Got EQ?

Increasing Cultural and Clinical Competence Through Emotional Intelligence

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Cultural intelligence has been described across three parameters of human behavior: cognitive intelligence, emotional intelligence (EQ), and physical intelligence. Each contributes a unique and important perspective to the ability of speech-language pathologists and audiologists to provide benefits to their clients regardless of cultural backgrounds. This article provides an overview of the concept of EQ and its historic and theoretical foundations. Strategies for developing and implementing skills related to EQ to enhance clinical competence and cultural proficiency are explored.

Keywords: cultural/linguistic diversity; basic interpersonal communication skills; emotional intelligence; service delivery

Not so very long ago, professional work settings for most speech-language pathologists (SLPs) and audiologists were generally inhabited by colleagues and clients who shared cultural backgrounds that were more similar to one another than they were different. Communicative interactions, test instruments, and intervention strategies were generally of the one-size-fits-all genre—at least in terms of cultural considerations. Over the years, as our society has become more mobile, it has also become more diverse (Bradberry & Greaves, 2005). Consequently, most of us are now privileged to work with clients and colleagues whose religious, ethnic, and economical backgrounds may be substantially different from our own. To be most effective working in today’s rich cultural milieu, SLPs and audiologists must develop skills that go beyond the technical proficiencies traditionally taught in university programs into a new realm of expertise that requires us to embrace and acknowledge the very human aspects of communication and culture (Robertson, 2007). In fact, as outlined in the article by Westby (2008) in this issue, the American Speech-Language-Hearing Association recognizes that providers of services related to communicative disorders must be culturally competent and culturally proficient.

Interacting effectively with all persons in a sensitive and respectful manner, regardless of their backgrounds, requires a complex set of skills that, taken together, has been described in the Harvard Business Review as cultural intelligence (CQ; Earley & Mosakowski, 2004). Earley and Mosakowski (2004) describe CQ across three dimensions of human behavior: cognitive intelligence, emotional intelligence (EQ), and physical intelligence. Each component plays an important role in the development of an individual’s overall CQ. Although some aspects of CQ are considered to be innate, the authors suggest that “anyone reasonably alert, motivated, and poised can attain an acceptable level of cultural intelligence” (p. 140). The purpose of this article is to explore the concept of EQ and how it relates to increasing clinical skills and maximizing clinical outcomes with persons from all cultures.

Defining EQ

Since the Western world has traditionally viewed the terms intelligence and emotional as being incompatible with one another, some might view EQ as an oxymoron—one of those unique terms, such as jumbo shrimp and deafening silence, that are made up of normally contradictory words. Furthermore, as epitomized by Mr. Spock of Star Trek fame, many people, particularly from Western cultures, emphatically believe that the cognitive process is actually more effective (i.e., we think better) when emotions are suppressed (Bar-On, 2000). From this

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cultural foundation may come the oft-given, but rarely welcomed, advice, "Think with your head, not with your heart!"

In recent years, however, theorists and researchers have begun to argue against a viewpoint that identifies cognition, as measured by IQ, as a high-level process and emotion as little more than the leftovers from more primitive levels of evolution (Schutte & Malouff, 1999). To the contrary, these individuals argue that emotions, when managed appropriately, can substantially enhance, rather than impede, the decision-making process. For instance, whereas IQ involves linear problem solving and deductive reasoning, EQ accounts for those exhilarating "aha" moments when we experience leaps of intuition in which everything suddenly becomes clear (Earley & Soon, 2003). In fact, Cooper (1997) suggests that ignoring emotions when making a decision is like "walking on one leg" (p. 19). If we wish to avoid toppling over (or making a bad decision), we clearly need to use both cognition and emotion to maintain the appropriate balance.

We all know people who succeed in school but fail in life, and vice versa. However, despite posting obscenely high test scores (and ruining the class curve for the rest of us), many of these individuals never seemed to amount to much. They had school smarts but lacked the common sense and creativity that allowed those who may have fallen farther down the curve to start a successful business, write a best selling book, or develop a new product. In fact, Sternberg (1996) argues that the correlation between high IQ and real-world success may be as small as 4% to 10%. This would suggest that other types of intelligence account for more than 90% of the success people experience in their lives (Goleman, 1998).

