7 Cultural Considerations in the Context of Establishing Rapport: A Contextual Behavioral View on Common Factors

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Background: The Emergence of Common Factors Theories

> *At last the Dodo said,* 'Everybody *has won, and all must have prizes.'*

And with Rosenzweig's first reference to the absurdity of the Caucus race from *Alice in Wonderland* (Rosenzweig, 1936), the great debate around common factors made its debut in the psychotherapy and behavioral health literature. In the classic C.S. Lewis tale, the dodo bird initiates a race so those in attendance might have an opportunity to dry themselves off, with no defined rules, nor direction, nor finish line. When the race is—rather arbitrarily—called to an end, he proclaims that all participants have won and deserve to receive prizes. Rosenzweig uses this scene to bring life to the notion that therapies of his day all "win," in terms of patient outcomes. By this he meant that there was no true way of knowing whether the salutary outcomes observed in clients were attributable to a given therapy's unique qualities, to some set of *shared qualities across therapies*, a combination of these, or something else entirely.

The therapies du jour Rosenzweig refers to were those based upon theories of personality (Rosenzweig, 1936); he names psychoanalysis, Christian Science, and Pavolov's behaviorism in this first commentary on common factors. By his estimation, there were three *considerations* which applied to all of these therapies and accounted for success:

1. the operation of implicit, unverbalized factors, such as catharsis, and the as-yet undefined effect of the personality of the good therapist;
2. the formal consistency of the therapeutic ideology as a basis for reintegration; and,
3. the alternative formulation of psychological events and the interdependence of personality organization as concepts which reduce the effectual importance of mooted differences between one form of psychotherapy and another.

Though the conceptualization of common factors morphed over time, these were the germinative seeds that were planted for several decades of dialogue to follow. In his positioning of psychotherapy as a problem in learning theory, Shoben (1949) asserted two "common tools" found across all forms of psychotherapy: the relationship and conversational content. Black (1952) then went so far as to blame psychologists'

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loyalties to certain psychotherapeutic approaches for *limiting* the field's potential for discovery in what he deemed to be the true mechanism for change, "the interpersonal relationship itself." According to Black, rapport, acceptance, and relational efficacy were at the heart of this conception of the therapeutic relationship. Albert Ellis, one of the founders of the modern day cognitive behavioral approach, included, in his 1955 account of the 26 qualifications of the therapist, acceptance of the client as a person, despite their shortcomings, "real warmth, kindness, and love" toward the client, and an ability to establish "excellent rapport" so the client might easefully share their "innermost secrets" (Ellis, 1955). The list goes on and is a fascinating peek into his view on the role of subjective person-centered qualities essential to a successful therapist.

Evidence of Dodo Bird Verdict

Forty years after Rosenzweig's first dodo reference, Luborsky, Singer, and Luborsky (1975) presented a qualitative review on the first comparative psychotherapy *Dodo Bird Verdict* by examining various forms of psychotherapies across 33 studies. They concluded that there existed only insignificant differences across these psychotherapies in proportions of patients who improved, and cemented the notion of the *Dodo Bird Verdict* as a controversial claim that regardless of unique techniques or theoretical frameworks, all psychotherapies will result in comparable effects. Around the same time, the first quantitative meta-analysis was conducted to explore the differences in efficacy across therapies (Smith & Glass, 1977). This meta-analysis suggested that the *Dodo Bird Verdict* did indeed hold true under a quantitative lens, which were subsequently supported by Shapiro and Shapiro in their 1982 meta-analysis (Shapiro & Shapiro, 1982).

In the decades that followed, many studies, meta-analyses, and meta-meta-analyses would go down the same rabbit hole (e.g., Horvath & Symonds, 1991; Luborsky et al., 2002; Marcus, O'Connell, Norris, & Sawaqdeh, 2014). Most meta-analyses have generally or partially confirmed the *Dodo Bird Verdict*, though some contend that the very nature of randomized controlled trials—and the meta-analyses on which they are based—are inappropriate methods of study for the question of therapeutic difference in effect (see Budd & Hughes, 2009; Seligman, 1995).

Theories of Common Factors Today

More recently, common factors have been positioned not only as a group of impactful phenomena typically found in therapy, but as parts of *a defined theoretical model* explicating mechanisms of change in psychotherapy (e.g., Ahn & Wampold, 2001; Wampold, 2015). One notable theory of common factors today is Wampold and Imel's *contextual model* of common factors (Wampold, 2015; Wampold & Imel, 2015), which is different from the perspective of *contextual behavioral science* (CBS; Hayes, Barnes-Holmes, et al., 2012) that we present below. Wampold's contextual model identifies eight common factors, in order of effect size: goal consensus or collaboration, empathy, therapeutic alliance, positive regard, congruence or genuineness, therapist factors, cultural adaptation, and expectations (Wampold, 2015). The model views these factors as instrumental parts of major pathways of change in the inherently interpersonal process of therapy. These pathways are: (a) the real therapeutic relationship, (b) expectations, and (c) specific ingredients (i.e., aspects of a treatment that work particularly well for a particular client).

Wampold and Imel (2015) further argue that, before any of these three pathways takes form, the initial bond between the client and therapist should be solid. It is in this section of the model in which the common factor of *therapeutic alliance* is most elaborated upon. However, calling upon Ed Bordin's (1979) depiction of the uniquely deep bonds of trust and attachment in therapy, the authors position therapeutic alliance as foundational to all the three pathways. Once the bond is formed, the real therapeutic relationship can begin to take shape. A real therapeutic

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relationship is defined by the common factor of *genuineness* (i.e., authenticity, openness, and honesty)—with the common factor of *empathy* at the core of this process. As the authors of the contextual model note, therapist empathy ratings are one of the most reliable predictors of psychotherapy outcomes (e.g., Elliott, Bohart, Watson, & Greenberg, 2011). *Positive regard* and *therapist factors* are the third and fourth common factors associated with this pathway.

