The Importance of Lucid Dreaming to Psychotherapy within an Adlerian Psychology Context

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By

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Abstract

Adlerian psychology takes a holistic approach to understanding individuals, problems, and mental illness. It holds that people are complex and cannot be viewed in isolation, but must consider the social context, environmental factors, biological considerations, and individual perceptions of each person’s experience. This makes it a very flexible framework and philosophy for engaging in therapy with clients, and promoting mental health. As a part of maintaining client health, sleep and dreaming are essential functions to human physiology. Sleeping and dreaming offer restorative properties to the body and mind. Lucid dreaming is the awareness that while dreaming, one is dreaming. There are several methods found to induce lucid dreaming, and when induced, a lucid dream allows for exploration of the dream scape, dream content, and interaction with dream characters. People spend roughly 28 years of life asleep, and approximately 5 years during a dream state. If half of this dream state time were spent lucid dreaming, that would 2.5 years of time to explore or create an inner dream world, engage in task rehearsal, experience cardiovascular benefits via dreamed exercise, lessen the impact of nightmares, and other potential experiences. Pertaining to psychology and therapy, this project attempted to answer the question: Does the phenomenon of lucid dreaming fit within an Adlerian philosophical framework?

Keywords: Adler, Adlerian, sleep, dreams, dreaming, lucid dreaming, lucid dreaming induction, lucid dreaming techniques
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Importance of Lucid Dreaming to Psychotherapy within an Adlerian Psychology Context

Introduction

Sleep, dreams, and specifically lucid dreaming, for the purpose of this literature review, are biological phenomena that apply to everyone. Everyone sleeps. The average life expectancy of a person in the United States (US) is 78.7 years (Centers for Disease Control [CDC], 2014). If people on average get 8 hours of sleep per night, then people spend about 35%, or roughly 28 years (Table 1), of their life sleeping. That is a considerable amount of time over the course of the lifespan.

Table 1

<table>
<thead>
<tr>
<th>Age Ranges</th>
<th>1 - 5</th>
<th>5 - 10</th>
<th>10 - 79¹</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep Hours per Night</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>na</td>
</tr>
<tr>
<td>Years During Age Range¹</td>
<td>5</td>
<td>5</td>
<td>69</td>
<td>79</td>
</tr>
<tr>
<td>Days per Year</td>
<td>365</td>
<td>365</td>
<td>365</td>
<td>365</td>
</tr>
<tr>
<td>Total Hours Sleeping</td>
<td>21,900</td>
<td>18,250</td>
<td>201,480</td>
<td>241,630</td>
</tr>
<tr>
<td>Hours per Day</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Total Sleep in Years</td>
<td>2.5</td>
<td>2.1</td>
<td>23.0</td>
<td>27.6</td>
</tr>
<tr>
<td>Percent of Life Asleep</td>
<td>50%</td>
<td>42%</td>
<td>33%</td>
<td>35%</td>
</tr>
</tbody>
</table>

¹average life expectancy is 79 year (CDC, 2014.)

It is estimated that, on average, people have between 3-5 dreams per night lasting anywhere from 5 – 45 minutes (Lewis, 2013; Silberman, 2008). That could equate to roughly 1.6 hours per night that people spend dreaming. Taking that math further that means over the course of a 79-year lifespan people spend about 5.2 years (~7%) of their life dreaming (Table 2).
Table 2

*Hours Spent Dreaming Over a Lifetime*

<table>
<thead>
<tr>
<th></th>
<th>Sleep Cycle</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Cycle Duration in Minutes</td>
<td>5</td>
<td>15</td>
<td>30</td>
<td>45</td>
<td>95</td>
</tr>
<tr>
<td>Cycle Duration in Hours</td>
<td>0.1</td>
<td>0.3</td>
<td>0.5</td>
<td>0.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Days per Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>365</td>
</tr>
<tr>
<td>Dream Hours per Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>578</td>
</tr>
<tr>
<td>Average life expectancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>79</td>
</tr>
<tr>
<td>Dream hours over lifespan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45,655</td>
</tr>
<tr>
<td>Years Dreaming over Lifespan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.2</td>
</tr>
<tr>
<td>Approximate Percent of Sleep spent Dreaming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7%</td>
</tr>
</tbody>
</table>

*Note: 1* information obtained from (Lewis, 2013; Silberman, 2008)

The literature review will attempt to answer many questions. Is the time spent sleeping and dreaming just idle time? What should people make of this time? What conclusions can be drawn from the images, meanings, emotions, and feelings that people draw from their dreams?

Lucid dreaming is of particular interest to this researcher. If people are able to induce lucid dreaming more frequently, what can someone do with this ability or time? Are there tasks one could learn or personal insights to glean? Could lucid dreaming help mental illnesses? If people could lucid dream half of the time they dream, it would mean roughly 2.5 years spent exploring dreams or potentially learning or practicing new skills. It might also be a potent alleviation of mental health issues that persist not only in sleeping or dreaming, but also during wakefulness.

In order to understand how lucid dreaming might be integrated into an Adlerian philosophical approach to counseling and therapy, a basic framework of Adlerian
LUCID DREAMING

psychology, sleep, and dreams will first be addressed. Both sections on sleep and dreams, although brief, will also include a discussion from an Adlerian perspective and their importance to the treatment of mental illness. This will be foundational in order to understand lucid dreaming within an Adlerian philosophical integration.

Particular to lucid dreams, this project will examine three aspects of this phenomenon and then propose how lucid dreaming might be integrated into Adlerian psychology philosophy. The first aspect was an overview highlighting the physiology and neurological changes experienced while lucid dreaming. The second aspect examined the ease of learning and applying lucid dreaming techniques. Thirdly, an investigation of how lucid dreaming techniques could be used to alleviate and reduce psychological symptoms as applied in psychotherapy was addressed.

The final discussion proposed an integration of Adlerian philosophy as applied to lucid dream discovery. As a research question, are lucid dreaming techniques applicable for use in psychological therapy, can they achieve therapeutic outcomes, and how does lucid dreaming integrate into Adlerian psychology?

**Adlerian Psychology**

Adler (1956) named his psychology Individual Psychology, as translated from his native Austrian language. The translation *Individual* is often mistaken, and in his native Austrian means that the entire individual must be considered, and that any one part cannot be separated or understood from the whole (Griffith & Powers, 2007). Adlerian psychology is one of holism, uniqueness, and unity of the individual. The cliché, *the whole is greater than the sum of its parts* is fitting as applied to Adlerian thought.
The thrust of this discourse on lucid dreaming is not only to gain an understanding of the phenomenon itself, but also how it can be integrated into an Adlerian psychology framework. It would be rash to assume that everyone is familiar with Alfred Adler and his Individual Psychology. To remedy that assumption, the next section will be a brief primer and provide a basic understanding of Adlerian psychology and a few of its major tenets that are germane to this literature review, and how they might be applied to conceptualizing lucid dreaming within an Adlerian philosophical framework.

