PARIS — Success rates for nonpharmacologic therapy in patients with fibromyalgia are climbing to previously unattainable levels by tailoring psychotherapy in accord with patient characteristics.

It is best to intervene before the physical and psychological impairments have hardened, and combining the tailored psychotherapy with an exercise training program seems to be important, mental health researchers said at the annual European Congress of Rheumatology.

Saskia van Kouli, Ph.D., summarized her recent comprehensive review of the published literature on nonpharmacologic therapies for fibromyalgia (Ann. Rheum. Dis. 2007;66:571-81) as showing modest and inconsistent benefits. In many studies, 30% or fewer of treated patients had at least a 50% improvement in symptoms and functioning, and the benefits typically faded over 6 months. But this poor showing is probably attributable to a past tendency to take a one-size-fits-all approach to psychotherapy for what is in reality a quite heterogeneous syndrome, said Dr. van Kouli of Radboud University, Nijmegen, the Netherlands.

She and her coworkers have developed a validated brief self-report screening instrument (Int. J. Behav. Med. 2008;15:211-20) to help differentiate the two major cognitive and behavioral patterns fibromyalgia patients exhibit: pain-avoidance behavior, which is an extension of the well-established psychological fear-avoidance model, and a pain-persistence pattern, in which patients ignore their pain and persist in painful activities to their detriment.

Fibromyalgia patients with a pain-avoidance pattern are more likely to benefit from operant-behavioral therapy focused on changing observable pain behaviors, while those with a predominantly pain-persistence pattern tend to fare better with cognitive-behavioral therapy addressing maladaptive thoughts. For patients who have elements of both patterns, either form of therapy appears to be appropriate, according to Dr. van Kouli.

She presented a randomized trial in which 216 fibromyalgia patients were assigned either to a multimodal intervention—including tailored psychotherapy— or to a usual-care control group. All had high levels of psychological distress as an inclusion criterion.

The intervention consisted of small, 3-hour-long group sessions twice weekly for 8 weeks. Half of each session was devoted to tailored group psychotherapy, the other half to exercise training, which included pool exercise, aerobics, and relaxation therapy. The patient’s significant other attended 3 sessions.

At the end of the intervention, patients rated its usefulness as 8.2 out of a possible 10. They also showed highly clinically relevant 80%-90% reductions on measures of pain, fatigue, functional disability, and anxiety.

At 6-month follow-up 57% of the multimodal intervention group maintained a clinically significant improvement as defined by at least a 0.5-standard deviation gain over baseline on physical functioning measures, compared with 24% of controls. Only 16% of the intervention arm showed a similar improvement in psycho- logical functioning, compared with 28% of controls.

Based upon these favorable results, the tailored nonpharmacologic intervention will be implemented nationally at the other Dutch university medical centers, Dr. van Kouli added.

Kati Thieme, Ph.D., reported on 125 fibromyalgia patients randomized to cognitive-behavioral therapy (CBT), operant-behavioral therapy (OBT), or a control group. Patients were followed for 12 months, at which point she and her colleagues looked retroactively at various pretreatment patient characteristics to see which ones separated subsequent responders from nonresponders.

The psychotherapy consisted of 15 once-weekly, 2-hour sessions conducted in small groups coterminated by a psychologist and a rheumatologist. The control group met on the same schedule for therapist-guided general discussions of the medical and emotional problems of fibromyalgia, with no therapist recommendations.

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