Mental Health Clinicians' Reports of Their Cultural Intelligence

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Arlene M. Arias

Introduction

As the overall population of the United States continues to grow, the demographics of the country have become more racially and ethnically diverse. In fact, the U.S. Census Bureau (2012) reported that the nation's minority population is now 116.2 million, which is 37% of the total population. This number is projected to rise to 57% of the population by 2060.The shifting U.S. demographic profile has had both negative and positive effects on the welfare of minority groups. Among other challenges are social and economic issues, including assimilation (integration) into the dominant culture and health disparities (Shrestha, 2006).Health disparities are the gaps between the health of ethnic and racial minorities and the health and mental health services they receive when compared with their White counterparts. Furthermore, racial and ethnic minorities are overrepresented among at-risk populations, including persons who are homeless, incarcerated, and institutionalized. Notably, these particular populations have higher rates of mental disorders and face more barriers to mental health care.

At the same time, providing culturally competent services to a quickly growing ethnic and racial population poses challenges to mental health systems, clinicians, and their leaders (Goode & Dunne, 2003). According to the Surgeon General's report titled *Mental Health Culture, Race, and Ethnicity* (U.S.DHHS, 2001), minorities (a) are least likely to receive needed mental health care, (b) receive poor quality of mental health care, (c) are underrepresented in research on mental health, and (d) experience less availability of and access to mental health. Organizations struggle in their capacity to provide effective health treatment to individuals from racial, ethnic, and culturally diverse groups.

Given the growing populations of ethnic and racial minorities along with disparities in health services and outcomes, the need for clinicians who are culturally intelligent is apparent. The purpose of this study was to explore and describe mental health clinicians' reports of their cultural intelligence. Data analyses led to several findings about mental health clinicians' cultural intelligence. Recommendations for practice and professional development are also included.

Need For a Culturally Intelligent Mental Health Services Workforce

Public policy initiatives and professional accreditation bodies have played a key role in pushing the agenda for culturally competent service delivery as a solution to ending health disparities among ethnic minorities. The Office of Minority Health (OMH) published the Culturally and Linguistically Appropriate Services (CLAS) standards (U.S.DHHS, 2001), which were designed to provide health care organizations with guidelines for cultural and linguistically competent service provision and address ethnic and racial health disparities. The CLAS standards address three primary areas: (a) culturally competent care, (b) language access services, and (c) organizational supports for cultural competence.

The need for culturally competent service delivery was also addressed through publications by professional associations in the medical (American Medical Association [AMA], 1999), psychological (American Psychological Association [APA], 1990), and social work (National Association of Social Workers, [NASW], 1996) fields. Likewise, authors in the field of counseling outlined specific methods of implementing culturally competent services and proposed detailed

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indicators of culturally competent care (Sue, Arrendondo, &McDavis, 1992; Arrendondo et al., 1996).

More recently, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO;2009) published proposed additions to their standards. These additions are aimed at increasing culturally competent service delivery in hospitals seeking accreditation. JCAHO certifies and accredits over 17,000 healthcare agencies in the United States including local mental health authorities in the state where this study took place. Cultural competence refers to "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency, or those professions to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13).Although terms such as cultural competence, intercultural competence, cross-cultural competence, and cultural intelligence are sometimes defined in slightly different ways, they are often used interchangeably in the literature.

Cultural Intelligence (CQ)

Individuals that possess cultural competence are culturally intelligent. Cultural intelligence (or CQ) is "a person's capability for successful adaptation to new cultural settings, that is, for unfamiliar settings attributable to cultural context" (Earley&Ang, 2003, p. 5). The concept of CQ is rooted in the contemporary theories of intelligence that emphasize the capability of a person to adapt or adjust to the environment. These contemporary theories of intelligence focus on particular domains including Salovey and Mayer's emotional intelligence, Cantor and Kihlstrom's social intelligence, and Gardner's multiple intelligences (as cited in Van Dyne, Ang, &Koh, 2008).Earley and Ang (2003) developed their CQ model to better explain why some people function more effectively than others in culturally diverse situations. Cultural intelligence is comprised of four distinct factors—motivational CQ, cognitive CQ, metacognitive CQ, and behavioral CQ (Earley & Ang, 2003).Each factor and the related components, which are explained next, are listed in Table 1.

Motivational CQ

Motivational CQ is an individual's ability to direct energy and attention toward functioning in and learning about culturally different situations. Earley and Ang (2003) identified three components of motivational CQ: (a) self-efficacy, (b) self-enhancement, and (c) self-consistency.

Self-efficacy is defined as the level of confidence an individual has in their ability to perform in cross-cultural situations (Earley & Ang, 2003).Self-efficacy is necessary in cultural settings because successful interactions require that individuals have a sense of confidence in the ability to adapt (Van Dyne et al., 2008).

