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CASE REPORT

EMDR Treatment of Trauma-Related Recurrent Nightmares: A Case Report

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ABSTRACT

Recurrent nightmares are a distressing manifestation of trauma-related disorders and can persist even in the absence of full post-traumatic stress disorder (PTSD). This case report describes the Eye Movement Desensitization and Reprocessing (EMDR) treatment of a 31-year-old male presenting with a recurring nightmare involving an identical scenario. The nightmare was characterized by intense fear, helplessness, and autonomic arousal and was linked to adverse adolescent experiences in a military high school. Although the patient did not meet full DSM-5-TR criteria for PTSD, the nightmares were conceptualized as a trauma-related sleep disturbance within the Adaptive Information Processing (AIP) framework. EMDR therapy was delivered using the standard eight-phase protocol across three weekly sessions with bilateral eye movements. Trauma-related emotional distress associated with the targeted memories and nightmares was substantially reduced following treatment. Nightmare frequency markedly decreased within one week and ceased entirely thereafter, with symptom remission maintained at three-month follow-up. This case highlights the potential utility of EMDR in treating isolated trauma-related nightmares rooted in adolescent experiences.

Keywords: EMDR, nightmares, trauma, sleep disturbance

Introduction

Nightmares are a core symptom of trauma-related psychopathology and are associated with impaired sleep quality, autonomic hyperarousal, and reduced quality of life. Trauma-related nightmares differ from ordinary dysphoric dreams in that they often involve direct re-experiencing of traumatic events or repetitive symbolic representations of unresolved emotional themes such as helplessness or entrapment, and may persist even when other trauma-related symptoms have attenuated.[1,2]

Psychotherapeutic approaches play a central role in the treatment of trauma-related nightmares. Eye Movement Desensitization and Reprocessing (EMDR) therapy is an evidence-based intervention grounded in the Adaptive Information Processing (AIP) model, which proposes that psychological symptoms arise from dysfunctionally stored memories that remain unintegrated within adaptive neural networks.[3,4] From this perspective, recurrent nightmares may represent repeated nocturnal activation of unresolved traumatic memory networks.

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Case

The patient was a 31-year-old married male employed as a surgeon. He was the middle child of three siblings raised in a highly disciplined family environment. He described his father as emotionally distant and controlling and his mother as passive. Attendance at a military high school was decided by his father. The patient reported no history of chronic medical illness, psychiatric treatment, or psychotropic medication use. His Adverse Childhood Experiences (ACE) score was 2.

He presented with a complaint of a recurrent nightmare that had been occurring intermittently since his high school years. The dream content was identical each time: he found himself in a military high school dormitory, convinced that he had missed the morning roll call. He ran in panic attempting to locate the assembly area but was unable to find it. Upon awakening, the episodes were accompanied by tachycardia, dyspnea, sweating, and intense fear. Although the frequency of these nightmares had gradually decreased over the years, the patient reported a recent exacerbation, occurring on an every-other-night basis over the past two weeks and reaching a frequency of three to four times per week, in the context of increasing occupational responsibilities, although no single acute event was identified. He stated that he frequently awoke in significant distress following these episodes. While he maintained his surgical duties, he reported that the nocturnal autonomic arousal and consequent sleep fragmentation necessitated compensatory cognitive and physical effort to maintain his psychomotor skills and attentional focus during operations. Clinical history and physical examination were not suggestive of an organic sleep disorder.

Although the patient did not meet full DSM-5-TR criteria for PTSD,[5] specifically due to the absence of persistent avoidance of external stimuli (Criterion C) and widespread negative alterations in cognitions and mood (Criterion D), the clinical presentation was conceptualized as a trauma-related sleep disturbance within the Adaptive Information Processing (AIP) framework. The nightmares were understood as the activation of unresolved memory networks formed during adolescence and subsequently reactivated by current life demands.

EMDR therapy was conducted according to the standard eight-phase protocol. Psychoeducation regarding the AIP model was provided during the preparation phase. Stabilization included a Safe Place exercise and resource development.

Treatment consisted of three EMDR sessions, conducted weekly, each lasting approximately 90 minutes. Bilateral stimulation was delivered using guided eye movements.

During assessment, the dominant negative cognition associated with the nightmare was identified as “I am helpless.” When this cognition was targeted using floatback techniques, earlier memories associated with the same emotional state emerged. The earliest memory linked to helplessness involved witnessing a classmate being physically punished by a teacher at age eight. This experience appeared to function as an early emotional template that was later reinforced during adolescence.

