**Acceptance and Commitment Therapy for Obsessive Compulsive Disorder in a Brazilian Context: Treatment Of Three Cases**

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# Acceptance and Commitment Therapy for Obsessive Compulsive Disorder in a Brazilian Context: Treatment of Three Cases

# Abstract

Previous research indicates that a combination of Acceptance and Commitment Therapy (ACT) and Exposure and Response Prevention (ERP) is an effective treatment for obsessive-compulsive disorder (OCD). However, there are no studies to date of ACT for OCD in Latin American populations. Because socio-cultural context influences OCD symptomatology, it is worth adapting and testing ACT for OCD in such cultures. Three patients seeking treatment for OCD at a public health center in Rio De Janeiro, Brazil were treated with 16 sessions of ACT and ERP. All participants showed decreased OCD scores from baseline to post-treatment that remained lower at follow-up, suggesting that a version of ACT for OCD adapted for a Brazilian cultural context was effective. The intervention also had positive effects on depression, quality of life, and psychological flexibility. This paper focuses on the adaptations that reflect the unique needs of Brazilian culture, as well as how to integrate ACT within existing systems of care. This study shows the effectiveness of this approach in Brazil and offers promise for future cultural adaptations of ACT in other Latin American contexts.

**Keywords:** Obsessive-compulsive disorder; Acceptance and Commitment Therapy; Cultural Adaptations; Latin America; Brazil.

# Introduction

Obsessive-compulsive disorder (OCD) involves recurrent unwanted inner experiences (obsessions) that are neutralized by engaging in specific actions (compulsions). The obsessions and compulsions occur at such a high intensity and frequency that one’s functioning is greatly limited. Meta-analyses point to exposure and response prevention (ERP) as the treatment of choice for OCD (Abramowitz & Jacoby, 2015). Acceptance and Commitment Therapy (ACT) has been studied as a distinct approach to framing ERP (Twohig, et al., 2015). It emphasizes willingness to experience anxiety and obsessions in the service of values as a different way to relate with the aversive internal states of OCD (Twohig et al., 2015). In the only study to date to compare ACT-based exposure therapy for OCD to ERP alone, 58 adults were randomly assigned to one of two conditions and were treated in 16 two-hour individual sessions (Twohig et al, 2018). Overall outcomes were strong, with 68% of those in ERP and 70% of those in ACT+ERP considered treatment responders. Results were maintained at six month follow-up with ERP having a 64% response rate and ACT+ERP having a 60% response rate. These findings, plus many other ACT alone and ACT+ERP trials (e.g., Bluett, Homan, Morrison, Levin, & Twohig, 2014; Shabani et al., 2019) show that ACT is a useful treatment for OCD alone or as a model from which to do exposure therapy.

While there are many models of exposure therapy (e.g., habituation, inhibitory learning) ACT-based exposures have notable empirical and theoretical supports (e.g., Arch, Eifert, Davies, Vilardaga, Rose, & Craske, 2012; Thompson, Luoma, & LeJeune, 2013; Twohig et al., 2015). In general, the ACT-based model of exposure therapy uses in and out of session exposure exercises as opportunities to practice building psychological flexibility. Consistent with ACT’s focus on increasing functioning and quality of life, overall outcome goals for ACT-based exposures are to learn to function with anxiety and obsessions. Severity, intensity, and situational sensitivity are less of an issue than one’s ability to effectively live while a myriad of internal experiences are present. Relatedly, the exposures are tied to values in that clients usually practice engaging in activities that have some inherent or related meaning to the client. Integrating ACT aims to increase clients’ willingness to engage in exposure exercises and promote a more purposeful connection with treatment.

ACT is an international therapy, with work occurring in almost every country (Masuda, 2020). Nonetheless, there has been limited work showing how ACT is implemented across countries. The work seems to stay within particular countries with a limited exchange of ideas about how these important cultural adaptations of ACT are being made. For example, to our knowledge, ACT for OCD research has only been conducted in North America and the Middle East–-specifically Iran (Rohani et al., 2018; Shabani et al., 2019; Vakili et al., 2015). It is very useful for the larger readership to see what cultural adaptations occur in this work and how it is implemented across countries. At present, however, there are no studies of ACT for OCD in Latin countries, leaving an unfortunate gap in the understanding of how ACT for OCD may work with a large and diverse population.