On the 1st day of the counseling course I teach to graduate students in our communicative disorders program, I ask the class to brainstorm a list of attributes to describe a successful, top-notch SLP. The students clearly enjoy this exercise, and the list generated is usually close to 50 items. Then, I ask the class to identify those characteristics that are actually taught in their university courses. From a list that includes qualities such as flexible, compassionate, empathetic, and intuitive, students are generally only able to identify one or two, such as knowledgeable or up-to-date, that relate to the cognitive aspects of the profession. The remaining terms are more closely linked to skills associated with EQ. Clearly, there is more to success than merely knowing the correct answer on a test!

Popular belief attributes the birth of the term emotional intelligence in 1990 to Peter Salovey and John Mayer, who were discussing a variety of topics while they were painting a house. The conversation eventually turned to the recent antics of a well-known politician that caused them to speculate how someone "so smart could be so dumb" (Goleman, 1998). They hypothesized that there must be more to intelligence than merely a high IQ and coined the term emotional intelligence to describe what they believed made up this missing component in the current descriptions of human intellect. Since then, 15 years (and perhaps a few more coats of paint) later, interest in the concept of EQ has boomed. Applications of EQ to nearly every facet of the human condition—leadership, communication, self-improvement, child-raising, education, medicine, and corporate development—are readily available in numerous books, articles, and online resources (e.g., Brackett, Mayer, & Warner, 2004; Bradberry, 2005; Caruso & Salovey, 2004; Cooper, 1997; Mauer, Bracket, & Plain, 2004; Tillman, 2004).

Unfortunately, while the American Dialect Society (1999) selected emotional intelligence as among the most useful new words or phrases of the late 1990s, there are nearly as many definitions of EQ as there are people who choose to write about it. However, most agree that the main components include identification of one's own emotions, self-regulation of those emotions, and the use of this knowledge to successfully manage relationships (e.g., Bar-On, 2000; Goleman, 1998; Salovey & Sluyt, 1990). Others have expanded this model in a variety of ways, suggesting that other variables, such as optimism and goal orientation, also contribute to EQ (e.g., Cooper, 1997; Weisinger, 2000).

One of the most common misconceptions about EQ is that it means giving free rein to one's emotions and, à la the 1960s, letting it all hang out (Goleman, 1998). To the contrary, an individual with a high level of EQ effectively manages emotions and feelings so that they are expressed accurately and appropriately, whereas those on the low end of the EQ continuum will almost surely stumble through a life filled with frustrations, miscommunications, misunderstandings, and failed relationships (Matthews, Zeidner, & Roberts, 2002).

Theoretical Foundations of Emotional Intelligence

To address the real-world dichotomy between school smarts and street smarts, some theorists have proposed that we expand our view of human intelligence to include a broader range of abilities. Rather than merely equating intelligence with cognition, à la Piaget (1963), newer approaches to human intelligence encompass such constructs as personal characteristics and environmental influences (Mayer, Salovey, & Caruso, 2000).
One of the earliest theories to distinguish between academic and nonacademic forms of intelligence was proposed by E. L. Thorndike in 1920. He suggested that human intellect was made up of three types of intelligence—social, mechanical, and abstract. His ideas were expanded by R. K. Thorndike (1936), who eventually defined social intelligence as the ability to understand and manage people and to act wisely in human relationships.

More recently, and more influential to the notion of EQ, Howard Gardner (1983) proposed that human intellect should be viewed not as a discrete measurement at a certain point in time (such as an IQ score) but rather as a profile of individual strengths and weaknesses. That is, a person can be smart in more ways than one. He further argued that intelligence is more appropriately measured by an individual’s contribution to society (i.e., real-world success) than by traditional forms of IQ testing. One of the first to separate traditional ideas of intellect and emotion, Gardner originally proposed seven types of intelligence—bodily-kinesthetic, musical, logical-mathematical, spatial, linguistic, interpersonal, and intrapersonal. He has continued to include additional types of intelligence to his profile, such as the naturalist and spiritual domains, as they are identified.