**Life Tasks, Lifestyle, and Teleology**

Adler believed that the main problems in life are problems of human cooperation, as people are bound and tied together around three core tasks; love and marriage, social relations, and occupation (Ansbacher & Ansbacher, 1956). His philosophy held that in order to live a human experience, one will at some point be confronted by these three life tasks, which gave rise to the three major problems inherent in human collaboration (Ansbacher & Ansbacher, 1956; Griffith & Powers, 2007). Adler called them “unavoidable” (Griffith & Powers, 2007, p.64). Each task cannot be solved separately, as they are inextricably linked (Ansbacher & Ansbacher, 1956).

Griffith and Powers (2007) inform that lifestyle is akin to the term personality in other systems of psychology. In the pursuit of overcoming the three life tasks, a person develops a lifestyle, or style of living, and potentially encounters trouble that might manifest as a mental health disorder. Oberst and Stewart (2003) declared much the same when they added that from an Adlerian point of view, mental health disorders all have a common etiology in that they are unsuccessful attempts to respond to the demands of the three tasks of life.
Oberst and Stewart (2003) also stated that the Life Style is conveyed by the opinion that clients take towards their experiences. They shared that it is often understood by having a client answer questions such as, “I am…”, “The world is…”, “Life is…”, “Other people are …”, and “Therefore I want, or I have, to…” (p. 69). The answers to these questions show what a client thinks of himself or herself, their view of the world and life, their view of others, and their goals.

**Psychology of Use**

Adlerian psychology holds that people exhibit behaviors and hold beliefs that in some way are useful in the pursuit of their goals (Ansbacher & Ansbacher, 1956; Griffith and Powers, 2007; Mosak and Di Pietro, 2006). The purpose of an Adlerian practitioner then, in alliance with a client, is to understand what use a client’s thoughts, patterns of behavior, perceptions, and beliefs are towards their life and goals. According to Adler, other psychology theories were focused on what a person brought into the world, which he called “possession”, whereas he was more interested in the use one made of these possessions (Ansbacher & Ansbacher, 1956, p. 205).

Adler conceptualized Adlerian psychology as being concerned with the relationship between the outside world and the individual, as the raw material with which a psychologist would observe and work with (Ansbacher & Ansbacher, 1956). This relationship between how an individual relates to the outside world, are the bricks that an individual uses in the creation of their attitude towards life (Ansbacher & Ansbacher, 1956). For Adler, the initial bricks were laid very early on in development, and a therapist and client can potentially discover them, via early recollections.
Early Recollections and Mistaken Beliefs

Early recollections (ER’s) are both a core Adlerian concept, as well as an assessment tool and intervention utilized by Adlerian practitioners (Griffith & Powers, 2007; Mosak & Di Pietro, 2006). Adler proposed that children draw conclusions about the world from their experiences and that from a young age they strive for belonging, security, and acceptance in their familial, cultural, and social environments (Ansbacher & Ansbacher, 1956). Asking about and exploring these thoughts, feelings, and use of early memories are very important to an Adlerian practitioner. Adler said, “There are no “chance memories”: out of the incalculable number of impressions which meet an individual, he chooses to remember only those he feels, however darkly, to have bearing on his situation” (Ansbacher & Ansbacher, 1956; p. 351). People retain early memories that are in some manner important, to them, even if they do not remember every single event of their lives. Oberest and Stewart (2003) added that memories exemplify the current Life Style as it is projected back to events that happened long ago, and illustrate a person’s concerns, goals, and manner of coping (p. 68).

Yet memory can be tricky, as there is a significant body of research proving that it can be unreliable (Loftus, 2005). So to an Adlerian, the factual details of the actual memory are not as important as the thoughts, feelings, and to what use a client makes of the memory. Adler (1956) claimed as much when he stated:

We do not believe that all early recollections are correct records of actual facts. Many are even fancied, and most perhaps are changed or distorted at a time later than that in which the events are supposed to have occurred: . . . old remembrances are not reasons, they are hints. They indicate the movement toward a goal and what obstacles had to be overcome (Ansbacher & Ansbacher, p. 352).
Adler’s concept of ER’s are similar to Piaget’s cognitive theory of development, though Adler’s ideas pre-dated Piaget’s, who published his research in 1936 (McLeod, 2015), by a few years. Both Piaget and Adler thought that children are very observant (Ansbacher & Ansbacher, 1956; McLeod, 2015). McLeod (2015) reported that Piaget’s cognitive theory of development held that as children grow older they add more and more schema’s that grow more and more elaborate. They often internalize a misguided cognitive schema about their place and importance in the world, and their behaviors are based on their perceptions of their role in familial, social, and cultural contexts.

In a similar concept, Adler believed that children, although great observers, lack the wisdom and maturity to draw appropriate conclusions from their experiences (Ansbacher & Ansbacher, 1956; Griffin & Powers, 2007). These erroneous conclusions lead people to form Mistaken Beliefs about themselves, others, and the world. (Ansbacher & Ansbacher, 1956; Griffin & Powers, 2007, Mosak & Di Pietro, 2006). Mistaken Beliefs form a private logic that starts to interfere with the Life Tasks, causing clients to experience difficulties in their lives. It is the basis, or at least a possible reason, for people to present for therapy.

ER’s are often used as both an assessment tool, and an intervention by Adlerian therapists. A therapist will typically ask a client for a recollection as far back as the client can remember, usually between the ages of 4 to 10 (Ansbacher & Ansbacher, 1956; Mosak & Di Pietro, 2006). The memory is written down verbatim as the client tells it to the therapist. The therapist will ask for the most vivid moment, or highlight of the memory, which is also written down. Often several ERs are gathered.
ER’s lead an Adlerian practitioner to a conceptualization of how, perhaps even when, and why people are the way that they are. This knowledge can help both client and therapist during counseling. The information gathered from an ER will illustrate a client’s view of the world, according to Adlerian theory, and will also clarify how they operate or move within it (Mosak & Di Pietro, 2006). Thoughts, perceptions, and actions are unified and do not contradict each other, which is a central tenet of Adlerian philosophy (Mosak & Di Pietro, 2006). Thus, ER’s are extremely useful in understanding how people see others, themselves, and the world around them.

Summary

Adlerian psychology takes a holistic approach to understanding the individual. It recognizes that people are complex and cannot be viewed without taking into account a person’s social context, environmental factors, biological considerations, and individual perceptions. This makes it a very flexible framework and philosophy for engaging in therapy with clients.