Brazil is the most populated Latin American country with over 200 million inhabitants. Brazilians in particular may show a certain pattern of OCD symptoms and characteristics as a consequence of socio-cultural influences (Wetterneck et al., 2012). A study conducted in Rio de Janeiro with treatment-seeking OCD clients (Fontenelle et al., 2004) found that themes of aggression were the most common content of obsessions, a finding consistent with older Brazilian studies (Petribú & Bastos, 1997; Del Porto, 1994). The authors argue that this may be related to the context of violence in Brazil, which is evident in its high rates of homicide and deaths caused by traffic accidents. A cross-cultural clinical comparison between treatment-seeking OCD clients from the United States and Brazil likewise reported key differences: OCD Brazilian participants presented with more anxiety and trauma symptoms, while the comorbidity of OCD and substance use was more frequent in U.S. participants (Medeiros et al., 2017). In addition to the thematic differences in OCD, there are cultural differences that affect how therapy in general occurs (political, financial, religious, governmental factors). Finally, thus far there has not been an ACT for OCD protocol developed specifically for Brazilian populations. Thus, adaptation of a U.S.-based protocol would be the logical first step for ACT for OCD work in Brazil.

Protocol adaptation across cultures is a multifaceted process that must take many issues into account. It is important to consider how treatments for OCD can be successfully implemented with Brazilian clients given its particular social, cultural, and clinical factors. Research has shown that culturally adapted treatments that are specific to clients of a given subpopulation are more effective than treatments without such adaptations (Smith et al., 2011, Woidneck et al., 2012). Therefore, this study aims to adapt ACT for OCD for a Brazilian population. We describe the steps taken to adapt the original treatment protocol considering cultural and socioeconomic differences. Then, we present the results of a pilot study examining the effectiveness of the adapted ACT for OCD intervention delivered to three Brazilian clients. Our adaptations also reflect changes made during the COVID-19 pandemic, which had a significant impact on Brazilian clients.

**Methods**

**Participants**

Participants were recruited from an OCD speciality clinic at a large public university in Rio de Janeiro. Inclusion criteria were as follows: (i) current diagnosis of OCD according to the Mini International Neuropsychiatric Interview (MINI; Amorim, 2000), (ii) psychiatric medication stabilized for at least one month; (iii) at least 18 years of age, and (iv) ability to read and complete questionnaires. Patients were excluded if they had a psychotic or bipolar disorder, active suicidal ideation, severe personality disorder, recent history of substance abuse, a serious medical condition, intellectual disability or dementia, or if currently in psychotherapy. Fourteen outpatients were screened to participate in the study (six males, eight females), with four meeting inclusion criteria. However, only three men were ultimately included in data analysis as one female participant dropped out at midtreatment. All three participants were currently taking selective serotonin reuptake inhibitors (SSRIs) prescribed for OCD. All study procedures were approved by the research ethics committee at the study university and all participants provided written consent. As this is a case series report, we provide detailed demographics on our three participants in the results section.

**Measures**

 All measures were collected at baseline, posttreatment (16 weeks), and follow-up (6 months after posttreatment). All assessments were completed via self-report with the exception of the MINI diagnostic interview. Baseline assessments were completed in-person at the university clinic. The posttreatment and follow-up assessments moved online due to the COVID-19 lockdown in Brazil. After moving to remote delivery, we made efforts to ensure that all participants could complete assessments despite differences in access to technology. For instance, we displayed surveys via screen sharing and asked them to provide their responses.

***Primary outcome***

 The *Yale-Brown Obsessive Compulsive Scale (Y-BOCS)* was our primary outcome measure and evaluates global severity of OCD through a semi-structured interview that includes a symptom checklist and a 10-item scale. This clinician-rated instrument assesses the primary obsessions and compulsions. The respondent ranks each item from 0 (no symptoms) to 4 (extreme) based on the previous week. The items are added together to produce a total severity score ranging from 0 to 40 with higher scores representing greater severity of OCD. The Y-BOCS is the most widely used measure of OCD severity and has satisfactory psychometric properties (Goodman et al., 1989), also having been translated to Brazilian Portuguese (Fontenelle et al., 1998).