Self-enhancement reflects a tendency to recall and recognize information that is likely to maintain a positive self-concept. An individual with high motivational CQ looks for both positive and negative information about themselves versus selectively interpreting and remembering positive elements (Earley, Ang, & Tan, 2006).

Self-consistency refers to the need to maintain coherent and consistent cognitions and experiences (Earley & Ang, 2003).An individual with high motivation for self-consistency will have a lower level of CQ (Earley et al., 2006).A high level of self-consistency results in rigidity during cross-cultural encounters.

Cognitive CQ

Cognitive CQ is an individual's knowledge of cultural practices, norms, and conventions acquired from personal and educational experiences (Ang & Van Dyne, 2008).Cognitive CQ is a critical factor in CQ because cultural knowledge influences an individual's behaviors and thoughts. Earley and Ang (2003) identified three components of cognitive CQ: (a) declarative knowledge, (b) procedural knowledge, and (c) conditional knowledge.

Declarative knowledge is what an individual knows about facts, propositions, or events involving a particular culture (Earley & Ang, 2003).It is the most direct form of information for an individual. Declarative knowledge is primarily gained from observing activities and inquiring about cultural issues.

Procedural knowledge reflects knowledge of the functions or actions of a culture (Earley & Ang, 2003).It is about knowing how to do things or how something functions. This type of

Table 1
CQ Factors and Components (Earley&Ang, 2003)

CQ Factors	Components
Motivational CQ	Self-efficacy Self-enhancement Self-consistency
Cognitive CQ	Declarative knowledge Procedural knowledge Conditional knowledge
Metacognitive CQ	Inductive reasoning Analogical reasoning Self-awareness
Behavioral CQ	Repertoire of behavior Culturally intelligent behaviors Positive self-presentation

knowledge might be gained by direct observation and mimicking others. Individuals with high levels of procedural knowledge sequence strategies better, use better quality strategies, and perform actions automatically in cross-cultural situations.

Conditional knowledge involves knowing why and when to use certain cognitive processes. This type of knowledge addresses the usefulness of particular strategies in cross-cultural interactions. Culturally intelligent individuals are able to use conditional knowledge when adjusting their knowledge across different cultural interactions.

Metacognitive CQ

Metacognitive CQ refers to a person's level of "conscious cultural awareness" (Ang & Van Dyne, 2008) during interactions that are cross-cultural. Individuals with strong metacognitive CQ self-reflect, monitor behaviors, adjust their cultural knowledge, and question their cultural assumptions. The components of metacognitive CQ include(a) inductive reasoning, (b) analogical reasoning, and (c) self-awareness.

Inductive reasoning allows an individual to predict and interpret new information and step beyond what is known in order to understand new cultural situations (Earley & Ang, 2003).An individual with high metacognitive CQ is able to look at existing knowledge and use cues to anticipate what should happen.

Analogical reasoning assists an individual in transferring experience and knowledge from one domain to another. Reasoning analogically is related to the ability to draw inferences from what

one knows or has learned (Earley & Ang, 2003).

Self-awareness refers to the knowledge of self, the way in which one views their thoughts and themselves (Earley & Ang, 2003).Individuals with self-awareness are in touch with their values, biases, and personal preferences. They are aware of their own culture and how this might influence their actions in culturally unfamiliar situations.

Behavioral CQ

Behavioral CQ reflects the capability to use appropriate verbal and nonverbal actions during cross-cultural interactions (Ang & Van Dyne, 2008).These behaviors are intertwined with cognition and motivation. There are three components of behavioral CQ: (a) repertoire of behaviors, (b) culturally intelligent behaviors, and (c) positive self-representation.

Repertoire of behaviors includes verbal and nonverbal responses or actions that are used to navigate across various cultural contexts. Individuals get cues about appropriate behavior through observing others and making inferences about how to act.

Earley and Ang (2003) described *culturally intelligent behaviors* as "external behaviors where the actors are assumed to be actively interpreting the meanings of their cultural surroundings, and are motivated to participate, understand, and attach meanings to their responses to situational cues" (p. 160).These behaviors are purposeful.

Positive self-presentation is the ability of individuals to create favorable and positive impressions of themselves to others. Individuals attempt

to shape the perceptions of others by avoiding or doing something that would make them look incompetent.

To summarize, Earley and Ang (2003) developed theCQ model in an effort to better understand why some people function more effectively than others in culturally diverse situations. Van Dyne, Ang, and Livermore (2010) rightly pointed out that cultural intelligence is not about mastering "all the norms, values, and practices of cultures encountered" (p. 132).Rather, they stated, CQ is about being capable of successfully adapting views and behaviors in cross-cultural situations. Said differently, individuals who are culturally intelligent are more apt to display cultural competence.