Although Gardner’s theory does not specifically mention EQ per se, the concepts of interpersonal and intrapersonal intelligence describe many of the basic concepts associated with EQ. Specifically, individuals with high levels of interpersonal intelligence interact effectively with other people because they are able to accurately perceive their intentions, desires, and motivations. This allows them to communicate effectively, help others feel good about themselves, solve interpersonal conflicts, and convey knowledge. In a similar vein, high levels of intrapersonal intelligence make it possible for people to perceive their own feelings and emotions. They know their emotional triggers—what makes them happy or frustrated—and how to regulate them to meet personal goals. They understand their vulnerabilities and act to overcome them (Gardner, 1983).

Most experts do not suggest that EQ should be viewed as a replacement for IQ but as an additional component of human cognition that provides unique and important contributions to achieving personal and professional success (Bradberry & Greaves, 2005). Goleman (1998) proposes that IQ, or technical expertise, merely accounts for a threshold level of performance on a job. From this perspective, the difference between clinicians who excel and those who do not often lies not in technical expertise but rather in their ability to relate to others, understand their own strengths and weaknesses, and use this knowledge to advance the clinical relationship to the benefit of their clients (Klevans, 1988; Robertson, 2007).

This viewpoint is supported by an investigation by Damasio (1994) involving individuals who suffered brain damage that resulted in an inability to experience emotion but whose cognitive abilities were intact. Although they retained the technical knowledge to perform a job, they were found to be poor planners and poor decision makers. They had difficulty making even trivial decisions and experienced substantial social and professional problems in their vocational settings. These findings support the notion that although IQ may help you get a job, EQ helps you succeed at it.

The Components of EQ and the Culturally Competent Clinician

Contrary to traditional views that intelligence is genetically predetermined (e.g., Piaget), the skills associated with EQ can be learned—although some people find it easier than others to do so (Goleman, McKee, & Boyatzis, 2002; Weisinger, 2000). Unlike IQ, EQ does not emerge during the earliest stages of development and is, therefore, not fixed by the time an individual reaches the teen years. Rather, the competencies associated with EQ are largely learned in the context of interacting with others, and they continue to develop across the life span (Schutte & Malouf, 1999).

Fortunately, SLPs and audiologists may be predisposed to developing EQ skills more easily than those who gravitate toward other professions. Mayer et al. (2000) state that “the high EI [emotional intelligence] person is drawn to occupations involving social interactions such as teaching and counseling more so than to occupations involving clerical or administrative tasks” (p. 410). Perhaps this is why my students consistently identify more traits associated with EQ than with IQ when contemplating their future success.

As mentioned previously, there are a wide variety of EQ models that have been proposed by an equally wide variety of authors (e.g., Bar-On, 2006; Goleman, 1998; Mayer et al., 2000; Petrides & Furnham, 2000). For the purpose of this article, four areas outlined by Goleman et al. (2002) are presented as the foundation skills on which clinicians can build, or sharpen, their EQ skills and create better clinical relationships with persons of all backgrounds and traditions. This model was chosen both for its clarity and for the ease in which it can be applied to the skills used by SLPs and audiologists across a variety of professional settings.

Building Block 1: Self-Awareness

The most basic EQ skill is the ability to perceive one’s own emotions and be aware of how one responds
to specific situations and people. Emotions tend to arise intuitively and immediately in response to specific stimuli and are usually paired with physical and behavioral changes (Shipley & Rosenberry-McKibbin, 2006). Basic emotions, such as happiness or grief, are generally expressed and perceived similarly by people throughout the world, regardless of culture (Su, 2004). Facial expression, body language, choice of words, and tone of voice communicate our emotions to others. Consequently, a critical skill in developing EQ is to learn to consciously recognize our own emotions, and the ways we express them to others, so that we are sending the messages that we mean to send.

