SLEEP-WAKE DISORDERS

Nightmare Disorder

DSM-5-TR 307.47 | ICD-10-CM F51.5

Repeated well-remembered dysphoric dreams that wake the sleeper fully alert, producing distress, sleep avoidance, and daytime impairment.

ADULT PREVALENCE	TYPICAL ONSET	IN PTSD	COURSE
~2-6% weekly nightmares	Ages 3-6; peaks in teens	~50-90% report nightmares	Often chronic if untreated

CLINICAL PICTURE

- Extended dysphoric dreams involving threat to survival, security, or physical integrity, recalled in vivid narrative detail on awakening.
- The awakening is rapid and fully oriented, which is the cardinal feature distinguishing nightmares from the confusion of sleep terrors.
- Episodes cluster in the second half of the night when REM sleep predominates, typically in the hours after 3 a.m.
- Autonomic arousal is present but modest compared with the tachycardia, sweating, and screaming of NREM arousal disorders.
- Sleep avoidance emerges as patients delay bedtime to escape dreaming, producing secondary insomnia and cumulative sleep deprivation.
- Daytime sequelae include intrusive dream imagery, mood disturbance, fatigue, and mounting anxiety as nightfall approaches.

DIAGNOSTIC CRITERIA AT A GLANCE

- Repeated extended and well-remembered dysphoric dreams, usually involving threats to survival, security, or physical integrity.
- On awakening from the dysphoric dream the person becomes rapidly oriented and alert with clear recall of the dream content.
- Clinically significant distress or impairment is required, so nightmares without daytime consequence do not meet the threshold.
- Specify acute at one month or less, subacute at one to six months, and persistent at six months or longer, plus a frequency-based severity rating.
- Not attributable to a substance or medical condition, and not better explained by another mental disorder such as PTSD.

NEUROBIOLOGY & PHYSIOLOGY

- Nightmares arise in REM sleep with heightened limbic activation in the **amygdala** and anterior cingulate alongside reduced prefrontal regulation.
- The failed REM fear-extinction model holds that REM normally decouples emotional charge from memory, and nightmares represent that failure.
- Noradrenergic tone is elevated during REM in trauma-related nightmares, which is the rationale for alpha-1 blockade with **prazosin**.
- Heritability estimates run roughly 35% to 45%, with twin data supporting a shared diathesis with anxiety and dissociative traits.
- Beta blockers, SSRIs, varenicline, dopamine agonists, and abrupt withdrawal of REM suppressants all provoke nightmares pharmacologically.
- Frequent nightmares independently predict suicidal ideation and attempts even after controlling for depression and insomnia severity.

PSYCHOLOGICAL MECHANISMS

- Nightmares function as a conditioned cue, turning the bed into a threat context so that avoidance reinforces both insomnia and fear.
- Continuity theory holds that dream content tracks waking concerns, so nightmare themes map onto current stressors and trauma memory.
- Rescripting works by changing the dream schema through rehearsal rather than by exposing the patient to the trauma content itself.
- Nightmare-related distress predicts impairment better than raw nightmare frequency, making distress the more useful treatment target.
- Childhood nightmares are usually developmental and self-limiting, but persistence past adolescence signals elevated psychopathology risk.

DIFFERENTIAL & COMORBIDITY

- Sleep terrors occur in early-night NREM sleep with confusion, amnesia, and an intense autonomic surge rather than clear dream recall.
- REM sleep behavior disorder features dream enactment with vigorous movement, which nightmare disorder lacks because REM atonia stays intact.
- Nocturnal panic attacks arise from NREM sleep without dream content, and nocturnal seizures are brief, stereotyped, and highly repetitive.
- PTSD, depression, borderline personality disorder, and substance withdrawal are the dominant comorbidities to screen for at intake.
- Nightmares are an independent suicide risk factor, so ask about them directly rather than assuming depression accounts for the risk.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **Prazosin** titrated from 1 mg upward to 10-15 mg at bedtime is the best-studied agent for trauma-related nightmares despite one large negative trial.
- Monitor first-dose orthostatic hypotension and syncope with prazosin, dosing at bedtime and titrating slowly, especially in older adults.
- Treating the underlying disorder helps, since **sertraline**, **paroxetine**, or **venlafaxine** reduce nightmares as PTSD or depression remits.
- Withdraw offending agents where possible: beta blockers, varenicline, dopamine agonists, and abruptly discontinued REM suppressants.
- **Trazodone**, **topiramate**, and low-dose atypical antipsychotics carry weak evidence, and benzodiazepines do not treat nightmares.

PSYCHOTHERAPY

- **Imagery rehearsal therapy** across 4 to 6 sessions is first-line: the patient rewrites the nightmare into a new ending and rehearses it daily.
- **Exposure, relaxation, and rescripting therapy** adds sleep scheduling and exposure to rescripting and achieves comparable outcomes.
- **CBT-I** addresses the sleep avoidance and conditioned arousal that nightmares generate and is frequently delivered concurrently.
- Lucid dreaming therapy and systematic desensitization have supportive but distinctly weaker evidence than rescripting approaches.
- Trauma-focused protocols including **cognitive processing therapy** and **prolonged exposure** reduce nightmares as PTSD symptoms improve.

ADJUNCT & SUPPORTIVE

- Track frequency, intensity, and distress in a nightly log rather than relying on retrospective recall at widely spaced visits.
- Address the sleep deprivation caused by avoidance directly, since curtailed sleep produces REM rebound and more nightmares.
- Screen for and treat comorbid sleep apnea, as positive airway pressure alone reduces PTSD-related nightmare frequency in some patients.
- Limit alcohol and cannabis, both of which suppress REM sleep and generate rebound nightmares during withdrawal.
- A structured wind-down, reduced evening exposure to violent media, and a safe well-lit environment lower nocturnal threat priming.

CLINICAL PEARLS

- Imagery rehearsal beats medication and works without reliving the trauma itself.
- Nightmares independently raise suicide risk; ask about them and about safety.
- Confused, amnestic, early-night episodes are sleep terrors, not nightmares.

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NOTE

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