In a theoretical piece, Goh, Koch, and Sanger (2008) suggested that the concept of cultural intelligence be integrated into counseling psychology. Goh et al. (2008) went on to demonstrate how the CQ model components align with and expand upon previous multicultural counseling concepts proposed by other researchers in the counseling field. Research employing the CQ model has been conducted primarily in international business settings and executive development programs that emphasized cross-cultural management (e.g., Ang et al., 2007).

Empirical investigations of practitioners' cultural intelligence conducted in the health related fields are scant with none centered specifically on mental health clinicians. Exploratory research that considers mental health clinicians' CQ is a first step in addressing this gap and is critically important to the field because mental health clinicians are responsible for providing direct services to clients representing a variety of culturally diverse backgrounds.

Methodology

A cross-sectional survey design was used in this exploratory study. A sample of 34 clinicians was recruited via email from a population of 146 mental health clinicians (social work and nurse professionals) providing direct services in a mental health clinic in a northeastern U.S. state. The *Cultural Intelligence Scale* (CQS; Cultural Intelligence Center, 2005) was administered via the Internet using an online survey tool. The tool is readily available online to be used for research. The

CQS contains 20 items. The first section contains five items that probe for basic demographic information about the respondents and their primary position as a mental health clinician.

The second section contains 16 researcher-modified items derived from the CQS (Cultural Intelligence Center, 2005), which was developed to measure a person's cultural intelligence and the four factors that comprise the construct—metacognitive CQ, cognitive CQ, motivational CQ, and behavioral CQ. Each survey item reflects a statement that queries respondents about their capabilities related to a specific behavior (e.g., "*I am conscious of the cultural knowledge I use when interacting with people with different cultural backgrounds.*"). Respondents were asked to select a number on a 7-point Likert scale (1 = *strongly disagree*, 7 = *strongly agree*) that best describes the degree to which they agree or disagree with each statement.

Scale scores, one for each of the four factors, were computed in SPSS by summing the ratings on the four items related to each factor (i.e., metacognitive CQ, cognitive CQ, motivational CQ, and behavioral CQ).The Total CQS score was calculated in SPSS by summing the ratings for all items.

To better describe the results of the CQS, it was anticipated that the frequency and percentage of item responses will be categorized as respondents reporting low, moderate, or high agreement. Responses of 1 or 2 on the 7-point Likert scale were categorized as reports of low agreement, responses of 3, 4, or 5 were categorized as reports of moderate agreement, and responses of 6 or 7 were categorized as reports of high agreement. Item findings were generated when at least 50% of the responses clustered into one of the categories.

The CQS scale scores and Total Score were categorized in a similar way. The minimum score for the high range (suggesting a high degree of CQ) for a given scale is the number of items times six (i.e., to be in the high range would require at least a response of six on all items for that scale). The minimum score for the moderate range (suggesting a moderate degree of CQ) is the number of items times three (i.e., to be in the

Table 2

Sample Demographic Data (N = 34)

Demographic	n	%
Length of Employment		
Less than 1 year	1	2.94
1-5 years	8	23.52
5-10 years	9	26.47
10 or more years	16	47.05
Employment		
Full-time	32	94.11
Part-time	2	5.88
Age		
18-29	1	2.94
30- 39	7	20.58
40- 49	8	23.52
50 or older	18	52.94
Gender		
Female	27	79.41
Male	7	20.58
Racial or Ethnic Identification		
American Indian or Native American	—	—
Asian, Asian American, or Pacific Islander	—	—
Native Hawaiian	—	—
Black of African American, Non-Hispanic	6	17.64
White, Non-Hispanic	24	70.58
Hispanic, Latino, or Spanish	4	11.76
Other	—	—

moderate range would require at least a response of three on all items for that scale).All scores below the minimum score for the moderate range were classified as low, suggesting a low degree of CQ. Scale score findings were generated when at least 50% of the responses clustered into one of the categories.

Descriptive statistics were used to analyze demographic data and the CQS item responses. Table 2 summarizes respondent (*N* = 34) characteristics. Concerning employment, 94% (*n* = 32) of the participants reported being employed full time at their agency. Of the 34 respondents, 79.41% reported they were female, and 70.58% (*n* = 24) identified themselves as White, Non-Hispanic. Nearly 53% (*n* = 18) of respondents were age 50 or older.

Results

The data indicate that 82.35% (*n* = 28) of respondents (*N* = 34) reported what could be categorized as moderate levels of cultural intelligence. Specifically, 55.88% (*n* = 19) of respondents reported what could be categorized as high levels of metacognitive CQ, 88.23% (*n* = 30) of respondents reported moderate levels of cognitive CQ, 85.29% (n = 29) of respondents reported high levels of motivational CQ, and 82.35% (*n* = 28) of respondents reported what could be categorized as moderate levels of behavioral CQ.

