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Grief, interpersonal disputes, and role transitions: the breadth of interpersonal telepsychotherapy as a strategy to reduce mental health suffering due to the COVID-19 pandemic among health professionals

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The COVID-19 pandemic necessitated the rapid development of strategies to treat mental suffering among health professionals. Our letter reports the prevalence of problem areas used in interpersonal psychotherapy (IPT)[1] and the fitness of the IPT model as applied to health professionals seeking emotional support during the COVID-19 pandemic.

We investigated the appropriateness of IPT problem areas in a sample of participants in the TelePSI project.[2] TelePSI is a 3-arm randomized clinical trial started in May 2020 designed to evaluate the effects of ultra-brief IPT, cognitive behavioral therapy (4 sessions), and psychoeducation (1 session with reinforcing videos) to reduce symptoms of anxiety, depression, and irritability among health workers in Brazil.[2] TelePSI chose IPT due to its versatility and evidence of efficacy in psychiatric conditions with anxiety and depressive symptoms.[3] It is level-1 evidence in guidelines for treating depression, eating disorders, and bipolar disorders. IPT originally includes four problem areas, but three of them (grief, interpersonal disputes, and role transitions) are more suitable for brief treatment.[1]

We analyzed data from the first 300 participants in the TelePSI interpersonal arm. The participants were 83.6% female, with a mean age of 37.8 (SD = 9.7) years. Nine therapists provided online IPT for health professionals during the pandemic, with weekly supervision. The average score for the Clinical Global Impression - Severity scale, which ranges from 1 (asymptomatic) to 7 (among the most symptomatic patients), was 3.58 (SD = 1.29), and the functionality score, which ranges from 1 (no impairment) to 4 (severe impairment), was 1.96 (SD = 0.81).

A total of 69.4% participants only had one problem area, and 27.4% had two problem areas. A total of 5% had all three problem areas. Regardless of the combinations, a total of 12% (n=36) selected grief as the primary IPT problem area, 45.7% (n=137) selected interpersonal dispute as the primary IPT problem area, and 71.3% (n=214) selected role transition as the primary IPT problem area.

In a multiple regression model including all three problem areas and adjusting for the effects of co-occurrence, role transition as the IPT area was independently associated with higher severity in crude severity scores ($b = 0.51$, $p < 0.001$) and crude functionality scores ($b = 0.26$, $p = 0.025$). The role transitions group seems to have more diffuse difficulties in dealing with the pandemic as a whole than the other two groups.

The TelePSI project observed that the IPT model adequately fits most pandemic-associated clinical situations presented by health workers. The IPT problem area model was an excellent way to focus ultra-brief psychotherapy during the COVID-19 pandemic. In 95% of our sample, the therapist detected a primary IPT area problem, confirming the fitness of the IPT model for the COVID-19 pandemic. Role transition was the most prevalent IPT problem area, as expected, and was associated with greater symptom severity. IPT is a life-event psychotherapy,[4] and its model appears to be a promising approach for mental suffering during the COVID-19 pandemic.

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Comments on the translated version of the modified Yale Food Addiction Scale 2.0 into Brazilian Portuguese

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The interest of researchers and clinicians in the food addiction (FA) construct is growing worldwide. The Yale Food Addiction Scale (YFAS) and its versions are currently the main FA assessment tools in use, and the scale has been translated and validated into several languages, including Korean, Spanish, and German.[1] One of these versions, the modified YFAS 2.0 (mYFAS 2.0), which is based on DSM-5 diagnostic criteria for substance use disorders, is a shortened version suitable for population studies.[2] Nunes-Neto et al.'s[3] translation of the mYFAS 2.0 into Brazilian Portuguese, including validation with a large sample (n=7,639), was an excellent initiative.

Nevertheless, their translation has some inconsistencies that could impair respondent understanding, as well as the tool's diagnostic capacity. First, in the original version of the mYFAS 2.0, item 13 says "My friends or family were worried about how much I overate." In the Brazilian version, this item was translated to "My friends or family were worried about how much I ate" (in Portuguese: "Meus amigos ou familiares estavam preocupados com o quanto eu comia"), disregarding the meaning of "overate." This mistranslation may lead to confusion and lead to inaccurate answers, since the respondents' social circles may be concerned with both low and high food intake. Hence, someone who eats less than expected (due to anorexia or food insecurity, for example) could score points for this item. The second inconsistency refers to the instructions for scoring the scale. Each item is assigned a number according to the frequency of occurrence (0 = never to 7 = every day). Points are scored for each item if the reported frequency is above the given threshold for each item. The frequency values assigned by Nunes-Neto et al.[3] are all higher than those of Schulte & Gearhardt's[2] original version (Table 1). We emphasize that although the numerical values are incorrect, the verbal transcriptions are correct (e.g., "once a month"). Nevertheless, the higher and incorrect numerical values required to reach the threshold for each item in the Brazilian Portuguese version[3] could lead to confusion and underestimate the prevalence and number of FA symptoms in respondents. This could explain the lower prevalence of FA (4.31%) they observed compared to the weighted mean prevalence observed in the general population (20%) in a meta-analysis that included 272 studies,[4] as well as in a representative sample (n=5,368) of Brazilian university students (19.1%).[5]

Given these inconsistencies, perhaps the adequacy and validity of the translated version of this scale should be reassessed, since its use may lead to inaccurate results in Brazilian research on FA.

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Table 1 Thresholds for each of the diagnostic criteria for food addition in the original and Brazilian Portuguese versions of the modified Yale Food Addiction Scale 2.0

mYFAS 2.0 items	Threshold in Schulte & Gearhardt[2]	Threshold in Nunes-Neto et al.[3]
# 3, # 7, # 12, # 13	Once a month ($\geqslant$ 2)	Once a month (= 3)
# 1, # 4, # 8, # 10	Once a week ($\geqslant$ 4)	Once a week (= 5)
# 2, # 5, # 6, # 9, # 11	Two to three times a week ($\geqslant$ 5)	Two to three times a week (= 6)