A brief primer on Adlerian psychology has now been established. In order have a good understanding of lucid dreaming, it is important to understand the context in which it takes place; sleep and dreaming to be specific. To that end, the next section will discuss the sleep stages and physiology, sleep related benefits, and how sleep is viewed from an Adlerian perspective.

What is Sleep?

Stages and Physiology

Researchers have divided one sleep cycle into four stages with one complete cycle lasting approximately 90 minutes, and occurring roughly four to five times per night
The four stages are stage N1, stage N2, stage N3, and REM or the Rapid Eye Movement (REM) stage (Lewis, 2013; Silberman, 2008). The American Psychiatric Association, The American Psychological Association, the National Sleep Foundation, as well as the National Institute of Neurological Disorders and Stroke confirm the sleep stages.

The brain cycles through the stages repetitively. As the sleep cycles progress, stage N3 and REM become inversely proportional (Lewis, 2013). There is a greater percent of time spent in stage N3 sleep, with less in REM, during the first part of the night, and less time spent in stage N3 sleep with more time spent in REM sleep later in the night.

Stage N1 is a transition phase between wakefulness and sleep, and is marked by slow rolling eye movements waking consciousness fades, possible muscle twitches or jerks, and the potential to be easily awakened (Lewis, 2013; Silberman, 2008). Silberman (2008) reported it was also the shortest sleep cycle accounting for approximately 10% of the total time spent sleeping, and was considered the lightest stage of the four stages.

Stage N2 is the next stage, and Silberman (2008) reported it was a deeper stage of sleep that could be distinguished by two measurable occurrences using an electroencephalogram (EEG). An EEG measures electrical activity between brain cells, and is connected to the outside of the scalp by small flat metal discs, called electrodes. Researchers have used an EEG to measure electrical brain activity during both wakefulness and sleeping (Lewis, 2013; Silberman, 2008).
The first measurable occurrence in the N2 stage of sleep, according to Silberman (2008), is the detection of sleep spindles. These spindles are a certain frequency of electrical waves in the 12- to 16-hertz range (Silberman, 2008). They appear as a burst of activity on an EEG. See figure 1 for an illustration of sleep spindle waves as might be measured on an EEG.

![Figure 1. Stage N2 EEG.](image)

**Figure 1.** Stage N2 EEG.

*Note.* Frequency of electrical waves appear as a burst of activity on an EEG. Illustration of sleep spindle waves as might be measured on an EEG. Notice the range of waves between depicted between roughly 12-16 hertz, as measured by an EEG. These tight groupings are the spindles that occur in stage N2. Figure created with information from Silberman (2008).

Silberman (2008) described the second occurrence in the N2 stage of sleep as K-complexes. This is a brief, peak high voltage waveform that occurs at random, but is also found in responses to auditory stimuli during sleep (Silberman, 2008). Conscious awareness of the environment disappears during this stage, and there is also reduced muscle activity (Silberman, 2008). According to Bowman and Mosenin (2003), a person may spend between 35 and 55% of the night in this stage of sleep, or the majority of time spent asleep in this stage (as cited in Silberman, 2008).

The third stage, N3, is also known as slow wave sleep (Lewis, 2013; Silberman, 2008). It is the deepest of the sleep cycles, and gets its name from the slow wave-like
read outs on an EEG also called delta waves (Lewis, 2013; Silberman, 2008). Figure 2 illustrates what an EEG readout of stage N3 sleep may look like.

![Figure 2. Stage N3 EEG](Image)

*Note.* Illustration of what an EEG readout of stage N3 sleep may look like. As compared to the previous N2 stage, which contains the tight groupings of spindles, the peaks and valleys of brain wave activity in N3 are much longer and smoother. Figure created with information from Silberman (2008) and Lewis (2013).

During stage N3, according to Silberman (2008), it can be difficult to wake a person up, and then they often have no recollection of the event the next morning or upon wakefulness. It has been thought to be the most restorative time, yet also the period that has the most sleep disorders, called parasomnias, such as sleep talking, sleepwalking, night terrors, and bed wetting (Silberman, 2008). Rothenberg (1997) described parasomnias as “behaviors that intrude into sleep, occur during transitions from one sleep stage to another, or occur during the transitions between sleep and waking” (as cited in Silberman, 2008, p. 163). These disorders are also confirmed and listed in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association [APA], 2013).

The fourth stage of sleep is REM sleep, which takes its name from the observable movement of the eyes (Silberman, 2008). The REM stage is often associated with the
stage that dreaming occurs, but Silberman (2008), and Lewis (2013) both have informed that dreams can occur in other stages as well. Adults spend about 20 – 25% of sleep time in this phase (Silberman, 2008) making it the second longest stage.

There are unique psychophysiological interactions during REM sleep, where the body undergoes a near paralysis that inhibits any acting out of dream content (Erlacher and Schredl, 2008; Lewis, 2013; Silberman, 2008). Jouvet (1965) pinpointed the area of the brain responsible for this condition, in what Mastin (2013) and others call skeletal paralysis, during dreaming where “the efferent motor commands are actively suppressed by neural structures in the brain stem” (as cited in Erlacher & Schredl, 2008, p. 112). This skeletal paralysis is not present in any other stage of the sleep cycle.

There has been a lot more research done since Jouvet’s 1965 study, and several researchers provided a more current understanding of the neurochemistry of sleep. Mastin (2013) described REM sleep as regulated from a group of neurons in the pons region of the brainstem, providing a little more specificity to Jouvet’s (1965) general description of neural structures. The pons is located just above the medulla, at the base of the brain (Hall, 1998). The section of the pons at work during REM sleep is called the peribrachial area. A neurotransmitter called acetylcholine is found in great abundance in the peribrachial area during REM stage sleep (Hall, 1998). Hall (1998) also reports that acetylcholine is also found during wakefulness, yet its presence in the brain doubles during sleep, which was confirmed by Lewis (2013). Serotonin, another neurotransmitter, impedes REM sleep (Lewis, 2013). Serotonin reuptake inhibitors (SSRI’s), which are a common class of anti-depressant drugs, prevent acetylcholine intake in the peribrachial area of the pons, which is why they are often used as a
treatment for insomnia (Lewis, 2013). This information from Lewis (2013) and Hall (1998) highlighted just how important acetylcholine is to the neurochemistry of the sleeping brain.