The second pathway of *expectations*, also conceptualized as a common factor, is formed through explanations of the treatment by the client, and through treatment actions. Psychotherapy provides an account of the client's mental health that positions the alleviation of their suffering as achievable, given a set of steps and activities. In doing so, the client's expectations of success are heightened. In the contextual model, what is key for creating expectations is not the epistemological validity of a theory, but whether or not the explanation of the disorder is accepted by the client, and if actions in therapy are consistent with the explanation. The common factors of therapist influence and goal consensus would logically play into this pathway, though they are not explicitly called out in the description provided by Wampold and Imel (2015). While expectations alone have been found to have salutary effects on symptom outcomes, expectations as conceptualized here require "the systematic use of some set of specific ingredients, delivered in a cogent and convincing matter to the client and accepted by the client," positioned as both a common factor and the third pathway in the contextual model.

Specific ingredients, the third pathway in the model, are those treatment actions which elicit change and ultimately correct the client's particular symptoms. These actions specifically target some aspect of psychopathology, and are more broadly defined by the client engaging in activities that promote wellbeing or attenuate suffering. It is these effects that would not be considered "general effects," not part of the common factors.

Finally, with six of the seven common factors accounted for in the contextual model, the last, and perhaps the newest addition to the list of common factors is *cultural adaptation*. "Culture and context are inextricably blended with all aspects of the therapy enterprise," according to the contextual model (Wampold & Imel, 2015).

Rapport and Rapport Building in Contemporary Common Factor Models

Among a wide range of common factors, therapeutic alliance is the most extensively studied behavioral phenomenon in psychotherapy (Wampold, 2015), and very closely related to this concept is *rapport*. Healthy rapport is the harmonious relationship or bond between a client and therapist framed by understanding, trust, and open communication. In and of itself a "powerful therapeutic factor" (Hathaway, 1948), rapport involves aspects of all the common factors. More specifically, the proponents of common factors theories argue that genuineness, empathy, positive regard, and cultural adaptation can lead to better rapport, while alliance and collaboration might be enhanced if rapport has already been established. Using empathy, one might establish stronger rapport, and when rapport is solid, mutually agreed upon goals and expectations become much easier to arrive upon. Goals and expectations will ebb and flow throughout the course of therapy and rapport can be powerful leverage in helping the client better align expectations with value-based goals and behaviors.

The terms, therapeutic alliance, therapeutic relationship, and rapport are sometimes used interchangeably. The literature is rich with evidence of therapeutic alliance supporting better outcomes in PTSD (Cloitre, Chase Stovall-McClough, Miranda, & Chemtob, 2004), depression (Krupnick et al., 2006), alcoholism (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997), and non-chronic schizophrenia (Frank & Gunderson, 1990). In studies with medical patients, strong rapport is associated with minimized defensive attitudes, more accurate diagnoses, and fewer malpractice suits (Eastaugh, 2004).

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In the 2018 issue of *Psychotherapy* (e.g., Norcross & Lambert, 2018), the American Psychological Association (APA) Task Force on Evidence-Based Relationships and Responsiveness outlines the depreciation of the therapeutic relationship in modern treatment guidelines and evidence-based practices. In the issue's 16 articles, meta-analytic methods are used to illustrate the links between relationship elements and treatment outcome. A consensus of experts deemed 9 of the relationship elements as "demonstrably effective": alliance in individual psychotherapy; alliance in child and adolescent psychotherapy; alliances in couple and family therapy; collaboration; goal consensus; cohesion in group therapy; empathy; positive regard and affirmation; and collecting and delivering client feedback. A further 7 elements of relationship were found to be "probably effective": congruence and genuineness; real relationship; emotional expression; cultivating positive expectations; promoting treatment credibility; managing countertransference; and repairing alliance ruptures. Finally, in terms of *methods of adaptation*, culture (race and ethnicity), religion and spirituality, and patient preferences were found to be "demonstrably important" for effective therapy.

In sum, the consensus is that the psychotherapy relationship "makes substantial and consistent contributions to outcome independent of the type of treatment" (see Norcross & Lambert, 2018 for the task force's formal conclusions and recommendations). Each element of the therapeutic relationship explored by the expert task force informs and is informed by rapport.

Critiques of Contemporary Common Factor Models

Across the history of psychotherapy and behavioral health, common factor models such as the contextual model have emerged as an alternative to the medical model that primarily focuses on specific treatment techniques and ingredients (e.g., Norcross & Lambert, 2018; Wampold & Imel, 2015). Contemporary common factor models such as the contextual model postulate key mechanisms of therapeutic change, such as therapeutic relationship, expectation, and specific treatment ingredients, through which psychotherapy produces its benefits, while conceptualizing common factors as part of these mechanisms. The contextual model has been many decades in the making and is presented with great benefit to students, therapists, researchers, and allies in behavioral health and wellbeing. As we will present below, seeing the relationships between pathways of therapeutic change and common factors through the lens of CBS offers even greater nuance and structure that can serve to inform improvements upon our approaches to treatment. A CBS approach assumes that therapeutic relationship and therapeutic procedure are *inseparable* as both reflect the act of therapist in a context, the act of client in a context, and the interaction of the two in a context (Hayes, Villatte, Levin, & Hildebrandt, 2011; Masuda & Rivzvi, 2019).

Furthermore, a CBS perspective provides the guiding theories of behavioral health and behavior change that are applicable to a broad range of clinical and applied cases in various sociocultural contexts (Hayes, 2005a; Hayes, Long, Levin, & Follette, 2013; Masuda & Rivzvi, 2019). A lack of these guiding theories is devastating in theory and practice (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Klepac et al., 2012; Mennin, Ellard, Fresco, & Gross, 2013). Without common language and theory, progress toward the shared goal of alleviating human suffering is decelerated. Following the framework of contemporary common factor models, goal consensus, alliance, empathy, and positive regard and affirmation are viewed as common factors only when they serve as a means to or are the reflection of behavioral health and wellness (Wampold, 2015). Without clearly stated models of what behavioral health is and how to promote it (i.e., behavior change), there is no way for us to adequately conceptualize whether a given behavioral and interpersonal phenomenon that unfolds in therapy is therapeutic, to evaluate whether a given therapeutic work reflects the heart of these key common factors, and to systematically adjust and promote thera-

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peutic work. To this end, we present the broad concepts of cultural considerations and rapport below, elaborate upon the contextual behavioral scientific perspective, and provide commentary on how one might approach culture and rapport through this lens.

