# Lucid Dream Therapy As A Treatment For Post Traumatic Stress Disorder: The Stigma Surrounding Dreams

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The stigma that has accompanied dreams into our century can be thought of as quite unfortunate. In our society, dreams are often thought of as unimportant or as "pure nonsense."(Gackenbach, 1997.) This stigma accompanies all types of dreams, including lucid dreams. There is a very small body of research that indicates the possible therapeutic uses of lucid dreaming. We can see how hard it would be for our society to accept this kind of therapy if they view the key element, dreaming, as "pure nonsense."(Gackenbach, 1997.) Society needs to change the attitudes around dreaming due to the possible benefits that dream therapy could have on problems such as post traumatic stress disorder. I plan to demonstrate the benefits that lucid dream therapy could have for the treatment of post traumatic stress disorder and show why society needs to embrace all types of dreaming as an important and useful human resource.

Lucid dreaming has been noted in history numerous times. Aristotle mentioned lucid dreaming (LaBerge, 1988.) Even the philosopher Thomas Reid spoke of using lucid dreams to control his nightmares (LaBerge, 1988.) Some have disputed lucid dreaming and said that there is no such thing. Green and McCreery offer an explanation for the dispute: "If people doubt lucid dreams they do so because they have never experienced one." (1994, p.5.) This is an interesting argument and quite possibly true. Stephen LaBerge explains why some dispute lucid dreams and why this dispute is faulty: "One might object that lucid dreamers are simply not attending to the environment; rather than being asleep, perhaps they are merely absorbed in their private fantasy worlds. . . . . .if subjects claim to have been awake while showing physiological signs of sleep (or vice versa), we might have cause to doubt their subjective reports."(1990, p.111.) The question that now must be raised is: what is considered to be a lucid dream?

As defined by Green and McCreery "Lucid dreams are those in which a person becomes aware that he is dreaming." (1994, p.1.) Despite the exclusive language, this is a clear and simple definition. Those who have had a lucid dream but are unfamiliar with the terminology could easily recognise their dream as "lucid." Hobson outlines some possible characteristics of lucid dreams and lucid dreamers: "(a) that lucid dreamers will frequently awaken from REM sleep once dream consciousness is achieved and (b) that lucidity will be easiest to induce at times in the night when the system is likely to be changing from REM to waking." (1990, p.38.) This quotation makes lucid dreaming sound quite disruptive to sleep. It is perhaps a relief that LaBerge says "Lucid dreaming is normally a rare experience." (1990, p.109.)

I propose that lucid dreaming has a connection to the treatment of post traumatic stress disorder, however before addressing this issue we must outline a definition of post traumatic stress disorder. In Appendix A there are two tables outlining various aspects of post traumatic stress disorder. The first is

taken from Ursano, Fullerton and McCaughey (1994, p.9) and the other is from Scurfield (1985, p.233.) In the first table there is a mention of dreams being a symptom of post traumatic stress disorder. This obviously means dreams of the trauma and these dreams are often of a disturbing nature. Kramer gives a definition of what would be considered "disturbing": ". . .our criteria for a disturbing dream: Troubling contents lead to an awakening associated with negative affect and the recall of a prior troubling dream." (1990, p.191.) Other general symptoms of post traumatic stress disorder listed in the tables include feelings of fear, guilt and detachment.

There are many varied ways to treat and provide therapy for post traumatic stress disorder. The literature indicates that early post trauma intervention and debriefing seem very effective. "Several studies, however, provide a rational for early intervention and delineate its optimal timing and its target population. The first line of evidence concerns the pathogenic effects of the secondary stressors that may follow the trauma itself. . . . Interventions which reduce these secondary stressors may improve the long-term outcome after traumas and disasters." (Shalev, 1994, p. 203.) Shalev also mentions several debriefing techniques such as: Task-oriented debriefing, Historical group debriefing and Psychological group debriefing (1994, p.204-209.) Debriefing is said to have positive effects because it possibly addresses both the emotional overload and the impaired psychic structures, which Shalev explains is the psychological foundation for post traumatic stress disorder (1994.)

Even though disturbing dreams are said to be a symptom of post traumatic stress disorder, the treatment is non-dream oriented. This is logical because physical problems can be treated in non-physical ways and vice versa. What is illogical is that dream oriented treatment is *not* considered. This could be simply an oversight, but it could also be an indicator of the aforementioned stigma surrounding dreams. Dream therapy is not a new phenomenon but it seems unfortunate that it is popular within only select circles or therapists. Lucid dreams could be an important tool for the recovery of post traumatic victims and it is unfortunate that a stigma could be the preventing factor surrounding this type of therapy.

Green and McCreery say, with no ambivalence, the advantage of lucid dreams: "Release from nightmares is one of the most obviously useful applications of lucid dreaming, and it might be considered in the context of treatment for people suffering from post-traumatic stress disorder in which the sufferer is sometimes tormented by recurrent bad dreams. . . ." (1994, p.125.) This quotation could deceivingly show us that researchers are recognising lucid dreaming as a therapeutic technique. The problem with that assumption being that Green and McCreery are in the dream field, not the field of psychological trauma. They are going to recognise the importance of dreams because they are not affected by the stigma that surrounds dreaming. The book *Trauma and Disaster* has no mention of lucid dreaming, so therefore the obvious connection to post traumatic stress disorder must only be obvious to those who specialise in dreams and not to those who specialise in psychological trauma. It is certainly tempting to blame a stigma for this sort of oversight on the part of trauma psychologists.