***Secondary outcomes***

 Depression and quality of life were our secondary outcome measures. The*Beck Depression Inventory (BDI)* is a self-report instrument for assessing symptoms of depression (Beck et al., 1988). It consists of 21 items, each one varying from 0 to 3, with a total score of 63. Higher scores represent greater severity of depression. It was validated in Brazilian Portuguese, having demonstrated satisfactory psychometric characteristics (Gorenstein & Andrade, 1998). *The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)* was used to assess general pleasure and satisfaction with different areas of life including physical health, work, social and family relationships, daily functioning, sexual life, and financial stability. Items are assessed on a 5-point scale and total scores are converted to a percentage representing overall quality of life, with 70% or higher suggesting quality of life consistent with a nonclinical community population (Endicott et al., 1993).

***Psychological flexibility measure***

 We assessed psychological flexibility, the central theorized process of chance in ACT, using a freely translated version of *The Acceptance and Action Questionnaire - Obsessive Compulsive (AAQ - OC)* to Brazilian Portuguese. The AAQ-OC measures psychological inflexibility in relation to unwanted intrusive thoughts. The 13 items of this instrument are added together to produce a total score representing impairments in valued action and willingness to experience intrusive thoughts (Jacoby et al., 2018). Higher scores represent psychological inflexibility with obsessions; lower scores indicate psychological flexibility.

**Intervention Overview**

We adapted the original ACT+ERP treatment protocol by Twohig et al. (2018), which can be referenced for further detail. The first two sessions of ACT+ERP for OCD involved collecting information, having a collaborative discussion of the ACT model of OCD and ERP (i.e., the aim of promoting psychological flexibility), and teaching ways of self-monitoring obsessions and rituals. In the third session, an exposure hierarchy was developed consisting of activities that trigger compulsions but are personally meaningful. Exposure practices are similar to the traditional ERP of Foa & Kozak (2004) but framed as an opportunity to practice and promote psychological flexibility, that is, “willingness” to experience obsessions and anxiety, when they occur, instead of habituation of fear. Clients were taught skills to respond flexibly in the presence of obsessions, anxiety and urges to ritualize. In the fourth through fifteenth sessions, patients practice their exposures within sessions using psychological flexibility skills and continue these practices outside of therapy with behavioral commitments. The final session focused on maintaining gains made during therapy by reorienting patients towards their personal values.

**Treatment Providers**

All of the three treatment providers were postgraduate students in mental health at a university clinic in Rio De Janeiro, Brazil. The same providers served as assessors throughout the study, with only one of them conducting the pretreatment assessment. This was especially useful as the COVID-19 pandemic made it difficult to coordinate research staff and stay in touch with participants. Client demographics, history, and self-report measures were largely collected by the client’s therapist. However, two research assistants also helped with data collection at intake. During the treatment period, only therapists collected data. To promote treatment fidelity, a monthly consultation meeting was held with Dr. Twohig (author), who is a peer reviewed ACT trainer, to discuss the cases and the cultural adaptations of the therapy.

**Unique Cultural Factors in Brazil**

 Brazil is a diverse country divided into 26 states (Instituto Brasileiro de Geografia e Estatística [IBGE], 2021). All these regions of Brazil have a high level of socioeconomic inequality (IBGE, 1998). These disparities are reflected in Brazilian healthcare (Neri & Soares, 2002). Public health care is a universal right guaranteed under the 1988´s Brazilian Constitution, but the Unified Health System (SUS) is historically underfunded with patient demand greatly exceeding available resources, generating long waiting queues. Compared to lower class Brazilians, middle and upper class citizens are typically served through private health services (Sanabria, 2010; Chazan & Faro, 2016).