Culture and Cultural Considerations in Establishing Rapport

Although contemporary theories of common factors include cultural adaptations of treatments (Wampold, 2015), the literature of common factors and that of cultural considerations remains somewhat disjointed. Further, if healthy rapport requires understanding and trust, it stands to reason that cultural considerations will play a crucial role in the formation of rapport. To understand the role of cultural considerations in rapport building and the therapeutic relationship, it may be best to start with reviewing our understanding of culture.

Definitions of culture vary across disciplines and moments in time. Nevertheless, in the field of behavioral health, *culture* is generally viewed as:

> A dynamic process involving worldviews and ways of living in a physical and social environment shared by groups, which are passed from generation to generation and may be modified by contacts between cultures in a particular social, historical, and political context. Cultures vary on a continuum of interconnection from independence (i.e., internally homogeneous) to interdependence to complete dependence on other cultures. The latter two forms are hybrid cultures, which probably constitute the majority in our global community (Whaley & Davis, 2007).

From this perspective of culture, knowing about a client's self-identified culture does not equate to knowing about the individual's experience within a particular culture (e.g., ethnic, ability, or gender-based), and how that should or should not inform the process of rapport building. For example, even if an individual has been raised following the dictates of a particular culture, the individual may not identify with all aspects of that culture. To provide a more concrete example, the author of this section, Jo, was raised in a home that integrated Japanese, Hawaiian, and Portuguese family values and she identifies strongly with the Hawaiian approach to warm open communication. She was taught the skills involved in the more subtle and reserved form of Japanese communication, though she only utilizes such an approach with certain members of her family or in particular social circumstances. How might a clinician use this information to optimize rapport? Psychotherapy itself is a cultural phenomenon that plays a vital role in the treatment process (Bernal & Scharró-del-Río, 2001). As such, a dynamic functional and contextual approach, one which may incorporate, but does not require, specific elements of content, warrants exploration.

Current Frameworks for Considering Culture in Client Relationships

In this section, we will present three major frameworks that are currently used for considering culture in the therapeutic relationship. These are (a) the ADDRESSING model by Hays (2008); (b) the model of cultural competence by Sue and Sue (2016); and (c) the guidelines provided by the American Psychological Association, *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017).

The ADDRESSING framework for clinicians and counselors guides psychologists working with clients in identifying key intersectional aspects of identity (Hays, 2008). These are age, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. Making meaningful connections within this framework requires the establishment of both *rapport and respect*, and Hays suggests several noteworthy guidelines in support of these dynamics. For example, she recommends that clinicians be aware of the central role respect plays in many cultures (e.g., Japanese, Latinx) and, as such, should ask a client the title with which they prefer to be addressed. She further notes that self-disclosure can be used to help clients assess the

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clinician's ability to help them (e.g., admitting ignorance about a particular culturally related phenomenon the client is describing). Finally, Hays calls out the nuanced role of nonverbal communication, as it can have very different meanings across cultures (e.g., eye contact, silence).

Hays (2008) stresses that the ADDRESSING acronym should be used to attune to within-group differences, even when a clinician is knowledgeable about the culture of the client. Critical thinking skills are invaluable in discerning both verbal and nonverbal communication dynamics, always keeping in mind one's own assumptions. Hard and fast rules will always involve potentially harmful assumptions, making the awareness, engagement, and decision-making skills of the therapist key.

The second major framework of cultural consideration comes from the multicultural counseling field, as systematized by Sue and Sue. According to Sue and Sue, cultural competence comprises of three major elements: awareness, knowledge, and skills (Sue & Sue, 2016). Clinician self-awareness of values, beliefs, biases, and patterned reactions provide a strong foundation for relating to clients and building rapport. Expanding one's understanding of other cultures through research and experience, as well as exploring adaptations of interventions for certain cultures in the literature, therapists can build upon the second dimension of multicultural competency (i.e., knowledge). Finally, counselors should build specific skills needed to work with diverse clientele. Sue and Sue suggest that rapport "sets the stage on which other essential conditions can become effective" (Sue & Sue, 2016, p. 159). From their view, building rapport through verbal (e.g., communication style) and nonverbal actions (e.g., body language) serves to create an environment of understanding. Such an environment entails trust, positive emotional climate, credibility, and sharing of worldviews, aspects of the therapeutic relationship that lead to optimal results in counseling.

Finally, in the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017), the APA urges psychologists to both be aware of and take action based upon ten guiding principles:

1. Identity is fluid, intersectional, and shaped by the multiplicity of social contexts;
2. Psychologists have limiting assumptions and biases and should work to acknowledge and move beyond them;
3. Language and communication are unique to individuals and important to consider in interactions;
4. Social and physical environments are important aspects of life;
5. Power, privilege, and oppression should be considered and equitable mental health access pursued;
6. Interventions should be culturally adapted;
7. Globalization has an impact on the psychologist's self-definition, purpose, role, and function;
8. Taking a lifespan perspective, psychologists must consider how developmental stages intersect with biosocial cultural contexts to inform identity and worldview;
9. Strive to conduct culturally appropriate and informed practices;
10. Take a strengths-based approach, build resilience, and attenuate the negative effects of trauma.

These ten recommendations are presented within an ecological framework of five nested levels from the bidirectional model of self-definition and relationships to community, school, and family context. Level 3 is the institutional level, which is nested in level 4, international climate. Outcomes of treatment define level 5. To improve rapport, the therapist should recognize barriers clients face in their journey toward wellbeing, especially those related to legal status, stigma, gender identity, and unfamiliarity with research or healthcare systems. The framework and recommendations presented by the APA have the powerful potential to raise awareness about issues that can directly impact rapport between the therapist and client.

