Insomnia is a serious and costly public health problem with estimates of prevalence among patients with co-morbid medical and psychiatric disorders up to 50-75%. Comprehensive evaluation and appropriate treatment are important.

**Methods**

This is another Psychopharmacology Algorithm Project from the Harvard South Shore Program (PAPHS). Comprehensive literature reviews were done. However there has been relatively little research focused on treating insomnia secondary to mental disorders.

**Results**

First, delineate contributing causes of the patient’s insomnia. Address sleep hygiene and the impact of prescribed/OTC drugs on sleep; reduce caffeine and other stimulants. Assess and treat sleep apnea, restless leg syndrome and other medical causes. Identify specific psychiatric disorders present. Treat, guided by evidence-supported psychopharmacology algorithms. Often, this contributing cause of the insomnia will resolve without having to add hypnotics. For major depression, SSRIs or bupropion are first-line. Although sometimes activating, these eventually ameliorate insomnia in most depressed patients. Trazodone is the first choice when an adjunct for sleep is needed. For bipolar mania/hypomania, lithium is first line, quetiapine second-line, valproate third. Sleep problems should resolve. Brief use of a benzodiazepine may help the patient while waiting for mood stabilizer effects. For anxiety disorders, antidepressants are usually first line but for PTSD with insomnia, prazosin and/or trazodone come first. For schizophrenia and other psychoses, antipsychotics are first-line with adjunctive Z-drugs or benzodiazepines added temporarily for sleep if needed, but note that rebound insomnia occurs after even one dose.

**Conclusions**

Application of this algorithm should reduce unnecessary hypnotic prescriptions with their associated side effects.

**References**