Behavioral and Psychological Treatments for Insomnia: A Provider's Guide

Recommendations/suggestions for the treatment of chronic insomnia disorder

The 2025 VA/DOD Clinical Practice Guideline for the Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea:

- Recommends offering cognitive behavioral therapy for insomnia (CBT-I) and suggests offering brief behavioral therapy for insomnia (BBT-I)
- Suggests CBT-I over pharmacotherapy as first-line treatment
- Suggests against sleep hygiene education as a standalone treatment

What is CBT-I?

CBT-I is a multi-session, multi-component treatment focused on sleep-specific thoughts and behaviors. Its behavioral components include sleep restriction, stimulus control, relaxation therapy/counter-arousal strategies, and sleep hygiene education. Cognitive therapy components target maladaptive thoughts and beliefs about sleep.

What is BBT-I?

BBT-I is a treatment that focuses on the behavioral components of sleep restriction, stimulus control, and some sleep hygiene education.

Updated CPG Screening Recommendation

For screening of patients with sleep complaints, we suggest using validated screening instruments for both insomnia (e.g., Insomnia Severity Index or Athens Insomnia Scale) and obstructive sleep apnea (e.g., STOP) to identify patients who need further evaluation. The Work Group also considered the high prevalence of comorbid insomnia and obstructive sleep apnea (COMISA) in patients presenting with signs and symptoms of sleep disorders, and the importance of screening for both chronic insomnia and obstructive sleep apnea (OSA) concurrently in at-risk patients.

For more information on assessing sleep complaints and OSA visit: https://www.healthquality.va.gov/guidelines/CD/insomnia/index.asp

CBT-I and BBT-I Techniques

Sleep Restriction Therapy: Limits time in bed to actual sleep duration to increase sleep drive; time in bed extended across treatment

Stimulus Control: Strengthens bed as a cue for sleep rather than wakefulness

Arousal Reduction Techniques: Introduction of calming bedtime routine, relaxation techniques to reduce physiological arousal such as diaphragmatic breathing, body scan, or grounding exercises

Sleep Hygiene Education (optional): Planned changes in target behaviors and environmental factors that negatively impact sleep including light/noise exposure, eating/drinking near bedtime and at night, caffeine/nicotine/alcohol use

Cognitive Restructuring (CBT-I only): Addresses cognitive arousal (busy or racing mind) and inaccurate sleep-related thoughts by challenging unhelpful thoughts and beliefs about sleep

Factors to note when considering CBT-I or BBT-I for your patient

Patients with certain comorbidities may need adapted or delayed treatment:

- An unstable medical condition (delay)
- An active alcohol or other substance use disorder (delay)
- Excessive daytime sleepiness (adapt/delay)
- An uncontrolled seizure disorder (delay)
- Bipolar disorder (adapt)
- Acute mental health symptoms (delay)
- Trouble getting in and out of bed (adapt)
- Engaged in exposure-based PTSD treatment (delay)
- Pregnancy/postpartum insomnia (adapt)

What should I tell my patients about CBT-I and BBT-I?

Primary care providers are encouraged to provide patient education to individuals with insomnia, including an accurate description of behaviorally-based treatments. The following examples are from *Appendix D: Provider Guide To Sleep Education for Insomnia Disorder in the Clinical Practice Guideline.*

How do I describe CBT-I and BBT-I to my patients?

CBT-I and BBT-I are primarily behavioral treatments for insomnia. There is good evidence that these are the treatments of choice for people with insomnia that has lasted a few months or longer. For example, they are more effective than if I just gave you some sleep strategies to help your sleep which we call 'sleep hygiene.' Also, the effects of CBT-I and BBT-I are longer lasting than if we treated insomnia with sleep medication, and these behavioral treatments do not have the risk of medication interactions and side effects. I also want you to know that, in the short run, sleep-inducing medications are less effective than behavioral therapies for chronic insomnia. In the long run, sleep medications seem to be even less effective than behavioral therapies, suggesting that behavioral therapies may address the underlying cause of chronic insomnia.

What key points about CBT-I and BBT-I techniques should I share with patients?

In addition to including the sleep hygiene education I mentioned, CBT-I and BBT-I use multiple techniques to target factors that maintain insomnia, and they provide you with skills that will help you to regulate when you are asleep and awake. For example, a technique called 'stimulus control' will help make the bed and the bedroom stronger cues for your brain to know that it is time to be asleep. Another technique will help you figure out how much time you should spend in bed to sleep well. You may also learn skills to help you relax at bedtime and techniques to address thoughts and beliefs that interfere with your sleep. The provider will work with you to create an individualized plan to best suit your needs. What questions do you have about this? Could I set you up with an initial appointment (or provide a referral) to learn more about it?

Resources

Path to Better Sleep: Free CBT-I based course offered by the VA. This course is **not** designed to replace health care but can be used to support a patient's care. veterantraining.va.gov/sleep/index.asp

CBT-i Coach: For people who are engaged in CBT-I, this free app provides supplemental support and strategies to improve sleep. Find it at mobile.va.gov/app/cbt-i-coach, or your preferred app store.

Reference

Department of Veterans Affairs and Department of Defense. (2025). *VA/DOD Clinical Practice Guideline for the Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea*. Version 3.0. https://www.healthquality.va.gov/guidelines/CD/insomnia/I-OSA-CPG_2025-Guideline_final_20250915.pdf

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