Paul Tholey outlined a variety of advantages to lucid dreaming. It is easy to apply these to the notion of post-traumatic stress therapy. "Advantages to Lucid Dreams:

> 1. Because of the lucidity, the dream ego is less afraid of threatening dream figures or situations. For this reason, there is less resistance to confrontation with these figures or situations.
>
> 2. Using appropriate techniques for manipulating lucid dreaming, the dream ego can get in touch with places, times, situations or persons that are important to the dreamer.
>
> 3. Especially in dialogue with other dream figures, the dream ego is able to recognise the present personality dynamics and their etiology (diagnostic function).
>
> 4. Through appropriate activity of the dream ego, a change of personality structure is possible (therapeutic of creative function.)" (1988, p.267.)

The first of these advantages involves being less afraid of the threatening situation. If a person suffering from post traumatic stress disorder has a distressing dream about their trauma it could be very beneficial to re-experience the trauma while having more control and less fear. This gives the opportunity for exploration of other possible outcomes or the exploration of feelings in general. The second advantage involves being able to get in touch with certain places/people/situations. A person in therapy for post traumatic stress disorder could be instructed in their therapy sessions to use this lucidity to their advantage. If the dreamer becomes lucid they could be instructed to change the setting of their dream to the setting or situation of their trauma and use this shift to initiate exploration. This is only some of the possible connections of lucid dream therapy to post traumatic stress disorder.

One of the largest advantages could be the element of control that lucid dreaming offers. If the victim of post traumatic stress is often plagued by distressing dreams they could use this control to shift the nature of the dream entirely rather than being left to suffer through the nightmare. They can use this control to deal with the stress in a sort of "virtual" way and also be free to go at a pace that they feel is comfortable. They could also use this control in much the same way the Buddhists do. The Buddhists use lucid dreaming to create their greatest fears and "monsters" in order to "transcend" these things (Gackenbach, 1997.) Certain post traumatic stress victims may use lucid dreaming to push their distressing dreams to the absolute edge of their imagination. Perhaps it could be beneficial to know the "limit," or, how far things could go since sometimes the "unknown" can be worse than the "known."

Paul Tholey also outlined a variety of ways to deal with threatening dream figures. It could be useful to give this outline to post traumatic stress victims so as to instruct them on what to do should they become lucid in a dream with a threatening character:

> "Appropriate behaviours toward threatening dream figures:
>
> 1. It is useful to confront the threatening dream situation despite rising fears.
>
> 2. It is better to reconcile with the dream figure through constructive dialogue than to attack it aggressively.
>
> 3. After the dialogue, the threatening figure can be transformed into a friendly one, who can provide help." (1988, p.265.)

Regardless of the exact way that lucid dreaming could be used to treat post traumatic stress disorder, the fact that there are so many diverse ways to use lucid dreams in this type of therapy is compelling. Surely if there are so many possibilities one of them might find its way into the therapeutic circles. There is no question that dream experts see the importance of lucid dreaming, so why has lucid dream therapy been overlooked by everyone else? It is possible that with the great variety of possible therapies for post traumatic stress disorder the therapists feel that there is no need for additional methods. Scurfield lists a variety of therapies for post traumatic stress disorder cited from other scientists:

> "Various behavioural techniques seem particularly effective: imaginal flooding and implosive therapy (Black & Keane, 1982; Fairbank & Keane, 1982; Keane & Kaloupek, 1982; Miniszek, 1984); systematic desensitization (Cellucci & Lawrence, 1978; Schindler, 1980); other behavioural techniques such as thought stopping, cognitive restructuring, behavioural bibliotherapy (Marafiote, 1980; Parson, 1984), and establishing ‘hierarchial routes of behaviour’ to improve impulse control (Horowitz & Solomon, 1975). There is some evidence to suggest that flooding may be most effective when used in conjunction with other treatment modalities (Miniszek, 1984)." (1985, p.244.)

This is just a sample of the possible therapies. Scurfield continues on for several paragraphs and, perhaps as expected, makes no mention of dream therapy. The only mention of treatment for the sleep disturbances associated with post traumatic stress disorder is "psychopharmacological treatment" (Scurfield, 1985, p.244.) This indicates the attitude that you must stop the sleep disturbances

and use other methods to treat the disorder, rather than the attitude that using the sleep disturbances constructively could actually be a tool to treat the disorder. One can only speculate at the reasons behind this sort of oversight. Though I have hypothesised that the therapists may feel they do not need additional methods of therapy, I do not believe that this is the case. It is doubtful that any therapist would say that better means of therapy should not be explored or discovered. Another factor could be that the ones who do the research on therapeutic methods are not always the therapists. Even if the therapists thought that additional methods were unnecessary, this does not mean that some experimental research would not be done in this area. It is not likely the lack of need which has prevented lucid dream therapy from being explored, but more likely the previously discussed stigma which presents dreams as useless and nonsensical. It is true that the attitudes surrounding dreams are changing. These changes are characterised by the growing field of dream research and dream experts, but not the development of positive dream attitudes in non-dream-oriented psychology. Better attitudes surrounding dreams in non-dream psychology must be developed before dream therapy reaches a popular status.