These socioeconomic factors are especially pronounced in the provision of mental health services (Campanha et. al., 2015; Quintana et al., 2013). For instance, despite the high prevalence of psychiatric disorders in Brazil (Gonçalves et. al., 2014; Blay et al., 2018, Andrade et al. 2012), a population-based study from São Paulo showed that only 30% of severe or moderate cases received any treatment. Psychotherapy was reported by 10% of cases treated in general medical services and by 20% of cases seen at specialized mental health services (Campanha et al., 2015). These data suggest an emphasis on biomedical approaches, such as medication, as opposed to psychosocial interventions (Lakoff, 2005). Relatedly, there is a low population-level understanding of psychological issues and their treatments, meaning that interventions should include education of the disorder and how it can be treated with a psychosocial intervention.

In addition to these systems-level factors, important aspects of Brazilian culture may arise in the delivery of psychosocial interventions themselves. Brazilians tend to have a more interdependent orientation compared to many cultures (Gouveia & Clemente, 2000; LeJeune & Luoma, 2019). Given this trend, interpersonal relationships are an important part of psychotherapeutic interventions, in which individuals tend to place more importance on personal relationships (*personalism*) than on institutional relationships (Trevino et al., 1991). In particular, being driven by *simpatia* (individuals tend to avoid conflict; Applewhite, 1998), or maintaining harmony and avoiding conflicts in relationships, is very common among Brazilian clients. Another feature that has direct repercussions on the therapeutic relationship is an inclination towards a more passive posture in the treatment process. We relate this observation to the influence of the biomedical model, in which compliance with medication management is emphasized as the primary goal and the client is less involved in decision-making. When transferred to psychotherapy, however, this passivity can lead to challenges in personal motivation and engagement in behavior change. For instance, clients may be very “compliant” with exposure exercises during a session, but fail to generalize new responses (e.g., ACT skills) in their daily lives. This may also be explained by a patient’s desire to please the therapist (maintain the relationship) and indicate they understand or engaged in the work when that is not fully accurate. A third interpersonal factor to consider is the influence of strong familial values (*familism*), in that each individual has essential roles to play within their family structure (Marin & Marin, 1991). These family roles generally have an important augmenting function, so that work with values in ACT can be focused on the quality of these relationships (e.g., “what kind of parent would you like to be?”). It can also be a barrier, however, in that patients may wish to focus on family issues over their OCD. This requires redirection or integration by the therapist.

Finally, as noted in the introduction, obsessive themes around aggression and harm are common in Brazil (Fontenelle et al., 2004). Brazil is heavily influenced by the Catholic religion and a “fear of God” is something that many Brazilians are raised with. Fear of harm coupled with supernatural beliefs can lead to reinforcement of magical and superstition thinking, thus influencing the development of OCD. In some Brazilian congregations, members are encouraged to suppress or push away dangerous thoughts. The therapist needs to consider and balance the influence of the patient's religion with standard therapy techniques for OCD.

**Adaptation of ACT for OCD for Brazilian Clients**

Adapted from the original version of Twohig, et al. (2018) and translated from English to Portuguese, the ACT + ERP protocol of the present study features 16 individual psychotherapy sessions occurring weekly. While the original protocol specified twice-weekly two hour sessions, we chose to offer weekly sessions of two hours each due to the possible financial and logistical difficulties of our patients. The treatment center which hosted this trial is under the public health system and serves a socioeconomically-diverse group of patients, with many living far away from the wealthier neighborhood where the center is located. The modified format was designed to facilitate access as it reduces the time and money spent commuting for patients. This extra burden can cause personal challenges by sacrificing time available to work or care for family and impact financially vulnerable patients. However, as lockdowns due to the COVID-19 pandemic were implemented in Brazil during this trial, all treatment was moved to remote video telehealth. This occurred at various points in treatment depending on the client, though all had at least one introductory session in-person. On the one hand, the switch to an online format may have served to benefit patients who no longer needed to travel to the treatment center. On the other hand, the switch to telehealth in the context of social isolation may have exacerbated the issue of client passivity described earlier, with therapists having less opportunities to build motivation for exposure exercises.