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The Case for a Comprehensive and Complete System

From the perspective of CBS (Hayes, Barnes-Holmes, et al., 2012; Hayes, Long, et al., 2013), which will be described in detail below, there is no doubt that extant frameworks of cultural considerations have addressed extremely important issues related to rapport building and effective therapeutic work. However, CBS also argues that, if it is our responsibility as behavioral health professionals to understand rapport and promote therapeutic work across a wide array of socioculturally diverse cases, we need a more comprehensive and coherent model, one that includes a pragmatic theory of behavioral health (e.g., one that defines greater behavioral health and wellness) and of behavior change (Masuda, 2014a, 2016). However, as argued elsewhere, recent cultural competence and humility efforts are said to be too commonly driven by ideology without considering the pros and cons of such culturally focused practices (Lilienfeld, 2017; O'Donohue & Benuto, 2010), or without evidence-based psychological principles as guides for a culturally competent and culturally humble practice (Masuda, 2016). This is a vitally important concern as well-intentioned efforts could yield counterintuitive results, such as the delivery of a more culturally stereotypical and insensitive treatment, promotion of implicit biases toward a client, or rapport that is indifferent to the client's behavioral functioning and wellbeing (Masuda, 2014a; Plaut, Thomas, Hurd, & Romano, 2018; Twohig, Domenech Rodriguez, & Enno, 2014).

What needs to be done, at least from a CBS perspective, is to clarify or build psychological principles that inform the link between cultural considerations and behavioral health and treatment outcome in greater detail. More specifically, such principles should help us see (a) the purpose of cultural considerations, (b) what makes given cultural factors important to be considered in the context of behavioral health and psychotherapy, (c) ways to identify which cultural factors are important to consider even when they are not explicitly shared in a case, (d) ways to promote cultural considerations, and (e) ways to evaluate our therapeutic work through the interrelated lenses of cultural considerations and clinical competency.

From the perspective of CBS, a guiding psychological principle, such as the one mentioned above, should be greater in both *precision* and *scope* (Hayes, Barnes-Holmes, et al., 2012; Hayes, Long, et al., 2013). Most frameworks of cultural considerations tend to focus on a specific group (e.g., culturally humble work for Asian American behavioral health) or topic (e.g., health disparities in mental health), and yet overlook other understudied groups (e.g., Black Americans, Latino/a Americans, multiracial, or LGBTQ clients in the USA) or issues that are equally important to be targeted. Said in another way, these models are only greater in precision for particular groups of clients or topics, but may not be greater in scope as their applicability is specific to these particular groups.

Finally, as implied above, extant frameworks of cultural considerations are largely *descriptive*, and they are not built based on the broadly applicable evidence-based psychological principles of change (Masuda, 2016). That is, these frameworks are extremely effective in raising our awareness of the topic of interest and perhaps to promote changes in their very specified domains. However, when the aim of the cultural considerations is change, especially one that is outside their scope, descriptive theory may not be so effective in pointing out how to bring about change. Once again, if the aim of cultural considerations is the actual change in behavioral, social, and interpersonal phenomena across diverse sociocultural cases without disparities, it is important for us to follow a particular way of understanding (i.e., basic unit of analysis), with particular goals of such understanding (i.e., analytic goals), and a particular criterion set to evaluate our efforts of such understanding in achieving our goals (i.e., truth criteria). We believe that a perspective of contextual behavioral science (CBS) and its underlying philosophy, theories, and practices are particularly useful to pursue this aim (Hayes, Long, et al., 2013; Masuda, 2014a, 2014b). Below is a brief overview of CBS.

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Contextual Behavioral Science as an Overarching Framework of Synthesis

Common factors and cultural considerations are both major topics in the complex process of treatment development. To date, there is no well-articulated and agreed upon model of treatment development in the field of behavioral health. The lack of a coherent model has obstructed progress in a number of important ways. Hayes, Long, et al. (2013) stated that:

> Outside forces such as research funding requirement, changes in psychiatric nosology, or agency regulations regarding evidence-based treatments, seem to have as much or more influence on methods of treatment development than do strategic visions of clinical researchers. As a result, psychological treatment development is a patchwork of strategies, many ad hoc, conducted in diverse research traditions. The field needs to consider how the various methods at its disposal can be integrated into a long-term strategy to create real progress (p. 871).

Hayes and colleagues (Hayes & Hofmann, 2018; Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013; Hayes, Long, et al., 2013) then proposed a contextual behavioral science (CBS) approach as one possible way to rise to this challenge. They defined CBS as follows:

> Grounded in contextualistic philosophical assumptions, and nested within multidimensional, multi-level evolution science as a contextual view of life, it seeks the development of basic and applied scientific concepts and methods that are useful in predicting-and-influencing the contextually embedded actions of whole organisms, individually and in groups, with precision, scope, and depth; and extends that approach into knowledge development itself so as to create a behavioral science mode adequate to the challenges of the human condition (Hayes, Barnes-Holmes, et al., 2012, p. 2).

Said in a more applied way, CBS is summarized as "a principle-focused, inductive strategy of psychological system building, which emphasizes developing interventions based on theoretical models tightly linked to basic principles that are themselves constantly upgraded and evaluated. It involves the integration and simultaneous development of multiple levels of a research program including philosophical assumption, basic science, basic and applied theory, intervention development, and treatment testing" (Hayes, Levin, et al., 2013). Further, CBS is "a wing of science that explicitly embraces pro-sociality and human development as a goal of scientific and professional development" rejecting all other models which seek to minimize aspects of the human experience in order to fit a given theory (Hayes, Barnes-Holmes, et al., 2012).