There are some potential problems with lucid dream therapy. Some of these could be the nature of lucid dreaming itself. We have already learned that lucid dreaming is a rare occurrence.(LaBerge, 1990.) What if the decision was made to use lucid dream therapy and the patient could not achieve lucidity? Lucidity can be "induced" or helped by a variety of means (Gackenbach, 1997) but this is still no guarantee. Another problem is lack of dream recall. The use of lucid dreams would be useless if the dreamer had no recollection of the events. One could argue that if the dreamer gained control to "tone down" the fear in the dream, they would be less likely to wake up with disturbed feeling from the nightmare, even if they did not remember the next day. Regardless of the recall, the dreamers sleep would not be disrupted. We have already seen that lucid dreaming can produce an awakening (Hobson, 1990) so the argument can be made that the lucidity will produce the same amount of awakenings as the nightmares. The affect will certainly be different, which is a benefit to the lucid induced awakening.

The benefits of lucid dream therapy seems to outweigh the possible disadvantages. The advantages hinge on the assumption that dream recall will be high and that the subjects will become lucid easily. These are large assumptions but they are not so large that they are the preventing factor of lucid dream therapy research. Research could still be possible while outlining these difficulties, so why has this not been addressed? Again, we return to the repeatedly mentioned stigma. Evidence has been presented to show the advantages of lucid dreaming for treating disturbing dreams. It has been noted that disturbing dreams are a key symptom of post traumatic stress disorder (Parker, 1996.) It has also been shown that lucid dreaming, though thought to treat disturbing dreams, has not been used in post traumatic stress therapy. Since we know there is a stigma surrounding dreams it is possible and logical to draw the conclusion that this stigma a factor in the omission of dream therapy from the treatment of post traumatic stress disorder. When the attitudes surrounding dreams and dream therapy changes in the scientific circles it is quite possible that lucid dream therapy will be used in the treatment of post traumatic stress disorder.

## Appendix A

### Table 1.1 *Posttraumatic Stress Disorder*

A. Exposure to a traumatic event

B. Reexperiencing symptoms (at least one of the following)

1. Intrusive recollections

2. Dreams

3. Acting or feeling as if the traumatic event were recurring

4. Distress at exposure to events that symbolise or resemble trauma

C. Avoidant symptoms (at least three of the following)

1. Avoid thoughts or feelings associated with the trauma

2. Avoid activities or situations that arouse recollections

3. Inability to recall important aspects of the trauma

4. Diminished interest in significant activities

5. Feelings of detachment or estrangement from others

6. Restricted range of affect

7. Sense of foreshortened future

D. Arousal symptoms (at least two of the following )

1. Difficulty falling asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating

4. Hypervigilance

5. Exaggerated startle

6. Physiologic reactivity upon exposure to events that symbolise

or resemble the trauma

**TABLE 1**

**Post-trauma Reactions and Symptoms**

1) Fear of repetition of the original trauma, including recurrence of the actual event or intrusive thoughts concerning the trauma.

2) Fear of being hurt similar to the victim.

3) Fear of loss of control over aggressive impulses, including withdrawal or rituals to avoid

aggressive expression.

4) Discomfort over vulnerability concerning both failure to prevent the trauma, and difficulties

that follow the trauma.

5) Rage at the source, toward any figure who might be blamed for responsibility for the trauma,

toward any persons who died, or toward any persons who are associated with the trauma.

6) Rage at those exempted from the trauma, or at those exempted from bereavement.

7) Discomfort over aggressive impulses toward anyone connected in actuality or symbolically to the personal frustrations triggered by the trauma

8) Guilt over self-responsibility for not preventing the trauma.

9) Survivor guilt, "I survived and __ didn't"; and other actions performed or not performed to survive.

10) Sadness over loss of another person, or of aspects of the self that have been lost, e.g., innocence, trust in the goodness of humanity, etc.

11) Isolation, alienation, paranoia--oftentimes directed toward authority figures.

12) Addictive disorders, including substance abuse or attempts to self-medicate or otherwise deny the impact of the trauma; thrills, risks and gambling--including gambling with fate as in chronic high-speed driving.

13) Somatic complaints--tension headaches or pains in the head, migraines, low-back syndrome, ulcers or other stomach complaints, irritable colon, hypertension, etc.

14) Significant life-style changes and/or loss of or confusion concerning values, direction and meaning in life. May be manifested through chronic (post-trauma) underachievement, "wandering" life-style, outbursts in antisocial activity, marked changes in relatedness to the country and its institutions.

Symptoms or themes 1-10 are taken mostly intact from Krupnick & Horowitz (1981). Themes 11-14 have been documented by various writers; for example, see Blank (1982).

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