We made a number of adaptations to the original protocol to make therapeutic language and concepts more accessible to our patients. Our participants were already under pharmacological treatment in a specialized center, reflecting the previously described emphasis on biomedical treatments, and our sample thus had some psychoeducation on OCD. However, psychosocial treatments such as ACT are much less commonly used in Brazil due to that emphasis on pharmacology. For instance, the first edition of the primary book for learning ACT (Hayes et al., 1999) was only recently published in Brazilian Portuguese (Hayes et al., 2021). Therefore patients may be less familiar with the psychological or behavioral terms that often come up in these treatments, such as “cognitions,” “exposure,” “reinforcement,” or “acceptance.” We made efforts to adapt more technical therapeutic concepts to everyday terms. For instance, we frequently used the image of creating or opening space instead of “acceptance.” Instead of describing certain behaviors as “reinforcing,” we would encourage patients to thoughtfully observe consequences or results of a particular action. Similarly, as opposed to talking about “values” we would discuss “what is important to you.”

We additionally made changes to the protocol to help clients move from “thinking medically” to “thinking behaviorally,” or counteracting the influence of the biomedical approach to mental health in Brazil. For this reason, the introductory sessions were extended from three sessions to approximately five, so that therapists had more time to help clients identify and track their OCD-related cognitions and behaviors. As we sometimes faced difficulties in having clients generalize exposure practices, we offered more opportunities for clients to complete homework assignments during sessions when they had not done so during the week.

Specific ACT metaphors used in the treatment were also adapted to better conform to the Brazilian context. For example, we substituted the “don’t think of a jelly donut” exercise (teaching the futility of efforts to control thoughts) for more traditional delicacies in Brazil such as *bolo de chocolate* (chocolate cake) and *sonhos* (cream doughnuts). Also, the metaphor “bum at the door” (to teach acceptance of unwanted feelings) was adapted as “unwanted neighbor,” to avoid any potential offense given the high prevalence of housing insecurity in Brazil. We also encountered themes of violence and physical safety which are common in Brazilian patients with OCD, and related to socioeconomic disparities. As described in detail later, one of our participants (Participant 3) suffered from obsessive thoughts of being responsible for some violent incident, for instance that he would steal the firearm of an armed police officer he passes in the street and shoot someone with it. Brazilian citizens are at increased risk for exposure to violence, including from heavily-armed law enforcement, as is evidenced by recent tragedies of violent police raids in Rio de Janeiro (The New York Times, 2021). When treating obsessions of this violent nature, we had to consider the interaction between OCD symptomatology and genuine efforts to protect oneself in an environmental context with a high risk of violence. In other words, having a heightened awareness of one’s physical environment could be functional to maintain safety, as could avoidance of certain activities (e.g., traveling in dangerous areas). In delivering ACT effectively, therapists had to carefully consider how the presence of violence and associated safety behaviors impacted a client’s valued living.

Aspects of treatment related to Latin cultural values such as familism, *simpatia*, and personalism appeared at various times. All participants alluded to family roles and responsibilities as being central to their clinical concerns and values. To incorporate this in therapy, we sought to emphasize familial relationships as a key motivator in engaging in exposures and practicing ACT skills. For example, practicing acceptance with one client (Participant 2) helped him to deal with his daughter's own compulsive behavior, which represented a trigger for his perfectionism. This attitude directed him toward his value of being a supportive father.

Familism was central with another client (Participant 1) whose obsessive thoughts concerned his body being "dirty" due to being gay and possibly “contaminating” his family members, whom he lives with. Exposures were challenging because they were performed at home. We emphasized contacting the value of familism as a motivator for engaging in exposures and ultimately promoting greater closeness. We explored how the client’s identity as being a gay man was not fully accepted in his family. We helped the client find a balance between his values of freedom and connection, and the Latin cultural values of familism and respect.

Related to the *simpatia* and personalism culture factors, we observed clients’ desires for social approval, including from the therapist, in all three cases. In this situation, the therapists were sensitive to the cultural factors at play, ultimately cultivating a closer relationship. The three clients showed a need to talk about personal events not directly related to OCD and not addressed by the protocol. These interpersonal behaviors made staying on track at the OCD protocol difficult at times. While asking the client to be more direct may be appropriate in other cultural contexts, in Brazilian culture this tends to trigger beliefs of being rude. Instead, we validated the patient's experience while reinforcing the interpersonal relationship in therapy. This may reflect both challenges in adhering to the original treatment protocol in addition to important cultural differences in how psychotherapy is perceived.