While acetylcholine neurotransmitters are activating in the pons, different areas are simultaneously dampened for REM sleep to take place (Hall, 1998). This dampening or inhibiting prevents the release of norepinephrine, serotonin, and histamine (Hall, 1998). These neurotransmitters are usually present for motor neurons to create muscle activity, and thus the body experiences muscle paralysis, or atonia, during REM sleep (Hall, 1998). This unique atonia prevents the body from carrying out any physical gestures during a dream state, even though other physical processes such as heart rate, blood pressure, and rate of breathing can be effected during dreams and especially lucid dreams, which will be covered later.

**Benefits**

Researching sleep related benefits has often been accomplished by measuring what happens when people go without sufficient sleep, known as sleep deprivation (Draganich & Erdal, 2009; Lewis, 2013, Silberman, 2008). Lewis (2013) reported that higher levels of the stress hormone cortisol, a slight drop in body temperature, and compromised immune function have been attributed to sleep deprivation in experiments. Thus at a basic physical level, reported Lewis (2013), researchers know that benefits of sleep include temperature regulation and a slower immune response (p. 5). Hall (1998) reported a similar effect of sleep on temperature regulation of the body, and linked this regulatory function to acetylcholine. Lewis (2013) also mentioned deficits in cognitive tasks such as memory, mood, and attention. The National Institutes of Health (NIH) also
added how sleep loss harms focus, higher levels of reasoning, attention to detail, and problem solving (Benefits of Slumber, 2013).

In addition to drops in cognitive functioning, there are a host of physical ailments that happen to the body. The Benefits of Slumber (2013) reported that without sufficient sleep there is increased risk of obesity, infections, heart disease, and weight management, as well as a decrease in reflexes and motor skills. They also reported that vaccinations are less effective, and that even in otherwise healthy people, sleep deficits can produce diabetic-like conditions (Benefits of Slumber, 2013).

As mentioned in the introduction, people spend roughly 35% of their lifespan sleeping. It is a necessary biological function. Without sleep, or a deficit in both sleep quantity and quality, both behavioral and physiological changes occur (Draganich & Erdal, 2014). Draganish and Erdal (2014) listed several studies on the effects of sleep deprivation. Ratcliff & Donger (2009) shared the impact to attention and focus, a slowdown of the brain’s central processing speed and power, and lower cognitive functioning. It can also have impacts on distractibility, reductions in logical reasoning and auditory alertness (Blagrove, Alexander, & Horne, 1995), lower cognitive processing and impact attentional arousal, impair central processing, and lower cognitive functioning overall (Ratcliff & Donger, 2009, as cited in Draganich & Erdal, 2014), it can significantly increase distractibility and diminish logical reasoning and attentiveness to audio stimuli (Blagrove, Alexander, & Horne, 1995). Sleep loss has also suggested a decrease in fluency (Harrison & Horne, 1997), slower response times and scoring accuracy on tasks involving working memory (Bartel, Offermeier, Smith, & Becker, 2004; Pilcher et al., 2007), and increased times completing mental math skills (Frey,
Badia, & Wright, 2004). As evidenced by all of these studies mentioned in Draginich & Erdal (2014), sleep loss and deprivation have an extremely negative impact on, mood, speech, memory, and the body.

**Adlerian Perspective**

Adlerians are interested in sleep disorders, as they are akin to any other disorder a client might present with. The curious Adlerian would like to know and perhaps discover what a client might be avoiding by not getting enough sleep (Williamson & Williamson, 2015). Adler (1944) had a very practical approach to sleep abnormalities and would ask clients “What could you do if you could sleep?” and “What are you thinking about if you do not sleep through the night?” (as cited in Williamson & Williamson, 2015, p. 60). The answers a client might give can lead an Adlerian therapist to clarify or understand client concerns, or fears.

This is a wonderful example demonstrating the Adlerian concept of the psychology of use. To what *use* does a client make of not sleeping? What might they be avoiding, or how are they using it as an excuse? Avoidance, via a sleep disorder, can serve a protective function, shielding a person from perceived inferiorities. Adler said, “Everyone who does not sleep has a purpose, in which he is supported by not sleeping” (as cited in Ansbacher & Ansbacher, 1956, p.312). Griffith and Powers (2007) added, “the psychologist does not seek an understanding of individuals by understanding traits . . . but rather in observing the ways they make use of their various capacities and opportunities in line with their goals” (p. 85). An Adlerian therapist would examine how a client might be using a sleep disorder to avoid facing another more difficult or painful self-realization.
Summary

In summary, one sleep cycle lasts about 90 minutes. Each cycle is further divided in 4 main stages of sleep, each with different functions and physiological happenings, and different lengths of time. Figure 3 summarizes 1 sleep cycle, with approximate duration of time spent in each stage.

Figure 3. Illustration of 1 complete sleep cycle with approximate duration of time spent at each sleep stage.

Furthermore, the literature reviewed confirmed that sleep is a vital part for restorative processes in the human body. A good night’s sleep can help fight off illnesses (Benefits of Slumber, 2013; Draganich & Erdal, 2014; Lewis, 2013; Silberman, 2008), perform tasks for memory consolidation (Lewis, 2013), as well as provide the platform for both lucid and non-lucid dreams (LaBerge, 1990) as will be shown in a forthcoming
section of this paper. Sleep is still an ongoing area of interest for researchers, and more discoveries on the intricacies of the brain and body connection during this period of rest are sure to come in the years ahead.

Dreams will be investigated in the next section. There will be a brief examination of the current theories and prevailing understanding on the nature and purpose of dreams, followed by a list of benefits that dreams may provide, and then a small discussion of an Adlerian view of dreaming and how dreams are applicable to therapy. At that point, there will be a sufficient base of knowledge to examine lucid dreaming, and how lucid dreaming fits within an Adlerian philosophical framework.

**Dreams**

Merriam-Webster defines a dream “as a series of thoughts, visions, or feelings that happen during sleep” (Dream, n.d.). There has long been a fascination with dreams throughout human history. A historical narrative on the importance of dreaming to culture, art, literature, and religion is outside the scope of this review. It is important just to note, that dreams have played an important part in history and are still an ongoing area of research today.

**Prevailing Understanding**

Dream research has focused on the neurology, physiology, content, and meaning of dreams. Yet, despite the many findings and advancement throughout history, dreams are still mysterious to this day. The research often has conflicting findings and theories, and are often misunderstood. As an example, as recently as 1998, a review of introductory psychology textbooks by Squeir and Domhoff (1998) found that almost all teach that dreaming only occurs primarily during REM sleep (p.152). The vast
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psychological literature on dreaming suggests otherwise (Squier & Domhoff, 1998), with dreaming found to take place in both non-REM (NREM) as well as REM sleep.