Functional Contextualism as the Worldview of Contextual Behavioral Science

Every researcher, clinician, and theorist in the field of behavioral health follows a particular philosophical worldview or two, often without knowing it (Hayes, Hayes, & Reese, 1988). For those of us who are involved in the field of behavioral health, it is important to explicate and take responsibility for our own underlying worldview (e.g., philosophy of science, a general perspective, a set of underlying assumptions). This is because one's worldview serves as a foundation where our theories, data, interpretation of data, and applications (e.g., treatment intervention, therapeutic relationship, cultural adaptation) are accumulated and refined over time (Herbert, Gaudiano, & Forman, 2013; Hughes, 2018; Klepac et al., 2012). Without a clear and coherent foundation, we run the risk of models and practices built upon it being disorganized and contradictory.

As described above, clarification of one's own philosophical worldview promotes the development and refinement of clinical knowledge (e.g., theories) and technology in a coherent fashion (Herbert et al., 2013; Klepac et al., 2012). Particularly relevant to the topic of the present chapter, the clarification of one's worldview is also crucial for integrating, assimilating, and synthesizing a vast array of theories and practices from diverse schools (e.g., common factors, cultural considerations, clinical effectiveness) into: (a) a philosophically coherent framework of analysis

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(e.g., what the subject of interest is and how it is understood); with (b) principal goal of analysis (e.g., description, prediction, influence, and prediction-and-influence); and (c) truth criteria to be followed to evaluate one's own work (e.g., correspondence, successful working) (Hayes et al., 1988; Masuda & Rivzvi, 2019). In other words, a given philosophical worldview gives us the framework of understanding with a given stated goal as well as the way to evaluate the progress of our work. Below is the brief overview of functional contextualism, the underlying worldview of CBS.

Regarding the fundamental unit of analysis, functional contextualism views the phenomenon of interest in terms of the "act of a whole person in context" (i.e., behavior–environment interactions as a whole) (Hayes, Barnes-Holmes, et al., 2012; Klepac et al., 2012). This means that, from a CBS perspective, any behavioral phenomenon of interest, such as cultural competency, treatment rapport, and common factors in psychotherapy, is assimilated into the framework of an act of a whole person (e.g., client, therapist) that is manifested as the intersection of one's learning history and current circumstance. It is also important to note that this functional unit of analysis can be set flexibly based on the analysis of interest, ranging from a single strand of a stable behavioral pattern (e.g., negative affect) of a person in a given therapeutic moment to a whole behavioral repertoire of an individual throughout course of intervention and follow-ups (Hayes, Barnes-Holmes, et al., 2012).

Regardless of the size of this functional unit, the primary goal of functional contextualism is the prediction-and-influence of the behavior of interest (Hayes, Barnes-Holmes, et al., 2012). "Prediction-and-influence" here is a unified goal: analyses should help accomplish both simultaneously. More specifically, theories and practices that are based on functional contextualism tend to insist on a stronger version of determinism as reflected in the emphasis on a principle-informed idiographic approach (Hayes, Long, et al., 2013; Klepac et al., 2012). For this reason, for a functional contextualist, it is not enough for a theoretical framework to be descriptive (e.g., what common factors and cultural humility are or whether Aki, an author of this chapter, is competently incorporating common factors and cultural humility into his practice). *For a functional contextualist, it is critical to understand which behaviors of Aki may reflect the concepts of common factors or cultural humility, which contextual factors currently maintain these behavioral tendencies, and which contextual factors one can systematically arrange to influence and promote his behaviors of cultural humility in the future.* Said in another way, functional contextualism emphasizes the importance of context (e.g., learning history and current circumstance) that can be *systematically arranged* by the person. It is only the context that the client and practitioner can systematically add and arrange for promoting and nurturing their effective therapeutic work (Hayes, 2005a; Hayes & Toarmino, 1995).

Furthermore, functional contextualism requires its analytic goal of prediction-and-influence to be greater in *precision and scope* (Hayes, Barnes-Holmes, et al., 2012; Hayes, Levin, et al., 2013). That is, theories and practices derived from the standpoint of functional contextualism must be useful in accurately predicting-and-influencing the target behavioral phenomena of interest (e.g., cultural humility) not only in a given specific circumstance (e.g., Aki working with a given client), but also in many other circumstances (e.g., Jo and other clinicians working with diverse clients in diverse sociocultural contexts).

Finally, unlike other worldviews, functional contextualism de-emphasizes ontology in truth criterion, and assumes that theory, practice, and knowledge are *constructed* and *justified* for a pre-analytically stated purpose and aim, rather than discovered. In other words, *what is true for functional contextualism is what is working* (Biglan & Hayes, 1996).

Psychological Flexibility as a Model of Behavioral Health

In CBS, the Psychological Flexibility Model (PFM) serves as an applied model of behavioral health and behavior change (Hayes, Barnes-

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Holmes, et al., 2012; Hayes, Long, et al., 2013). A larger body of evidence now suggests that the PFM and acceptance and commitment therapy (ACT), a PFM-informed psychosocial intervention, are useful in understanding, predicting, and influencing behavioral phenomena of interest in diverse sociocultural contexts (Atkins et al., 2017; Kashdan & Rottenberg, 2010). Empirical investigation directly exploring cultural competence in ACT is promising, though still in its nascent phase (see Woidneck, Pratt, Gundy, Nelson, & Twohig, 2012). Additionally, PFM-informed theoretical accounts of the therapeutic relationship and cultural considerations are available elsewhere (Hayes et al., 2011; Hayes, Strosahl, et al., 2012; 2014b; Masuda, in press).

According to the PFM, most behaviors (i.e., anything one does and says) in normally developed adolescents and adults are cognitively and socially regulated and maintained. In other words, the context of normally developed humans (e.g., clients, clinicians) is verbal, interpersonal, and sociocultural. Similarly, many presenting concerns brought by clients are cognitive and interpersonal, and our efforts to resolve these concerns are also cognitively and culturally regulated (Hayes et al., 2011; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). A major implication of this model is that the problems of cognitions and other private events (e.g., sensations, feelings, perceptions) are not so much their occurrence or content, but the way a person has learned to respond to them (Anderson, Hawkins, & Scotti, 1997; Hayes & Brownstein, 1986; Hayes & Wilson, 1995; Wilson, Hayes, & Gifford, 1997).