**Results**

Mean scores for the primary outcome (Y-BOCS), as well as secondary outcomes, for all participants at baseline, posttreatment, and follow-up are presented in Table 1. Additionally, individual scores for each participant on all outcomes are shown in Table 2.

**Participant 1**

Participant 1 (P1) was a 35-year mixed-race Brazilian (*“pardo”*). *“Pardo”* is a broad term sometimes used in Brazil to describe a mixed-race individual who may present on a spectrum from light to dark skin tone (Osorio, 2013). At the time of treatment, he was single, unemployed and living in a small house with several family members, all of whom were supported by a low income pension. P1 identifies as gay but had not yet come out to his family who hold socially-conservative beliefs. He also faced financial difficulties and once had to miss a session, before the transition to telehealth, because he could not afford a bus ticket. After suffering a lesion in his groin area several years ago, he felt that his body was "dirty" and developed obsessions about contaminating his family members (e.g., by using the same bathroom, washing his underwear and bedding in the same washing machine, and through touching household objects). P1 would engage in compulsions such as using gloves to turn on the tap and wash himself, throwing away used pairs of underwear, and using multiple sets of sheets. He eventually had to resort to selling off personal items to buy new gloves, sheets, and underwear, further exacerbating his financial distress. Also, P1 spent much time in therapy discussing family issues and sexuality and had difficulty completing homework and exposures between sessions. P1 tried to please the therapist by being very friendly and often apologizing for not doing something they agreed or for not doing what was thought to be expected. He also tried to extend the dialogue at the end of almost all sessions. When asked if there was a pattern in this behavior, he recognized the need to talk about himself and his life without judgments.

Willingness to experience his fear of contaminating his family was the most difficult challenge for P1. Success here depended largely on clarifying the values ​​that seemed to be aligned with obsessions in some way (for example, being a careful and respectful family member means protecting the loved ones from a disease). This was facilitated through defusion from thoughts about his body being a threat, and strengthened by taking the perspective of a neutral “observer” (i.e., self-as-context). His committed actions led to his first bath in years without wearing gloves, sitting with a bag of personal items held near his genitals, letting other people touch his objects, and washing and reusing underwear and bedding instead of throwing them away.

P1 also struggled with associations between having sex with other men and being “wrong” or “dirty.” Feeling guilt and fear, he had difficulties of coming out gay to his family and community. During treatment, he made a social media post signing as “a gay man who until then used to be concerned with what others would think.” P1 then felt more empowered to go out with men because did not have “anything to hide anymore.” He linked his public coming out with his values of freedom and connection.

P1 experienced overall reductions in OCD over the course of the study, though symptoms increased between posttreatment and follow-up (coinciding with the pandemic). P1 started treatment in the severe range for OCD according to the Y-BOCS (see Table 2). His decrease in symptoms between baseline and posttreatment was above the threshold for clinically-significant change, which is a 35% or more reduction in Y-BOCS scores (Lewin et al., 2011). The client did move from the severe to moderate symptom range up to follow-up.

 P1 also saw decreases in depression and psychological inflexibility, and had increases in quality of life. Likewise, P1’s depression was severe at baseline and within the minimal range at follow-up. Though improved, P1’s scores remained below the nonclinical range for quality of life.

**Participant 2**

Participant 2 (P2) was a 42-year old mixed-race Brazilian. He was married, living with his wife and 6-year-old daughter, and worked as a web designer. He presented symptoms of OCD related to perfectionism and exhibited repetitive behaviors to alleviate the uncertainty of not doing things in a “perfect” way. An example of these concerns was in the initial sessions when he became anxious about not correctly identifying his internal and external triggers, thus not being able to tell “exactly” what his experience is like. He purposefully performed compulsive behaviors (like drinking water or washing his hands repeatedly) in order to be able to record them in self-monitoring homework. The self-monitoring exercises served as a trigger (antecedent) for obsessive thoughts of perfectionism ("I have to demonstrate exactly what happens to me") and repetitive compulsive behaviors (drinking water, completing the whole self-monitoring several times). The patient was often concerned about the therapist's evaluation. For example, in one exposure he was asked to delete unnecessary computer files which he felt that he “had to save.” Instead of refusing to do so outright, he insisted that it would take too long and that he was afraid to leave the computer on all night. Because of these challenges, we began to conduct sessions that were more focused on learning core defusion and acceptance skills as opposed to self-monitoring.

