

Telehealth Program Targets Severe Sleeplessness Among Cancer Patients

Up to 85% of people treated for cancer face this problem. The five steps of Cognitive Behavioral Therapy for Insomnia may help.

April 21, 2025 By University of Colorado Cancer Center and Mark Harden

A project now underway takes aim at one of the most often-reported symptoms among cancer patients and survivors: Sleeplessness.

The six-month pilot program is led by [University of Colorado Cancer Center](#) member [Ben Brewer](#), PsyD, director of clinical psychology and counseling in the [CU Department of Medicine's Division of Hematology](#), and [Erin Baurle](#), PsyD, medical director of oncology counseling in the [Division of Medical Oncology](#). Both are clinical psychologists and associate professors.

Their ongoing project was supported by \$25,000 in funding from the [Colorado Comprehensive Cancer Control Program](#) at the Colorado Department of Public Health and Environment (CDPHE).

About 30% to 50% of cancer survivors report insomnia symptoms, a rate as much as three times higher than in the non-cancer population, according to research cited by Brewer and Baurle in their project proposal. For patients undergoing active cancer treatment, the rate of significant sleep impairment can be as high as 85%.

It's not just a matter of discomfort. These high levels of sleep impairment contribute to depression, anxiety, fatigue, pain, immunosuppression, and cognitive concerns among cancer populations, research shows.

"These are significant sleep problems we're talking about, not minor ones," says Brewer, who has published research on the sleep of cancer patients. "The definition of insomnia is pretty intense: It's difficulty with sleep that impairs you for at least three months at least three days a week. It's miserable."

→ [CU Cancer Center Psychologist Tests Bright White Light Therapy as a Remedy for Cancer-Related Fatigue](#)

Bridging the gap

The good news is, there's a treatment proven to be highly effective, long-lasting treatment for cancer-related insomnia. It's called Cognitive Behavioral Therapy for Insomnia (CBT-I).

"The problem is, it's kind of hard to do," Brewer says. "There's a lot of clinicians who know about it but don't use it with their patients." That's particularly true in smaller, more remote cancer treatment facilities, he says.

Patients "at world-class cancer centers like on the CU Anschutz Medical Campus can access this more readily because our clinicians and psychologists are trained in it," he adds. "But we suspect that's not true everywhere throughout the state."

Brewer and Baurle are trying to bridge that gap through a pilot program with two-pronged approach targeting both patients and their clinicians.

They're teaming up on a series of four live group video sessions for cancer patients, instructing them on CBT-I methods and goals, as well as leading them in discussion of their cancer experiences. Patients then track their sleep using either a free smartphone app called [CBT-I Coach](#) or a paper tracking sheet.

The classes are open to cancer patients for enrollment until April 15, 2025 or until available spots are filled. [Click here for information](#).

Also, later this month, the project will offer a live class for clinicians who work with cancer patients to train them on using CBT-I. Nearly 20 providers from community oncology practices across the state are registered. Enrollment is closed for the clinician class.

With the clinician training, "we're hoping for further reach and permanence of the program by training clinicians so they can use CBT-I with the patients they're seeing," Baurle says.

→ [Tech Can Improve Cancer Supportive Care, But It Takes Training to Use It Effectively](#)

Demystifying sleep

A key aim of CBT-I is "demystifying the sleep experience for people with sleeping difficulties," Baurle says. "It really feels out of reach for them, and a big part of CBT-I is providing them the confidence that they can get the rest that they need. CBT-I tends to go a long way towards establishing better sleep routines and outcomes."

CBT-I has five main components:

- Stimulus control – That simply means only sleeping in bed and also taking any awake time

out of the bed and bedroom, Brewer says. This helps to remove undesirable outcomes, such as being awake and feeling frustrated.

- Sleep restriction – Limiting the amount of time spent in bed, which increases the percentage of bed time that a person spends asleep and not tossing and turning. “With cancer patients, I will temporarily reduce their time in bed to near their total sleep time, which has the effect of clearing out some of the behavioral conditioning that maintains insomnia, then we expand it out again and their sleep follows,” Brewer says.
- Cognitive therapy, also called restructuring or reframing – Confronting negative thoughts and emotions about sleep, such as worry and stress over the day’s events. “You can address these with a rational approach, realizing you’ve had lots of times when you’re worried and you ended up sleeping great,” Brewer says.
- Relaxation training – Including progressive muscle relaxation, biofeedback, and slow abdominal breathing.
- Sleep hygiene – Including keeping to a regular sleep schedule, maintaining a healthy diet, exercising regularly, keeping things quiet in the bedroom, and avoiding napping.

→ [Navigating Mental Health Around a Cancer Diagnosis](#)

A healthier Colorado

“There’s great evidence that telehealth versions of CBT-I are nearly equivalent to in-person CBT-I in effectiveness,” Brewer says. However, “Just giving someone an app for sleep and saying, ‘Here, go fix your sleep,’ doesn’t work very well.”

He says the group telehealth format “also allows a unique opportunity for connecting with other people impacted by cancer across Colorado, hopefully reducing isolation.”

The CDPHE support for the project “has allowed the project to be much broader than what we

originally talked about and to expand it outside the UCHealth system, hopefully making for a healthier Colorado,” Baurle says.

Brewer and Baurle will assess their pilot project by obtaining patient feedback and clinician survey results, possibly in June. They’ll then report to the CDPHE and community cancer clinics and groups.

They also plan to apply for funding for the next fiscal year to expand the program further.

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