This can be particularly difficult when we are working with clients whose cultural backgrounds are different than our own and who may interpret our natural emotional responses as markers of disrespect, indifference, or even hostility (Battle, 2002). If we send clients the wrong signals, even inadvertently, the damage to the clinical relationship may be difficult, or even impossible, to repair.

Building Block 2: Self-Management

Once clinicians have developed an awareness of their emotions, they can learn to use this awareness to manage their emotional responses. Although basic emotions are universal and felt the same way, the methods by which people from various cultures manage their emotions is dependent on the context and the traditions of specific societies (Su, 2004). So, what is appropriate in one culture might be considered very inappropriate in another. For example, the tendency to raise the volume of one’s voice and use more exaggerated intonation to communicate enthusiasm could be construed as speaking down to some people who traditionally only use this form of communication with young children (Su, 2004).

Consequently, to be effective working with all types of people in all types of situations it is important for clinicians to be aware of how their responses to specific emotions could be interpreted by clients. This may require effort in learning how emotions are expressed in the culture of a specific client. However, one of the hallmarks of a person with a high EQ is a willingness to invest time and energy into developing effective interpersonal relationships with others (Weisinger, 2000).

Building Block 3: Social Awareness

This skill allows a clinician to accurately perceive the emotions of others and to understand what they might be thinking and feeling. We know that persons with communicative problems experience a variety of emotions such as anxiety, fear, anger, depression, frustration, loss, guilt, shame, and/or grief (Flasher & Fogel, 2004). Unfortunately, even with clients from one’s own culture, it can sometimes be difficult to determine the underlying emotion associated with a particular behavior. For example, tears might signal sadness, frustration, relief, or even happiness. What might be perceived as a lack of effort may reflect less on motivation, per se, than on the underlying emotional state of a particular client.

Furthermore, a clinician’s emotional response to a situation might be quite different from that of the client. In some cultures, an individual with a disability is not encouraged to actively seek independence. Rather, it is the responsibility of family members to provide care for the individual (Chan, 1998). Consequently, although a clinician may be delighted when a client meets a clinical target, the client may actually be fearful of success because it could be considered shameful to his or her family. Clinicians who are able to accurately tune in to the emotions of their clients, regardless of how they are expressed or if they make sense to the clinician, pave the way to the development of more effective clinical relationships with their clients (e.g., Rollin, 2000).

Building Block 4: Relationship Management

The final step in developing EQ is to consciously employ the previous three skills in combination to manage clinical relationships successfully. Clinicians who are truly tuned into their own emotions and those of their clients will likely be much more successful in communicating clearly, managing potential conflict, and facilitating positive change (Shipley & Rosenberry-McKibbin, 2006). Flasher and Fogel (2004) further suggest that how we interact with others is heavily influenced by our personal view of the world and our own cultural background. Because of our tendency to assume that the values of our own culture are the most appropriate, we may unconsciously impose our value systems onto our clients (see also Rollin, 2000).

For example, most Western cultures value timeliness and often equate a lack of punctuality with a lack of respect. However, this is not true in many other cultures where a more fluid interpretation of time is common (Shipley & Rosenberry-McKibbin, 2006). Today, your client has again arrived late for her session and assumes that you can extend her allotted time to make up for her tardiness. You believe that you have communicated on several occasions that this is not possible, and today your schedule is especially tight. As you start to explain this—again—you realize that your voice is getting louder, your
words clipped, and your gestures exaggerated. You also note that your client’s eyes have widened and she has taken several steps back from you. You recognize that you are becoming angry and appear to be frightening your client. Understanding that this is counterproductive to solving the problem, you consciously lower your voice and relax your body. Your client relaxes as well. Fortunately, you were able to employ your EQ skills to prevent a potentially relationship-ending confrontation. Although the problem is not solved, the door remains open for resolving the conflict.