A major influence on dream understanding came from Sigmund Freud, founder of psychoanalysis, who proposed that dream content was driven by wish fulfillment, and that examining dream content and their meanings would lead to a deeper understanding of the unconscious (Crain, 2011). Carl Jung was another important figure in the history of psychology, who believed that dreams were a part of the collective unconscious of all human kind, where archetypes of people existed. Jung differed from Freud slightly, in that he thought dreams were not as sexually oriented (Crain, 2011).

Freud, Jung, and Adler developed their theories almost 100 years ago, and there has been continued research, discussion, and testing in the scientific and psychological communities since their time. Many studies and current practitioners still hold to the framework that Freud, Jung, and Adler proposed (Carlson & Slavik, 1997), even though they differ and somewhat oppose each other. Advances in scientific understandings of the brain, sleep, and dreams have significantly improved and informed a general consensus of the physiology of dreams.

Currently, and even in addition to the theories proposed by the theorists above, there are still numerous theories about dreaming. Each proposed a different purpose and function of dreaming, with some shared similarities. Some of the major theories are the activation synthesis model (Porte & Hobson, 1996), which has since been further refined by Hobson and is now called the activation, input-output gating, and modulation (AIM) model (Hobson, 2009), a theory that dreams serve a function in memory consolidation.
Lewis (2013) also reported a similar finding on memory consolidation, as dreams reflect memory replay early on in the night, and gradually become more fragmented as the night continues. Lewis (2013) noted that this suggested a weak connectivity link between the hippocampus and the neocortex. She pointed out that during REM sleep, the hippocampus and the dream activated parts of the neocortex are active, yet they don’t appear to communicate as they often responded independently from one another (Lewis, 2013).

**Adlerian Perspective**

Adlerian’s treat descriptions of dreams by clients much the same way as early recollections (Oberst & Stewart, 2008). What is important about the content of dreams is the way a client feels, or experiences the dream. Adler believed in the “unity of personality” (Ansbacher & Ansbacher, 1956, p. 358), such that even dreams cannot function opposite of an individual’s life style. A dream is a bridge that illustrates the problem a client is facing in seeking their goal (Ansbacher & Ansbacher, 1956). The role of the therapist and client is to use the information that dreams provide to help both understand this goal, whether fictive or not, and what roadblocks, either internal or external, are preventing the client from reaching that goal.

Adler’s concept of psychology of use is also applicable as it pertains to dreaming. It also expanded more on why what a person feels about their dream is important. Adler (1956) paradoxically thought that if the purpose of dreams is to be discovered, then the purpose of not remembering or forgetting dreams must be found, and perhaps the whole point is not to be cognitively understood, but emotionally processed (Ansbacher & Ansbacher, 1956,).
Adlerian Use of Dreams

A real significant part of a dream could be to the minds intent to confuse, so that it’s not the thoughts that a therapist and client need to pay attention to, but in the emotions and feelings that the sometimes non-factual images convey. In a therapy session, focus should be placed on the use of emotion and mood, rather than logic, reason, and judgment, as thoughts can make errors in judgment (Ansbacher & Ansbacher, 1956, Oberst & Stewart, 2008, Carlson & Slavik, 1997). Robert Willhite (1991), an Adlerian therapist and educator, wrote that dreams can serve many purposes such as rehearsal experiences, function as a release for tension and anxiety, and help a therapist and client examine control issues. By placing attention on how a person experiences a dream, the use of the dream, being consistent with a person’s life style, should be clearer to both client and therapist.

Adlerian practitioners use can use dreams for short term, solution focused therapy (Carlson & Slavik, 1997. The principle is to use a client’s current attitudes and beliefs, or life style, as a mechanism to change behavior, as Adlerians believe that behavioral changes don’t have to occur after cognitive changes (Carlson & Slavik, 1997). Changes in behavior can indeed drive insight, as insight doesn’t have to precede behavioral changes. The attitudes, beliefs, and ingrained automatic behaviors that will reveal themselves while discussing a dream in therapy can be used to highlight the life style, and how a client is not using common sense to deal with the current problem. Carlson & Slavik (1997) stated that common sense has been clouded or replaced by distorted perceptions, and a client is using private logic. It is a goal of therapy, according to Adler (1956) to discover and reveal this private logic so that common sense can be applied to
problems (Ansbacher & Ansbacher, 1956). Thus, a technique would be to have a client recount a few dreams that they can recall, as this is the information the Adlerian practitioner would use (Carlson & Slavik, 1997).

**Summary**

In summary, dreaming is still a focus of research and study. Dream theory has undergone many revisions since Freud’s psychoanalytic theory was developed. Despite no one uniform scientific finding, current research from Hobson (2009) suggested that dreaming plays an important role in encoding memories. This is echoed in Lewis (2013), although she also proposed the idea that dreams are a “random firing in the cortex triggered by disordered activity in the brainstem” (p. 99).

Adlerians treat dreaming as another piece of data. The content of the dream is not as important, but rather how the client reacts to the dream, or how they feel about it is the information that is useful to an Adlerian. This understanding can help a therapist understand the use or purpose of not only the dream, but provide more information of the lifestyle of the client.

**Lucid Dreams**

**Definition, History, and Background**

Lucid dreaming is the awareness that while dreaming, one is dreaming. For background and context, according to Holzinger (2009) the notion of lucid dreaming begins with Aristotle in his treatise “On Dreams”. It was further refined by Dutch psychiatrist Frederik Willems van Eeden, who coined the term ‘lucid dreaming’, and was brought to popular attention by Freud (Holzinger, 2009). Holzinger (2009) also informed that this interest in dreams, brought about by Freud and his work, legitimimized modern day
scientific and scholarly study into sleep and dreams. Noted researchers such as Stephen LaBerge and Paul Tholey have made significant discoveries and are considered experts in this field (Holzinger, 2009).

Awareness in a lucid dream gives the dreamer the potential to influence, shape, or control the nature, course, and content of the dream (Laberge & Levitan, 1995). The word potential is used deliberately, as lucid dreaming is not a dichotomous off or on phenomenon. It should be viewed as a continuum, as researchers have struggled to arrive at a consensus on a clear definition of lucidity (Barrett, 1992). On one end of the continuum, lucid dreaming can be a state where one is aware they are dreaming, but unable to control, shape, or interact with the dream. Frequent lucid dreamers in test reports relay that they often can slip in and out of lucid dreaming several times within the course of a dream, or over the entire sleep period (Waggoner & McCready, 2015). The other side of the continuum is prolonged period of time and an outlet for fantasy free of the laws of physics, societal constraints, and risk of mental or physical injury (Laberge & Levitan, 1995).