P2 saw decreases in OCD over treatment, moving from the severe to moderate range, with a subsequent increase in symptoms being observed between posttreatment and follow-up. The difference between baseline and posttreatment scores was clinically-significant. Participant 2 also experienced similar reductions in depression and psychological inflexibility related to unwanted intrusive thoughts, along with increases in quality of life. His depression remained minimal throughout the study, while quality of life did not get above the cutoff for the nonclinical normative range.

**Participant 3**

Participant 3 (P3) was a 45-year old white Brazilian man. Despite being unemployed at the time of the study, P3 worked in several unskilled jobs, the last being a taxi driver. During the study he was supporting himself with the savings he had accumulated throughout his life. He was living alone after separating from his wife and had a 7-year-old son who lived with her and came to spend weekends or a few days with him. His OCD symptoms involved fears of harm, of being aggressive, or of being responsible for some tragic event. He engaged in checking rituals and reassurance behaviors in response to these uncomfortable beliefs. Some of his most common obsessive thoughts were: "The gate will be left open and someone will come in and do some harm," "the gas can leak and the house will explode or someone will die inside the house," and "I will take the police or security officer´s weapon and shoot someone.” Compulsions included checking (the gates and gas tanks) and constantly looking at armed police and security guards to reassure himself that he did not do harm. P3 was also diagnosed with Generalized Anxiety Disorder (GAD) comorbid to OCD at intake.

P3 found it very difficult to take action in his life, tending to remain inert and inactive. This was at odds with his belief that it was “important to change.” For example, he was aware that one reason why his ex-wife ended the relationship was because of his inert way of life. He was overly compliant with the therapist and showed an apparent fear of displeasing her including: fearing doing the exercises wrongly, feeling ashamed to show his self-monitoring exercise, and always reporting improvement in his symptoms and being very thankful for that. He always performed all the homework, exactly as directed, while showing little insight or criticism about his psychotherapeutic process. He was not self-motivated, instead repeating and conducting actions that were suggested in session by the therapist. For this reason, therapy with P3 was largely focused on values ​​and related committed actions. A large amount of time was spent discussing what is meaningful and important to him, such as through structured activities like the Values Bullseye, beyond his potentially rigid proposition that it is “important to change.”

Participant 3 experienced decreases in OCD, following the same pattern as P1 and P2 with a slight increase from posttreatment to follow-up. His pretreatment to posttreatment change was not clinically significant. He had reductions in depression from baseline to posttreatment, though an overall increase in depression was seen by follow-up. Similarly, P3 had a slight reduction in psychological inflexibility related to unwanted intrusive thoughts during treatment, with a subsequent increase observed at follow-up. P3’s quality of life improved during treatment though returned to baseline levels by follow-up. P3 started treatment in the mild range for depression though finished in the moderate range. Similar to the other two participants, quality of life did not reach the nonclinical range for P3.

**Discussion**

The results of this pilot study suggests that a version of ACT adapted for a Brazilian cultural context is potentially effective in reducing severity of OCD during treatment. We additionally found promising signs that the intervention had effects on depression, quality of life, and psychological flexibility. A common trend among our participants was that clinical improvements made during treatment were not fully maintained at follow-up, although remained lower than at pretreatment. This may suggest the utility of providing Brazilian clients with further opportunities to practice ACT skills after formal treatment has ended, such as peer support groups or self-help resources. These data can serve as pilot data for future trials on ACT-based exposure therapy for adults with OCD in Latin countries. The main focus of this paper is the cultural adaptation of this work.