The PFM also argues the paradox of cognitively regulated behavior as being at the core of human psychopathology. That is, otherwise useful and economical, cognitive process can also give rise to problems unique to humans by making individuals insensitive to the here-and-now experience (Hayes, Strosahl, et al., 2012). More specifically, this insensitivity due to human cognitive process (e.g., attachment to the literality of cognition, experiencing it as if it were a "true thing") perpetuates futile problem-solving and avoidance efforts that can exacerbate the psychological issues to be resolved further (Hayes et al., 1996; Hayes et al., 2011).

Furthermore, the PFM proposes three sets of behavior repertoires that collectively promote greater behavioral health and psychological flexibility. In CBS, these three repertoires are called *centered*, *open,* and *engaged* response styles. The centered response style is a group of contextually situated behavioral processes, including the skills of (a) intentionally becoming aware of whatever one is experiencing moment-by-moment; (b) shifting, focusing, and expanding one's intentional awareness and focus; and (c) experiencing the self as the context where all perceptual experiences unfolds (Masuda & Rivzvi, 2019). In practice, such terms as *present moment awareness*, *self-as-context*, and *being mode of mind* are used to describe and teach this skillset. For PFM-informed psychosocial interventions (see Hayes et al., 2011), this centered awareness or sense of self serves a behavioral prerequisite for establishing effective open and engaged response styles as well as for forming and sustaining an effective therapeutic relationship (Hayes, Strosahl, et al., 2012).

The open response style points to a particular functional quality of responding to the present moment experience in a given context. It refers to the extent to which one is experiencing whatever one is experiencing in the present moment *fully and openly as it is without reacting to them or acting on them* (Hayes et al., 2006; Hayes et al., 2011). In contemporary CBTs and other psychotherapies, the terms *acceptance*, *metacognitive awareness*, *mentalization*, *decentering, defusion* (i.e., *looking at a thought as a mental event*), and the like, often are used to capture the aspects of this behavioral process.

Finally, according to the PFM, what makes life truly meaningful is engaging in everyday activities directed by self-constructed *values*. Values in this context can be understood as freely chosen, verbally constructed consequences of ongoing, dynamic, and evolving patterns of activities (Wilson & Dufrene, 2008). In practice, for example, dedication and honesty are chosen values for many adult clients; these personally chosen values can serve as a behav-

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ioral compass, and makes any activities that reflect them (e.g., working through a challenging project without giving up) intrinsically meaningful. Another value example might be altruism; if a client values altruism, or acts of service, but has not actively engaged in such projects recently, a therapist may encourage such engagement. As such, the term *engaged response style* represents a set of behavioral repertoires with this *functional* quality (Hayes et al., 2011).

In sum, greater *behavioral health* or *psychological flexibility* is characterized by the combination of centered, open, and engaged response styles, and in CBS, this unified model serves as a generalized theory of behavioral health and well-being (Hayes, Long, et al., 2013; Kashdan & Rottenberg, 2010). These behavioral skills do not necessarily erase psychological struggles, but help individuals to navigate through the joy and sorrow of their lives. In a review of the PFM, Hayes et al. (2011) summarize the unification of centered, open, and engaged response styles as follows:

> Like the legs of a stool, when a person is open, aware, and active, a steady foundation is created for more flexible thinking, feeling, and behaving. Metaphorically, it is as if there is greater life space in which the person can experiment and grow and can be moved by experiences. Although not all of the approaches target all of the processes, it seems as though contextual forms of CBT are designed to increase the psychological flexibility of the participants by fostering a more open, aware, and active approach to living (p. 160).

Psychological Flexibility as a Model of Behavior Change

From a CBS perspective, the goal of psychotherapy and other forms of behavioral health practice is the promotion of behavioral health and psychological flexibility. As such, common factors, such as rapport, as well as cultural considerations, are understood using the framework of PFM and how to promote behavioral health and psychological flexibility.

A detailed description of how the PFM serves as a model of behavior change as well as practical methods derived from the PFM requires an entire volume, and in fact several such volumes are available elsewhere (e.g., Hayes, 2005b; Hayes, Strosahl, et al., 2012; Luoma, Hayes, & Walser, 2017). For this reason, this section will simply present a brief summary of applied guidelines for practice derived from the PFM (also see Masuda, 2016, in press). These are:

(a) Many of clients' presenting concerns (e.g., problematic behaviors, negative affect, loss of purpose, apathy, negative self-appraisal, relationship conflicts) are cognitively enmeshed and regulated, and their efforts to solve these concerns are also cognitively regulated.
(b) These cognitively regulated phenomena are learned, and socioculturally shaped and maintained.
(c) A case conceptualization is formulated in terms of act-in-context: That is, the extent to which clients engage in unworkable and automatic behavioral and cognitive efforts to downregulate unwanted private events (e.g., experiential avoidance), the deficits in activities that are meaningful or fulfilling (e.g., lack of committed action) for clients, and factors that maintain these behavioral patterns.
(d) The case conceptualization should inform the client's current levels of psychological flexibility as well as the targeted level of psychological flexibility (e.g., treatment goals) using the behavioral dimensions of centered, open, and engaged response styles. The case conceptualization also should inform a treatment plan by the behavioral chain-analysis of how to work with the client step-by-step toward the end goal.
(e) It is important to identify contextual factors that can be systematically manipulated by client, clinician, or both to promote centered, open, and engaged response styles.
(f) The promotion of centered, open, and engaged response styles is done by adding a new learning history and experience to the

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client's extant repertoires (i.e., adding a new contextual experience to one's extant "act-in-historical and situational context").
(g) The addition of new learning should be bottom-up (e.g., experiential) more so than top-down (e.g., "didactic").
(h) Clients' sociocultural factors (e.g., upbringing, learning history, verbal antecedent and consequence, verbal community) are functionally understood by translating them into the target behavioral processes of change identified in (c).
(i) From the perspective of a therapist, psychotherapy should be translated into "the act of therapist-in-context,"
(j) For the same reason, common factors and specific therapeutic ingredients should be translated into "the act of therapist-in-context."
(k) Therapeutic work and therapeutic relationship should be evaluated based on their effects on the intended outcomes in both immediate and long-term.
(l) Context in "the act of therapist-in-context" refers to the therapist learning history and the current and ongoing interaction with a client in therapy.
(m) The promotion of greater behavioral health and psychological flexibility does not necessarily require the elimination of presenting concerns in form or frequency.
(n) Change in how one relates or responds to problematic internal events (e.g., psychological openness) along with the promotion of intrinsically reinforcing and adaptive behaviors (e.g., committed action) is sufficient to promote greater behavioral health and psychological flexibility.

