Nightmare Disorder

This article refers to the International Classification of Diseases 10th edition (ICD-10) which is the official classification system for mental health professionals working in NHS clinical practice. The literature occasionally refers to the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system which - whilst used in clinical practice in the USA - is primarily used for research purposes elsewhere.

Nightmares can be defined as vivid and terrifying dreams which awaken the dreamer from sleep. Typically, the dreamer wakes from the rapid eye movement (REM) stage of sleep and can remember a detailed, perhaps bizarre dream plot. There is evidence that frequent nightmares are associated with insomnia and poor-quality sleep.\(^1\)

Although such dreams are part of normal human experience, for some they can be a recurrent and extremely troubling problem. This is particularly so for young children but they can be disruptive to the whole family. Explanation and reassurance are often helpful particularly for parents who can then in turn be more reassuring to the affected child.

It is important to distinguish nightmare disorder from night terrors (which are episodes of panic and confusion, with difficulty waking or bringing to awareness, and of which the sufferer has no recollection). The ICD-10 definition of the diagnosis of a nightmare disorder is detailed below:

**ICD-10 definition of the diagnosis of a nightmare disorder**\(^2\)

**F51.5 Nightmares**
A sleep disorder characterised by the repeated occurrence of frightening dreams which precipitate awakenings from sleep; on awakening, the individual becomes fully alert and oriented and has detailed recall of the nightmare, which usually involves imminent danger or extreme embarrassment to the individual.

**Epidemiology**

Nightmares are common, particularly in children.

**Children**\(^3\)
- 10-50% of those aged 3-6 years are estimated to suffer from nightmares that disturb their sleep, or that of their parents.
- They normally start between the ages of 2-5 years.
- A cross-sectional study of 4- to 12-year-olds suggests a peak prevalence between 7 and 9 years, with 87% and 95.7% of children retrospectively reporting bad dreams often or sometimes.\(^4\)

**Adults**\(^5\)
- A literature review reports that up to 85% of adults report at least one nightmare within the previous year, 8-29% report monthly nightmares and 2-6% report weekly nightmares.
- Older people were 20-50% less likely to have nightmares than young people.

**Aetiology**\(^6\)
- Nightmares are associated with a range of psychiatric symptoms, full-blown psychiatric disorders such as post-traumatic stress disorder (PTSD) and sleep disturbances. While some psychiatric, personality, sleep and biological correlates of nightmares have been described, the vast majority of extant studies are cross-sectional, precluding conclusive determination of causality and etiology. Traumatic events, waking psychological distress, or sleep disturbance may contribute to the onset and maintenance of nightmares. The results of longitudinal studies are awaited but in the meantime current thinking on the aetiology of nightmares is briefly summarised below:
  - Usually there is no underlying pathology.
  - It is thought that PTSD, sleep disturbance and psychological stress may contribute.
  - Nightmares may (rarely) be a symptom of a more serious psychiatric disorder such as borderline personality disorder.\(^8\)
  - Twin studies suggest that genetic factors may be involved.
  - A link with suicidality has been suggested.
  - One study of children viewing images depicting fantastic or real entities and situations revealed that children with nighttime fears demonstrated more fantasy-reality confusion compared to their controls.\(^7\)
  - Many medications are reported to increase nightmares:
Drugs linked to nightmares\cite{8, 9}

- **Antihypertensives:**
  - Beta-blockers (the water-soluble beta-blockers such as atenolol are **less** likely to cause nightmares, as they are less likely to cross the blood-brain barrier).\cite{10}
  - Centrally acting antihypertensives.

- **Antidepressants:** selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants and monoamine-oxidase inhibitors (MAOIs).

- **Anti-Parkinsonian agents:** levodopa, selegiline.

- **Sedatives:**
  - Ketamine\cite{11}
  - Short-acting barbiturates

- **Miscellaneous:**
  - Rauwolfia alkaloids
  - Alpha-agonists
  - Flutamide
  - Procarbazine

- **Medication withdrawal:** benzodiazepine or alcohol withdrawal leads to a rebound of REM sleep which may increase nightmares.