There are three main adaptations from ACT for OCD as developed in the USA to its use with Brazilian populations. Throughout our work with clients, we noticed the central importance of interpersonal values. Much of the motivation, as well as the challenges, of engaging with exposure exercises was centered on family-based factors. Therapists, especially those unaccustomed to Latin culture, should be careful to not view such an interdependent worldview as rigid or pliant, but rather an appropriate way for Brazilian clients to engage with important values (Masuda, 2019). Similarly, practitioners should consider the role of *simpatia*, or desire for interpersonal harmony, that also arose in our work with Brazilian clients. We spent much more time building positive working relationships than might be needed in other cultural contexts in order to build clients’ willingness to engage in the exposure protocol. Third, we faced the challenges of delivering a very behavioral treatment to a client population that was far more familiar with a biomedical approach to OCD. It took a good amount of time to help clients adjust to a treatment where they were actively participating as opposed to following the orders of a doctor.

The challenges we observed in maintaining treatment gains during the follow-up period may be reflective of the COVID-19 pandemic and lockdown measures. A systematic review shows that patients with preexisting psychiatric disorders reported worsening of symptoms in the pandemic (Vindegaard & Benros, 2020). More specifically, in a sample of 829 individuals evaluated before and during the COVID-19 pandemic, participants reported that OCD symptoms significantly worsened evolving with increased disability and reduced quality of life (Fontenelle et al., 2021).

In addition, associated economic losses and increased social inequality may have uniquely impacted our clients in Brazil. It is noteworthy that we saw the clinical improvements we did during treatment, as our trial largely occurred during the height of the pandemic in Brazil. Further study is warranted to explore how psychological interventions such as ACT could help clients cope with acute and continuous stressors as well as socioeconomic adversities, such as loss of employment and lack of financial resources, in addition to addressing clinical concerns.

 The treatment adaptations we made were intended to bring an evidence-based intervention, as ACT, to a cultural context where there is a notable lack of access to adequate psychosocial treatments for OCD. While our pilot results suggest that making a relatively small number of thoughtful adaptations to an ACT protocol that are responsive to cultural values and socioeconomic factors can help address this treatment gap, it is worth considering more substantive adaptations that could be made. For instance, given the communitarian values which are embedded in Latinx culture, group treatment formats may help increase motivation to practice ACT skills, as well as reducing stigma associated with having OCD.

Utilizing group treatment, in addition to remotely-delivered treatment such as video telehealth, could also extend the reach of mental healthcare in Brazil given economic and logistic challenges that clients face in accessing care. Given a growing interest in ACT worldwide, it is important to consider how to make adaptations that reflect the unique needs of different cultures, as well as how to integrate ACT within existing systems of care. This study indicates the effectiveness of using this approach in Brazil, and offers promise for future cultural adaptations of ACT in diverse global contexts.

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Table 1

*Aggregate means and standard deviations for all three participants at each timepoint*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Timepoint* | Y-BOCSM(SD) | Q-LES-Q-SF | BDIM(SD) | AAQ-OCM(SD) |
| Baseline | 24.0 (2.0) | 44.0 (7.0) | 16.3 (13.1) | 61.0 (11.1) |
| Posttreatment | 12.7 (2.1) | 48.3 (2.9) | 7.7 (4.5) | 44.0 (11.3) |
| Follow-up | 18.0 (1.0) | 51.7 (12.5) | 10.0 (9.8) | 47.3 (13.7) |

 *Note.* Y-BOCS = Yale-Brown Obsessive Compulsive Scale, Q-LES-Q-SF = Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form, BDI = Beck Depression Inventory, AAQ-OC = Acceptance and Action Questionnaire-Obsessions and Compulsions

Table 2

*Primary and secondary outcome scores for all participants at each timepoint*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Y-BOCS** | **Q-LES-Q-SF** | **BDI** | **AAQ-OC** |
|  | *BL* | *PT* | *FU* | *BL* | *PT* | *FU* | *BL* | *PT* | *FU* | *BL* | *PT* | *FU* |
| **P1** | 26 | 12 | 18 | 41 | 45 | 52 | 30 | 8 | 7 | 73 | 38 | 45 |
| **P2** | 24 | 11 | 19 | 52 | 50 | 64 | 4 | 3 | 2 | 51 | 37 | 35 |
| **P3** | 22 | 15 | 17 | 39 | 50 | 39 | 15 | 12 | 21 | 59 | 57 | 62 |

*Note.* BL = baseline, PT = posttreatment, FU = follow-up