**Physiology and Neurological Changes**

Advances in technology have opened up a broad array of data on what the brain is doing while a person is lucid dreaming, and sleeping in general. Methods and equipment such as Functional Magnetic Resonance Imaging (fMRI), which measures neural activity in active parts of the brain, an electrooculogram (EOG), which measures eye movement, and an EEG, which measures the frequency of brain waves, have all been used to monitor what is taking place during sleep, dreams, and even lucid dreaming.
LaBerge, Nagel, Dement, and Zarcone (1981) verified that lucid dreaming occurs predominately during REM sleep (as cited in LaBerge, 1990). They developed a verification system with specific dream actions that would be observable on a polygraph, and have further refined this signaling technique to be a specific series of eye movements, typically two sets of moving the eyes left, right, left right (Holzinger, LaBerge, & Levitan, 2006). This proved to the scientific community that lucid dreaming was a real, measureable, provable, and valid phenomenon.

Further examining neurological mechanisms of lucid dreaming during REM sleep, Holzinger et al. (2006) tentatively claimed that the EEG of lucid dreamers is associated with higher beta-1 activity versus non-lucid dreamers, with the greatest increases happening in the left parietal lobe. The importance of this finding to lucid dreaming is that this lobe of the brain is an essential site of the brain for consciousness, according to Taylor (1999, as cited in Holzinger et al. 2006). This EEG finding is also consistent with Pagel’s (2012) findings of the synchronous electrophysiology of conscious states and lucid dreaming during REM sleep.

LaBerge and Gackenbach (2000) illustrated the importance of this level of consciousness while in a lucid dream by saying, “To the functional systems of neuronal activity that construct our experiential world (model), dreaming of perceiving or doing something is equivalent to actually perceiving or doing it” (p. 163). While a more detailed discussion of any correlational aspects between lucid dreaming and physiological changes will take place in the next section, the potential power that lucid dreaming may entail is exciting. If dreaming about a situation, task, scenario, or goal, can bring results
similar to if they were actually performed, then the application possibilities for lucid dreams are large indeed.

Defining consciousness is important to lucid dream research because it helps validate that it could be a useful time to process thoughts, confront emotions, or rehearse actions, among other uses. The definition of consciousness, however, is elusive and difficult to philosophically define (Pagel, 2012). Pagel cited Lakoff and Johnson (1980), who describe conscious as “an absolute metaphor - something known to exist which cannot be otherwise described” (as cited in Pagel, p. 173). This level of consciousness might free up large lengths of time that have otherwise been occupied by dreams or non-dream sleep, but that were not under our direct conscious control. Time could be spent doing cognitive processes while the physical body enjoys the regenerative nature of rest.

The neurological basis for cognitive processing during dreams might be gates in the thalamus that occlude external stimuli, and the shutting down of the prefrontal executive system (Domhoff, 2011). Domhoff (2011) went on to explain that the prefrontal executive systems were what “connect us to the external world by integrating the massive amounts of external and internal information they are constantly receiving” (p. 17). This is how dreams can be so vivid and complex. A spinal paralysis prohibits movement and vocalization from being carried out, as the muscles will not execute the actions from the brain while sleeping (LaBerge, 1990).

Thus, paradoxically, activity in the brain while dreaming, and lucid dreaming, is very similar to normal waking consciousness. Dream sleep is explained by Domhoff (2003) as a subsystem of the default network, which are the parts of the brain active in
the mind wandering or daydreaming. Or more simply, the parts of the brain that control external information processing and muscle movement are switched off, yet the cognitive processes and emotions experienced while awake are still functioning. Dream lucidity brings this sleeping state of consciousness higher to more closely resemble waking thought (LaBerge, 1990) and allows for all kinds of cognitive exploration.

**Ease of Learning and Induction**

While it is now established within the larger medical field that lucid dreaming is a real and valid event (LaBerge, 1990), how does a person become a lucid dreamer? Broadly, there are cognitive techniques, technological techniques, and pharmacological ways to induce a lucid dream. The next sections will discuss each of these three ways that were found during the course of this literature review. Then some of the clinical interventions found in the literature using lucid dreams will be reviewed.

**Cognitive Techniques**

There are several cognitive techniques that can be used to induce lucid dreams. They share some overlapping similarities such as intent and rehearsal. Two prominent techniques are the Mnemonic Induction Lucid Dream (MILD) created by LaBerge (as cited in LaBerge & Levitan, 1995), and Tholey’s combined technique (as cited in Zadra et al., 1992). Both will be briefly explained.

The MILD technique developed by LaBerge (as cited in LaBerge & Levitan, 1995) incorporates using a mnemonic device to remind a person that they are dreaming. This technique requires practice and investment on the part of the subject to rehearse dreams and to visualize becoming lucid as sleep occurs. Using a personally developed
trigger, and with frequent rehearsal, it is possible for one to suddenly become aware they are dreaming.

Tholey’s (as cited in Zadra et al., 1992) combined technique borrows elements from LaBerge’s MILD approach but has added components of reality testing and intention. Reality testing is asking oneself several times a day, “Am I Dreaming?” This encourages a person to question their state of reality and enable one to more easily recognize a dream state.

The intention piece of Tholey’s technique is to tell oneself, “I will have a lucid dream tonight”. In Spoormaker, van den Bout, and Meijer’s (2003) study on lucid dreaming techniques for treatment of nightmares, intention alone was found to induce lucid dreams in several subjects. Although the results of Spoomaker, van den Bout, and Meijer’s study are unclear, the power of cognitive intention cannot be ignored. Paulson and Parker (2006) also found promising results using Tholey’s techniques in their 2-week study of a reflection-intention training program, although they acknowledge that their findings were suggestive as their sample size was small.

**Technological Techniques**

In addition to cognitive approaches, there are technological methods for inducing lucid dreaming. LaBerge and Levitan (1995) have created a device called the DreamLight, which is a mask worn around the eyes and head while sleeping. The device detects REM sleep and flashes a series of red lights and makes several auditory sounds. The intent is for the subject to realize the lights are coming from the device, thus prompting or triggering lucidity. It is similar to LaBerge’s MILD technique, previously discussed, except that it uses outside stimuli rather than a cognitive process to help
induce a lucid dream state. Stumbrys, Erlacher, Schädlich, & Schredl (2012) noted that a combination of cognitive and technological techniques seems to be even more promising than either technique on its own.

**Pharmacological**

Acetylcholine is a neurotransmitter associated with REM sleep and also with disordered dreaming according to Pagel and Helfter (2003). Stumbrys et al. (2012) noted in their literature review that drug applications were recently a new approach to inducing lucid dreams. Stumbrys et al. (2012), listed several drugs that they speculated may increase acetylcholine in the brain, but the only study they reviewed was a study done by LaBerge in 2004 using donepezil. Perhaps excited by the promise that pharmacological lucid dream induction holds, Stephen LaBerge applied for a provisional patent in 2004 ("Substances that Enhance Recall", n.d.). The patent lists drugs containing acetylcholine esterase inhibitors, which cause an increase in acetylcholine levels, such as Donepizil, Rivastigmin, Galantamine, and Huperzine, which according to the patent all have minimal side effects ("Substances that Enhance Recall", n.d.). LaBerge’s patent shows that lucid dreaming might be more readily available to the public at large, if a drug can be developed.