Presentation\cite{2, 3}

- Nightmares tend to start in the latter half of the sleep cycle, during REM sleep.
- The nightmare usually involves a threat of danger. This may be a physical threat such as being pursued, or a psychological one such as being teased. Frequent threatening characters for children are monsters, ferocious animals, ghosts, bullies or ‘bad’ people.
- It is unusual for the person to shout out, move or have autonomic disturbance during the experience, although these things may occur to a minor degree.
- When awoken it is usual for the person to be orientated, alert and responsive and to be receptive to calming by their parents/others. The details of the dream are usually remembered. This contrasts with night terrors where the person may be difficult to rouse and may not recall what has been troubling them.
- There may be a family history of similar problems.

Assessment

- Take a careful history, preferably also from parents, carers or relatives who have witnessed the event.
- Assess whether mental impairment, mental illness, depression, other central nervous system (CNS) disease or a febrile illness could be contributing.
- Consider medication history and alcohol/benzodiazepine withdrawal.
- Ask if there has been any recent traumatic event or conflict/stress.

Differential diagnosis

- **Night terrors** - the difference from nightmares is that: they tend to occur earlier rather than later during the night; the person may initially be unresponsive or disorientated; unlike nightmares, they usually cannot recall the event; signs of autonomic arousal such as dilated pupils, tachypnoea and tachycardia are more likely. See related separate article Night Terrors and Parasomnias.\cite{6}

- Underlying organic brain disorder - eg, delirium or mental impairment.\cite{12}

- **Post-traumatic stress disorder (PTSD):** nightmares are a feature of PTSD. However, in PTSD the dream content often involves reliving the trauma and there are other symptoms such as poor sleep and daytime anxiety.\cite{13}

- Medication or withdrawal from medication.\cite{14}

- Recurrent febrile illness causing delirium or predisposing to nightmares (this may also cause night terrors).\cite{15}

- **Seizures.**\cite{16}

- Depressive illness with melancholic features may be associated in adults.\cite{17}

- REM sleep behaviour disorder (a problem affecting particularly older adults).\cite{18}

Investigations

Investigations are not usually necessary if the diagnosis is clear from the history. However, bear in mind that:

- Night terrors (sleep terrors) and sleepwalking (which differ from nightmares, as explained above) have been linked to physical sleep disorders such as obstructive sleep apnoea and other types of sleep disordered breathing.\cite{19} If these problems are suspected, or the diagnosis is unclear, assessment at a sleep clinic may help.\cite{20}
Management\[3, 14]\n
- Reassurance of the patient or child and parents is all that is usually required.
- Helpful tips for children:
  - It may help to develop a relaxing bedtime routine that does not vary. Attention to causes of stress and upheaval within the home may help reduce the propensity to nightmares.
  - Use of night lights and other strategies that may reduce a child’s anxiety levels at night can help.
  - If the nightmare is recurrent then it may help for the parents to talk through the nightmare and imagine a less scary ending.
- If the problem is occurring, say, on a more than twice-weekly basis persistently, then it may be worth referring for psychological or child-psychoanalytic input.
- Cognitive behavioural therapy may be beneficial.
- There is evidence that psychological techniques such as imaginal confrontation with nightmare contents or imagery re-scripting and rehearsal may be helpful\[21\]
- Drug treatment is not usually helpful and is more likely to cause nightmares. (This contrasts with some other types of sleep disorder, where medication may help.) However, in persistent cases, an REM-suppressant drug such as a tricyclic antidepressant may be helpful.
- Prazosin may be helpful for nightmares associated with PTSD but further research is required.\[22\]

Prognosis\[23]\n
The prognosis is very good. The symptoms should resolve as time passes and after reassurance of the child and parents that this is a relatively normal experience for some young children. If the symptoms persist beyond the age of 6, consideration should be given to underlying conditions such as anxiety disorders, affective distress or PTSD.

Further reading & references

- Shneerson, J; Sleep Medicine: A Guide to Sleep and its Disorders, 2009
- 14. Delirium; NICE Clinical Guideline (July 2010)

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