A major takeaway from these guidelines, with regard to the aim of this chapter, can be found in principles (h) and (j): a client's sociocultural factors are *functionally* understood by translating them into the target behavioral processes of change identified in the case conceptualization, as formulated in terms of the act-in-context. Similarly, as described in detail below, therapeutic common factors and specific ingredients are also translated into the act-in-context both from the perspective of client and that of therapist. In other words, cultural phenomena and common factors are important insofar as they relate to the client's therapeutic goals.

Take, as an example, Soha, a 23-year-old woman who identifies as queer and Muslim and has a therapeutic goal of improving her relationship with her mother as the stress from this dyad exacerbates feelings of despondence and negative self-referential thinking. If Soha's mother is fully accepting of her daughter's sexual orientation, it is perhaps unnecessary to factor this cultural consideration into the analysis. However, if Soha's queerness is a point of contention between the two, analysis of this factor is functionally relevant to the therapeutic endeavor, and should therefore be considered by the clinician and discussed with the client. If Soha's mother references Islamic values in her disapproval of Soha's queerness, then the therapist should incorporate cultural considerations of religion and spirituality into the work. However, if Soha's mother disapproves of Soha's queerness because it may interfere with Soha's likelihood of having children, their Muslim orientation is not necessarily as relevant to the stated therapeutic goal. Clearly, a *topographical*, content-focused account of culture is not recommended from a CBS perspective. What is key here is the *process* of discerning the functionality and contextuality of cultural information as it relates to therapeutic success. For a more thorough examination of this process, please refer to Masuda (2014b).

Contextually and Pragmatically Situated Acts of the Clinician

In CBS and PFM, a therapeutic relationship is viewed as the *contextually situated*, ongoing, and dynamic interplay between the client and the therapist as *historical and situational beings* (Hayes, Strosahl, et al., 2012, see pp. 141–149). In this account, psychotherapy and therapeutic relationship can be understood from the perspective of a therapist as well as that of a client. From the perspective of the therapist, psychotherapy is

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a *contextually situated, purposeful act of a clinician* in a therapeutic context that is principle-informed and experientially guided (Masuda, 2014a, 2016). More specifically, psychotherapy is said to be *purposeful* in that the clinician's actions are intentionally directed toward a client's greater behavioral health (e.g., interpersonal connection, purposeful living, psychological flexibility) regardless of how it is manifested topographically. From the CBS perspective, psychotherapy is principle-informed, as the clinician's behavior is always guided, whether implicitly or explicitly, by the theoretical model of behavior change and wellness (i.e., the PFM of behavior health and behavior change). From its inception (see Hayes, Barnes-Holmes, et al., 2012; Hayes, Long, et al., 2013), the proponents of PFM have made great efforts to improve and refine the PFM as a guide for case formulation, treatment planning, and actual treatment that are applicable to diverse clinical cases (Hayes, Pistorello, & Levin, 2012; Hayes, Strosahl, et al., 2012). For clinicians, the therapeutic relationship is also an interpersonal context that requires them to be experiential and flexible in response to ongoing changes in each therapeutic moment with the client (Kohlenberg & Tsai, 2007).

For clients, the therapeutic relationship is a context where they can learn a new set of behaviors, insights, and personal growth (e.g., behavioral health and psychological flexibility) through interacting with a clinician (Robins, Schmidt, & Linehan, 2004). For them, it is also a context where the therapist serves as a crucial contextual factor for the client's behavior change. Particularly relevant to the topic of this chapter, the building of rapport requires the client and clinician to be psychologically flexible (i.e., centered, open, and engaged response styles) in any given moment and responsive to the context of the relationship and specific stated goals. A psychologically flexible therapist embodies the core concepts of open, aware, and engaged living (Hayes, Strosahl, et al., 2012). Doing so then creates a context in which the client can develop their own mastery of these orientations and skills.

Psychological Flexibility as Culturally Situated Behavioral Repertoires

The promotion of behavioral health and flexibility, characterized by centered, open, and engaged living is the overarching treatment goal and direction of psychotherapies that are informed by the PFM (Hayes et al., 2011). In CBS, this functional framework of psychological flexibility is theorized to be universally applicable, although its topographical manifestations can vary significantly across individuals (Masuda, 2014a, 2016, in press). The latter is the case because different sociocultural contingencies operate in these individuals' sociocultural contexts. For example, for some, an individualistic worldview (e.g., individuality, personal achievement, and autonomy) continues to be the driving force that shapes psychologically flexible behavioral patterns (Markus & Kitayama, 1991; Weisz, Rothbaum, & Blackburn, 1984). For others, a collective and interdependent worldview (e.g., harmony and conformity to the collective whole) may serve as an underlying principle of engaged and meaningful living (Markus & Kitayama, 2010).

