the research team will have your personalized details removed so that you cannot be recognized from it. We may wish to use a quote from you, but no one will be able to identify you.

There are rare and exceptional circumstances when confidentiality may need to be broken, for example, to protect patients or others. Please ask us if you would like us to explain this point in more detail.

How will data be collected, stored and how long will it be retained?

The interview with the researcher will be recorded. The researcher will transcribe (type out) the interviews afterwards but only the content of the conversation will be in the typed form (not your name or other identifiable information). The recording of the interview and the typed (anonymous version) will be securely stored. We are required to keep this information for some time after the research has finished and so it be stored for 5 years from the end of the research project and then destroyed.

What will happen to the results of the research study?

The results of the study will be written as a research report (or dissertation). As this is an interview-based study, quotes from the interviews may be used in the research report but these would anonymous. The report may be published in medical journals or publications but you will not be identified in any report or publication. If you would like to be sent details of how to obtain a copy of the results just let the researcher know when they meet you for the interview.

Who is organizing and funding the research?

This study is being organised by Dr.Abhijit Kanti Dam, Consultant palliative care physician, Kosish-the hospice, Bokaro Steel City, India.

The study currently has no access to funding.

Who has reviewed the study?

The medical research ethics committee of Kosish-the hospice has reviewed the study and granted their approval for the same.

2. The research team would be happy to answer any questions you may have:

Dr.Abhijit Kanti Dam

Email: ratuldam@yahoo.com

Mobile: +91 8789976351

KOSISH-the hospice

1036, Sector 4 B,

Bokaro Steel City, Jharkhand, India.

If you are interested in participating please contact:

Dr.Abhijit Kanti Dam

Email: ratuldam@yahoo.com

Mobile: +91 8986872998

KOSISH-the hospice

1036, Sector 4 B,

Bokaro Steel City, Jharkhand, India.

If you prefer you can return this page with your name and contact number or e-mail address and we will contact you

Your name ____

Contact telephone____

And/or e-mail address _____________________________________

Preferable time of day to call you ___________________________

The Confusion Assessment Method Instrument:

1. [Acute Onset] Is there evidence of an acute change in mental status from the patient's baseline?

2A. [Inattention] Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

2B. (If present or abnormal) Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?

3. [Disorganized thinking] Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. [Altered level of consciousness] Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily], Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma; [unarousable]; Uncertain)

5. [Disorientation] Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?

6. [Memory impairment] Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?

7. [Perceptual disturbances] Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?

8A. [Psychomotor agitation] At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?

8B. [Psychomotor retardation] At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?

9. [Altered sleep-wake cycle] Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset or Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of consciousness

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegal, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. `Annals of Internal Medicine, 113(12), 941-948.