**Clinical Interventions**

Lucid dreaming techniques are already being used in an attempt to treat issues relating to anxiety and nightmares (Been & Garg, 2010; Spoormaker, van den Bout, & Meijer, 2006; Spoormaker & van den Bout, 2003). These studies measured reductions in nightmare frequency by using lucid dreaming as a method of therapy. Subjects reported fewer nightmares after attempting lucid dream control. The correlation of the lucid
dreams and nightmare reduction, however, remained unclear (Spoormaker & van den Blout, 2006).

Was the lucid dream the mechanism that reduced nightmares? Researching a similar approach to lucid dreaming as applicable to nightmares, Waggoner & McCready (2015) said that it doesn’t work to ultimately control the dream, and Spoormaker and van den Bout (2006) further stated that nightmare sufferers reported a decrease in intensity and frequency, but not necessarily a reprieve from them altogether. While this is a nice step no doubt to people struggling with nightmares, it does not appear that lucid dreaming can be a panacea for nightmares.

While not specifically using an applied lucid dream correlation, Driskell, Cooper, & Moran (1994) found that mental practice can improve performance, depending on the type of task and the interval between practice and performance. They conducted a meta-analysis of 43 studies in an attempt to bring clarity to the research. Being quite specific on their definitions, they defined mental practice as a cognitive rehearsal without actually engaging in physical movement, and which must occur before being physically implemented. The result of their analysis was that while mental practice is effective, it is not as effective as physical practice, performance gains depend on the type of task being performed, and gains erode over time (Driskell et al., 1994). They recommended refresher training on a 1-2 week schedule in order to obtain maximum benefit.

It is not a huge leap to see how the potential of practicing a task while sleeping via lucid dreaming could have on performance over time. In fact, Blagrove et al. (2010) found that lucid dreamers scored better and faster on the Stroop Task Performance test,
and Erlacher and Shredl (2008) found statistically significant heart rate results in cardiovascular exercise that was imagined during a series of lucid dreams.

Additionally, Piller (2009) found that the right hemisphere of the brain is specialized for lucid dreaming, and that right hemisphere tasks are “thought to be more synthesizing, parallel, non-sequencing, appositional, creative, holistic, and focused on images” (p. 274). Drawing, music, and creative endeavors all seemed to come more easily to the subjects in his study, while efforts such as speech, logic, and writing were more difficult. If any psychological symptoms are more right hemisphere aligned, this finding might hold some promise using lucid dreaming as a treatment option. The viability for therapeutic application might be challenging; however, if symptoms are primarily of the left hemisphere.

**Summary**

A curiosity of this literature review was to explore the feasibility of learning and applying lucid dreaming techniques to reduce negative psychological symptoms. Despite the promise that lucid dreaming holds for task and skill refinement, it appears based on the information and studies examined, that lucid dreaming only *might* be a valid form or technique of psychological therapy.

The answer is mixed. It has the potential to be of some use, and yet it isn’t a panacea for a wide array of mental health disorders. There are significant hurdles to overcome in even being able to *induce* lucid dreams. Several studies devoted significant time to just teaching and applying induction techniques (Paulson & Parker, 2006; Spoormaker et al., 2003; Spoormaker & van den Blout, 2006; Zadra et al., 1992). This raises the question of whether a large investment of time in learning to lucid dream is an
effective, or even an ethical, use of the limited time that psychological therapy presents, and is a main concern in the feasibility of lucid dream applications.

It seems most likely, however, that any therapeutic application would best be used if limited to treat specific symptoms of larger mental disorders. Treating nightmares, for example, as a specific symptom of PTSD as Been and Garg (2010) noted in their case study. They showed promising results using lucid dreaming as a viable therapeutic method. Spoormaker et al. (2003) and Spoormaker and van den Bout (2006) discovered similar successes in their studies on nightmares, although the specific effectiveness of lucid dreaming was unclear. Or, for another example, using lucidity to rehearse a specific anxiety-causing event, rather than being able to treat the entire broader context and symptoms of an anxiety disorder could be a viable therapeutic use. Kuiken, Lee, Eng, & Singh (2006), also find that lucid dreams lead to a temporally unbounded sense of life that follows existential and transcendent dreams, and these has been found to alleviate emotional distress. There are also the studies on skill enhancement (Driskell, Cooper, & Moran, 1994; Erlacher 2012) that showed promise for certain refinements, rehearsals, or mental practice, and perhaps could be used to reduce certain aspects of an anxiety disorder.

Assuming lucid dreams could be induced easily, there is still the difficulty of what to do in the lucid dream state to reduce psychological symptoms or achieve therapeutic goals, however. How should one shape a dream to make any difference? In all the literature surveyed for this research question and topic, there was little found that specifically addressed this matter other than Waggoner and McCready (2015), and their
suggestions were more prone towards inward reflection and understanding of oneself via questioning characters within the dreamscape.

Schmidt, Stumbrys, and Erlacher (2014), explored the interactions between dream characters while lucid dreaming, and found that there was a connection between dream characters and the dream ego. The dream ego was defined as they designed a study where they had lucid dreamers ask their dream characters how many fingers they were holding up, and then asked again while they were holding their hands behind their back.

Lucid dreaming is not a dichotomous experience. This further compounds answering the question on if lucid dreaming techniques might be refined and harnessed to help alleviate mental health issues (Laberge & Gackenbach, 2000). Many approaches centered on Imagery Rehearsal Treatment (IRT; Spoormaker et al., 2003), and psychoeducation (Been & Garg, 2010) in coping with nightmares. Yet IRT and psychoeducation occur either before or after the nightmare, not during the nightmare itself.

Perhaps the difficulty lies in the individual nature and context inherent in dreams. Any specific therapeutic approach might need to be too tailored to an individual basis, depending on the nature of the psychological disturbance, to generalize to a larger population and refine into an overarching technique. Thus, any techniques would largely be up to each individual therapist. There is nothing inherently wrong with this approach, particularly from an Adlerian viewpoint that holds that all individuals are unique, and practitioners do not incorporate clients into archetypes and models (Oberst & Stewart, 2003, p. 50). As of yet, however, there is no step-by-step manual written to aid therapists
wanting to incorporate lucid dreaming into their therapy that was found for this literature review.