Unfortunately, despite our best efforts, it is not always easy to determine the emotional states and attitudes of our clients. Clinicians may make the mistake of assuming they know how their clients feel and what changes need to occur in order for them to meet their goals. But, the clinician’s idea of an appropriate goal may very well be something completely different from that of their clients (Rollin, 2000). Flasher and Fogel (2004) stress that to ensure that culturally sensitive decisions are made during the clinical process, clinicians must strive to understand and respect the different worldviews of their clients. In some cultures, for example, goal setting is an undertaking that involves families, not individuals. Conversely, persons from other cultures might view asking families to become involved in the intervention process as a sign of incompetence on the part of the professional (Shipley & Rosenberry-Mckibbin, 2006).

At the same time, clinicians should never assume that all persons from the same culture will respond in the same way to similar situations. As such, clients should be treated as individuals with their own values, beliefs, and emotions regardless of their cultural background (Battle, 2002). Clinicians with a high EQ learn from each interaction with each client and use this information to fine-tune their management of the clinical relationship, regardless of the individual’s cultural background.

Summary

In his essay All I Really Needed to Know I Learned in Kindergarten, Robert Fulghum (2004) outlines lessons that most children learn in their 1st year of school, such as sharing, playing well with others, and cleaning up after themselves. He further suggests that the world would be a better place if everyone continued to play by these rules. As we have discovered in this article, these skills, so important in kindergarten, are rooted more in EQ than in IQ, with the emphasis on learning to work and play with others. SLPs and audiologists who truly want to help their clients achieve meaningful change would do well to tap into the skills they began to learn in kindergarten as they learn to manage different situations with diverse clients. Learning to identify emotional cues and manage clinical relationships effectively is a dynamic process that takes time, practice, patience, and true commitment to valuing the cultural traditions of all persons. Developing your personal EQ is an important step in the journey toward true clinical competence and cultural proficiency.

References


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Continuing Education Questions

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Being Smart in a Diverse World

Westby

1. Transportability of tests requires that cultures share
   a. the same language, history, and resources.
   b. the same ethnic backgrounds.
   c. similarities in values, ways of knowing, and styles of communication.
   d. a formal educational system.

2. According to the ICF, which of the following would be a deficit in performance?
   a. A child with a low-average score on a language test who never volunteers to respond in class
   b. A poor score on a test of syntax and vocabulary
   c. A child’s difficulty in imitating nonsense words after the clinician
   d. A child who requires a cochlear implant to hear

Culturally Consistent Treatment for Late Talkers

Wing, Kohnert, Pham, Cordero, and Kan

5. A primary intervention goal for late talkers is
   a. to increase interactions between the parents and child.
   b. to promote the use of newly acquired words and sentences within meaningful communicative interactions.
   c. to increase accurate production of delayed speech sounds.
   d. to decrease challenging behavior through positive and negative reinforcements.

6. Which of the following is NOT a factor related to how cultural variation may collide with current treatment practices for late talkers?
   a. Nature and context of social interaction varies
   b. Specific language goals for children vary
   c. Desire for children to be successful communicators varies
   d. Techniques utilized to facilitate language vary

7. The common basis of intervention programs such as Focused Stimulation Approach, Conversational Recast Intervention, and It Takes Two to Talk: The Hanen Program for Parents is
   a. explicit instruction of target structures.
   b. social interaction.
   c. parent implementation of treatment.
   d. play-based intervention.

Got EQ? Increasing Culture and Clinical Competence through Emotional Intelligence

Robertson

3. According to Sternberg, IQ accounts for approximately what percentage of personal and professional success?
   a. 4% to 10%
   b. 10% to 18%
   c. 22% to 28%
   d. 48% to 56%

4. Theoretical foundations for the concept of emotional intelligence have been provided by:
   a. Piaget
   b. Gardner
   c. Vygotsky
   d. all of the above

Developing Cultural Intelligence in Preservice Speech-Language Pathologists and Educators

Griffer and Perlis

8. The development of cultural intelligence involves all but
   a. study of the self.
   b. awareness that everyone has a multi-perspective identity.