These differential social contingencies may shape psychologically flexible behaviors of individuals differently across key life domains, such as family relations, parenting, peer socialization, and intimacy (Hayes & Toarmino, 1995; Masuda, in press). For example, the direct expression of one's thoughts and opinions (e.g., assertiveness) tends to be valued in many Western sociocultural contexts, and it is often viewed as part of a psychologically flexible behavioral pattern. However, being assertive in this behavioral form may not be a culturally supported practice for individuals in other sociocultural contexts. For example, Aki grew up in a collective rural culture in Japan. When in Japan, he refrained from expressing his thoughts openly to peers and authority figures as he was taught that expressing what he wants leads to the disruption of interpersonal harmony and is a sign of personal weakness. As such, he developed a set of communication skills that appear too passive for Westerners, and yet functionally effective in his sociocultural context. As

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such, the *manifestations* of greater behavioral health may look different for different clients, on the behavioral surface. It is the underlying *process*—utilizing the psychological flexibility framework in achieving health and wellbeing—that is the key.

In sum, what is crucial for clinicians is to judge whether a given behavior of a client is linked to psychological flexibility for that client in a given sociocultural context by looking at its *functional* and *adaptive* qualities (e.g., centered, open, and engaged living). This is a primary requirement of cultural considerations from the CBS lens. In practice, a culturally and individually sensitive understanding of psychological flexibility can start with asking the client questions such as, "If this presenting concern is no longer an issue, what do you hope to do more of in your life?" and "If you are doing that, I was wondering if you feel alive, as opposed to feeling small or constrained." By asking about the client's hopes for the future, values, culturally informed and otherwise, will implicitly come to the fore. Questions need not be about culture, explicitly.

Rapport Building, Therapeutic Relationship, and Stance of the Therapist

As seen in many PFM-informed psychosocial treatments, an effective therapeutic relationship is often expected to be intense and experiential with a strong interpersonal and emotional connection between client and therapist (Hayes, Strosahl, et al., 2012, pp. 141–142). However, from a CBS perspective, it is important to note that this *form* of interpersonal style (e.g., the therapist being warm, expressing empathy, validating, etc.) will not necessarily be effective for all clients. Similarly, genuineness, empathy, positive regard, and cultural adaptation may take different forms across clients to be effective. Once again, whether a given therapeutic bond is optimal is determined by the extent to which it promotes the client's behavioral health and psychological flexibility. In fact, a therapeutic interaction that is vertical, prescriptive, and directive that are often considered less than ideal therapeutic relationship styles, may be optimally effective for other clients (Allen, Cox, et al., 2016; Allen, Kim, Smith, & Hafoka, 2016).

As presented elsewhere (Masuda, in press), when the author Aki works with Asian American and Native Hawaiian clients in Hawai'i who are younger than him, he tends to present himself as an authority figure, initially, in order to build their perceived confidence in Aki as their clinician. He also tends to be more directive than he might be in sessions held in the mainland USA. This is, in part, because Polynesian cultures often value the wisdom of age and respect for elders (Capstick, Norris, Sopoaga, & Tobata, 2009; Mesiona Lee & Look, 2017; Mokuau, 1990), and behaving in this way tends to be congruent with cultural expectations. Similarly, when he works with Asian American and Native Hawaiian clients, and even some White Americans in Hawai'i who are older than him, he tends to present himself as polite and humble to indirectly express his respect for them. As such, Aki's therapeutic relationship with clients in Hawai'i is not necessarily horizontal or non-directive, as is often suggested by person-focused and experiential psychotherapies, such as ACT. However, this *form* of therapeutic relationship is still PFM- or common factors theory-consistent (Hayes et al., 2011; Norcross & Lambert, 2018; Wampold & Imel, 2015) if it *functions to* promote greater behavioral health and psychological flexibility. The take-home message here is that effective styles of therapeutic relationships can vary greatly across different client-therapist dyads in form, and it is crucial for the therapist to have the ability to fine-tune their relationship in each moment accordingly, in service of the promotion of psychological flexibility (Koerner, 2012; Sue, Zane, Hall, & Berger, 2009).

Relatedly, a therapist's self-disclosure in session is often discussed in cultural consideration and common factors literature, and is a central topic in PFM-informed therapist training (Hayes, Strosahl, et al., 2012). Self-disclosure can be extremely helpful in building rapport, but should only be utilized if it is therapeutic for the client

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(Masuda, in press)—the therapist's self-disclosure may not always be therapeutic for all clients, at least initially. Self-disclosure could be in direct service of the client's goals (e.g., if they are trying to build interpersonal skills like empathy or understanding), or it could be indirect (e.g., the therapist could be modeling how the client may *openly* share their past experiences). For some clients, self-disclosure is not part of their sociocultural norm, at least not during the initial phase of interpersonal relationship, and the therapist's self-disclosure may evoke unintended reactions from clients (e.g., extreme discomfort, losing confidence in the therapist). For this reason, it is important for clinicians to be mindful of the timing and content of self-disclosure. For example, Aki will not self-disclose any of his own previous struggles unless they have established a safe therapeutic context where experiential learning, including self-disclosure, is validated and encouraged.

Summary and Conclusions

In conclusion, contextual behavioral science (CBS) provides a framework, within which clients' unique sociocultural factors (e.g., upbringing, learning history, one's sociocultural environment) as well as therapeutic common factors can be functionally and contextually understood. In terms of functionality, to what extent are these factors related to the unique therapeutic goals of this unique client? In terms of context, how might these factors reshape the contexts of the therapist, the client, and the therapist–client interaction? More specifically, to keep the pragmatic aim of prediction-and-influence with precision and scope in mind, these cultural and therapeutic common factors are translated into the "act-in-context" of the treatment target. In our view, the CBS approach provides guiding theories of behavioral health and behavior change to better understand cultural considerations and therapeutic common factors that are relevant to treatment and to bring about actual change in behavioral health and wellbeing via the psychological flexibility model. The CBS model encourages the client and clinician to be centered, open, and engaged in their therapeutic relationship to pursue greater psychological flexibility. Important cultural considerations and key common factors can therefore be understood through the lens of centered, open, and engaged response styles that unfold in the unique therapeutic relationship at hand. While the dodo bird may certainly have been on to something quite groundbreaking, CBS provides a lens through which only the most meaningful strides are pursued in the race toward greater wellbeing.

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