This is, perhaps, an area of potential future research. Some difficulty; however, might arise in finding methods to test these theories on people currently suffering from encumbering psychological disorders. It could potentially be not only cruel, but also perhaps unethical to devote significant portions of therapy time and effort in the pursuit of lucid dream exploration.

Even though some of the techniques look promising, unfortunately most of the induction techniques examined only produced slight results (Stumbrys et al., 2012). Despite their findings, however, they acknowledge that lucid dream induction techniques show some a promise. They also question the methodological validity of some of the studies. For example, discussing Laberge and Levitan’s (1995) study of the effectiveness of the DreamLight, Stumbrys et al. (2012) pointed out that their product is commercially available. Thus, there is some concern over possible bias on the part of the researchers. There are also numerous concerns over the difficulty of studying subjects in a sleep laboratory versus in the field, and the small sample sizes that may skew results (Barrett, 1992; Paulson & Parker, 2006; Stumbrys et al., 2012; Zadra et al., 1992).

Despite the uncertainty concerning a reliable method for inducing lucid dreams, they are still a phenomenon with potential therapeutic applicability. If more effective induction techniques are to be developed, it is important to understand the psychophysiological activities in a lucid dream state. Thankfully, there is a large body of evidence forming around what happens to the human body not only in sleep and dreaming, but also while lucid dreaming specifically.
Integration of Lucid Dreaming with Adlerian Psychology

Integrating lucid dreaming into Adlerian psychology hangs on a key tenant of Adlerian psychology, which is one’s individual unique perception and experience of the world. A person’s unique perceptions largely define their reality (Ansbacher & Ansbacher, 1956; Carlson & Slavik, 1997; Griffith & Powers, 2007; Oberst & Stewart, 2003). Lucid dreams are completely self-reported in much the same way other life events that are not directly experienced are discussed and shared, and thus are largely influenced by a person’s perception of the experience. In an Adlerian framework, each person creates a cognitive schema of how they relate to the world. Thoughts form patterns and create neurological pathways that are used over and over again when presented with similar stimuli (Leaf, 2010). These patterns are believed to be formed early in life (Ansbacher & Ansbacher, 1956) and can become entrenched and engrained (Griffith & Powers, 2007).

There is not a way, yet, of being able to fully record a subject’s inner world and project those images for others to view and engage. There is a recent technological breakthrough using fMRIs and machine learning that allows researchers to map images that people see while awake, to the same brain activity that happens while they sleep (Hoffman, 2013). Subjects looked at pictures of objects such as chairs, tables, and human faces to give researchers a baseline of brain activity. They were then woken up during their sleep to report what they were dreaming about, and the data was compared to the baseline. According to the 3 year study, there was 60% accuracy (Hoffman, 2013).

Prior to this technological leap, the aforementioned studies on lucid dreams largely relied on self-reports from subjects and clients, as doing double-blind controlled
studies is near impossible. More importantly, despite the promise that the Japan study holds, there is not a way for people to share how it feels. Meaning, someone might convey that they felt excited, scared, or sad in their lucid dream, and therapists and clinicians can draw on their own life examples to empathize, but there is no way to transplant those experiences into another person to truly share the exact feelings. Any reported feelings from person A to person B will be filtered through person B’s Life Style, experiences, perceptions, and beliefs.

Psychology of Use

A possible use of lucid dreaming in therapy would be as another avenue for a client to explore the meanings and patterns governing their perceptions. Waggoner and McCready (2015) shared an approach of asking questions of characters that appear during lucid dreams. The answers the dream characters gave to their questions would sometimes lead to great insight upon awakening. They believed that dream characters represent different parts of the consciousness, or unconsciousness, and hold a lot of meaningful information for a person.

Revealing of Lifestyle

Lucid dreaming could help people understand their Life Style. Adlerian practitioners use ER’s in much the same manner. Therapists can look for meaning in how clients view themselves, the world, and how they’ve chosen, consciously or not, to move through it.

As an example, perhaps a client reports to a therapist a recent lucid dream that he or she had. The actual content of the dream is not as important as how the client feels about the dream, or what perceptions they draw from it. If the client is able to lucid
dream on a frequent basis, the therapist and client may plan some activities to do during a session for the next lucid dream. If the client felt anxious during the dream, perhaps because of the content, scenery, or thematic elements of the dream, then perhaps the therapist and client could develop a plan of what to do in the event a similar dream happens again.

Similar to what Waggoner and McCready (2015) propose, the client could ask particular characters in the dream what they represent. Adding an Adlerian flair, perhaps the question could be, “What do you think the world is like?” Or, “What purpose do you serve?”, and “What do you represent for me?” Asking questions of dream characters, is in essence, asking questions to one’s own self (Waggoner & McCready, 2015). Even though Schmidt, Stumdys, and Erlacher (2014) informed that there has been little research overall on dream characters, Tholey (1989) stated that dream characters should be treated as if they were rational beings. This aligned well with an Adlerian philosophy to therapy, as it is a phenomenologically based approach to client understanding (Griffith & Powers, 2007). Conversations, answers, questions, and how the client responds or feels, perhaps most importantly, to these experiences would be highly important to an Adlerian practitioner. The data from this discourse would further help an Adlerian and client discover the Life Style, as it will manifest itself in all things. A double-blind study on dream characters would be almost impossible, and so researchers rely on self-reported data. Understanding a client’s perceptions and conclusions they draw from the dream and any answers provided by dream characters, may deliver useful information for an Adlerian therapist.
Summary

In summary, Adlerian philosophy is well suited to incorporate the new research discoveries surrounding lucid dreams. Adlerian therapy is flexible, adaptable, and is applicable to a wide range of presenting problems that a therapist might encounter (Oberst & Stewart, 2003 p. 50). The way lucid dreams might be handled in a therapy session are almost no different than any other report or issue a client would like to discuss. This gives an Adlerian therapist another aspect, or clue as to the Life Style, to help both client and practitioner understand a client’s goal.

Conclusion and Areas for Future Study

There are still large aspects of lucid dreaming worth exploring. Advancements in technology, drugs, or cognitive methods of inducing lucid dreams may make it easier in the future. If people can benefit from the physical regenerative qualities that sleep provides, but free their minds to pursue other activities during the time spent in the R stage of sleep, the possibilities are numerous. There does seem to be a big hurdle, however, in prompting and maintaining a lucid dream experience.

Further research on developing specific skills, such as music, writing, or art, increasing cardiovascular health, strength training, or sports applications, would all be fascinating undertakings. The findings of these studies would further clarify any role that lucid dreaming might provide on human activities. This researcher would be very curious to learn about any of these new endeavors.
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