Session 2 began with the processing of the touchstone memory (Age 8). The patient identified the image of a teacher physically punishing a classmate. The Negative Cognition (NC) was “I am helpless” (VOC: 3/7), with a SUD score of 4, accompanied by sensation of stomach emptiness and mild hand tension.

Desensitization proceeded smoothly; the patient shifted from fear to compassion toward his younger self and reframed the event as an injustice perpetrated by the authority figure. The SUD score decreased to 0, and the Positive Cognition "I can protect myself" was installed (VOC: 7). The body scan was clear.

Following this, processing of the target memory (Age 16 – Military High School) was initiated. The most disturbing image involved a teacher publicly cancelling the patient's weekend leave while peers observed. The NC evolved to "I cannot defend myself" (VOC: 2/7), with an initial SUD of 6. Prominent somatic sensations included chest pressure, stomach contraction, and jaw clenching. Initial processing reduced anger; however, due to time constraints, the SUD remained at 3. Processing was paused using the Container Exercise, and the patient reported feeling calm and grounded at session end.

Session 3 was conducted two days later. Re-evaluation confirmed maintenance of gains from the Age 8 memory and no adverse reactions between sessions. Processing of the Age 16 memory resumed. The patient recognized a direct link between the sensation of "running without a destination" in the nightmare and his inability to be heard during the original event. Emotional processing progressed effectively, and the SUD dropped to 0. The Positive Cognition "I can defend myself" was fully installed (VOC: 7), and the body scan revealed complete resolution of prior somatic distress. Future Template: To complete the protocol, a brief Future Template was administered. The patient visualized managing a future high-stress situation calmly while holding the positive cognition, confirming adaptive integration.

To objectively assess symptom severity, the Van Dream Anxiety Scale (VDAS; Van Rüya Bunaltı Ölçeği)[6] and the Insomnia Severity Index (ISI)[7] were administered. At baseline, the patient's VDAS score was 31, indicating significant nightmare-related distress and autonomic arousal. The ISI score was 9, reflecting mild sleep disruption secondary to nightmares, without meeting criteria for clinical insomnia. In the immediate post-treatment evaluation, the patient reported that he experienced the nightmare once on the night following the desensitization session; however, he noted that it no longer caused significant distress or autonomic arousal, with a post-treatment VDAS score of 2. In subsequent follow-up evaluations conducted over the following weeks, he reported complete cessation of the nightmares. At the one-month follow-up assessment, the VDAS score dropped to 0 and the ISI score decreased to 2, confirming complete symptom remission. Symptom remission was maintained at three-month follow-up.

Discussion

This case illustrates the effectiveness of EMDR therapy in resolving recurrent, scenario-identical nightmares rooted in adolescent trauma. The rapid reduction and cessation of nightmares support the AIP model, which conceptualizes symptoms as manifestations of unresolved memory networks.[3]

Unlike Imagery Rehearsal Therapy (IRT), which primarily targets the nightmare content, EMDR focuses on processing the underlying etiological memories driving the symptom.[8]

The occurrence of a single, non-distressing dream immediately following the desensitization session may plausibly reflect continued memory reconsolidation during early post-processing sleep rather than an incomplete therapeutic response, as emotional activation had already been effectively resolved.

Trauma-related nightmares may represent repeated nocturnal attempts at emotional processing of unresolved traumatic material. EMDR's bilateral stimulation has been hypothesized to facilitate memory integration through mechanisms analogous to REM sleep, as proposed in prior neurobiological models of EMDR.[9] In this case, targeting the etiological memory eliminated the need for repetitive nocturnal reactivation. From an Adaptive Information Processing perspective, the cessation of nightmares may reflect successful integration of previously dysfunctionally stored memory networks.[3] Additionally, the Working Memory account proposes that dual-attention tasks reduce the vividness and emotional intensity of traumatic memories by taxing limited working memory capacity, thereby facilitating reconsolidation in a less distressing form.[10]

An important clinical implication is that trauma-related symptoms may persist despite high occupational functioning, highlighting that professional success does not preclude the impact of adverse developmental experiences, consistent with findings from the Adverse Childhood Experiences literature.[11]

This report has several limitations. While specific validated measures for nightmares (VDAS) and insomnia (ISI) were utilized to objectively track the primary complaint, broader psychometric assessments for general post-traumatic symptomatology (e.g., PCL-5 or DASS-21) were not administered. Therefore, while the resolution of the specific sleep disturbance is objectively documented, the impact of treatment on the patient's global trauma symptoms relies on clinical observation. Future studies should incorporate a comprehensive battery of standardized assessments.

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