Table 3 summarizes the respondents' (*N* = 34) reports of metacognitive, cognitive, motivational, behavioral, and total CQ.

Conclusions

These results are promising in that clinicians with high metacognitive CQ are consciously aware of cultural norms, preferences, and differences before and during cultural interactions (Ang & Van Dyne, 2008). Goh et al. (2008) posited that the metacognitive practice of strategizing during cross-cultural counseling interactions allows for culturally competent practice. The ability of clinicians to self-reflect, monitor their behav-

iors, adjust their cultural knowledge, and question their cultural assumptions is critical given that they are responsible for providing direct services to clients representing a variety of ethnic and racial backgrounds. The individuals in this study appear to be building these competencies.

Cognitive CQ is an individual's knowledge of cultural practices, norms, and conventions acquired from personal and educational experiences (Ang & Van Dyne, 2008).Cognitive CQ is a critical factor in CQ because cultural knowledge influences an individual's behaviors and thoughts. Clinicians are expected to have knowledge about the client populations they serve.

Clinicians with high motivational CQ are internally motivated to engage in a variety of cross-cultural encounters. These clinicians also become actively involved in community events, social and political functions, celebrations, and neighborhood groups that are not part of work assignments. Participants in this study seem to have a low need for self-consistency and self-enhancement, which is consistent with high levels of motivational CQ.The results for motivational CQ are particularly promising, as participants reported the highest levels of capability in this area when compared with other factors of CQ.

Behavioral CQ reflects the capability to use appropriate verbal and nonverbal actions during cross-cultural interactions (Ang& Van Dyne, 2008).The appropriate use of verbal and nonverbal communication is a key clinical skill for mental health clinicians. Demonstration of behavioral CQ might include a counselor's use of interpreters when interacting with individuals who have a first language other than English.

The results from this study suggest that clinicians' CQ capabilities are at moderate levels. This study represents a milestone because it adds to the CQ knowledge base in that it examined reports of CQ of individuals in the field of mental health, which until now have not been explored. Moreover, the results hint at places where clinicians' CQ can be further developed.

Table 3

Respondents (N = 34) Level of Metacognitive, Cognitive, Motivational, Behavioral, and Total CQ

Level of CQ	Low	Moderate	High
Scales			
Metacognitive CQ	—	$n = 15$ 44.1 %	$n = 19$ 55.8 %
Cognitive CQ	$n = 1$ 2.9 %	$n = 30$ 88.2 %	$n = 3$ 8.8 %
Motivational CQ	—	$n = 5$ 14.7 %	$n = 29$ 85.2 %
Behavioral CQ	$n = 1$ 2.9 %	$n = 28$ 82.3 %	$n = 5$ 14.7 %
Total CQ	—	$n = 28$ 82.3 %	$n = 6$ 17.6 %

Recommendations for Practice and Professional Development

Self-assessment of CQ

In this study, clinicians reported moderate levels of cultural intelligence. Since CQ is malleable, meaning that it is open to outside influence, clinicians should routinely assess their CQ capabilities to increase and improve culturally competent service delivery. Livermore (2011) encourages CQ self-assessment and describes behaviors that indicate improvement in CQ. Clinicians could complete the modified version of the CQS used in the present study. The Cultural Intelligence Center (2005) also offers a 20-item CQ self-assessment as well as a five question quick self–assessment that are easily accessible online. An assessment of clinicians' CQ capabilities can provide the insight needed to improve practice with ethnically and racially diverse populations.

Gaining a sense of the relative strengths of motivational CQ, cognitive CQ, metacognitive CQ, and behavioral CQ (Earley & Ang, 2003) may spark clinicians' intrinsic motivation, or motivational CQ, to augment their capabilities to improve service delivery by applying various strategies. Engaging clients in ways that promote sharing of cultural practices and customs that are important to the client (Goh et al., 2008) could provide a scaffold for building clinicians' cognitive CQ and their knowledge of a particular culture.

Metacognitive CQ could be enhanced by adopting Schön's (1987) professional practice of *reflection in action*. Schön suggested that reflection typically assumes two forms—reflection on action or reflection in action. The first form is a more passive approach in which individuals reflect on an action after it has occurred to learn how what they did might have affected the outcome. The second form is a more active approach in which individuals think about their thinking and reflect on their actions in ways that help to change what they are doing while they are doing it. Reflection in action leads to inquiring further, deepening understanding, and discovering answers. In this way, clinicians can monitor their cultural assumptions as well as strategize and plan ways to improve relatedness and communication during clinical interactions with clients .Augmented motivational, cognitive, and metacognitive CQ could, in turn, lead to improved behavioral CQ. This might manifest in clinicians using both verbal and nonverbal behaviors that respect clients' preferences for personal space or eye contact, for example.

Professional Development Designed to CQ

The design of any professional development activity should be based on best practices. In the field of education, for example, seminars and workshops, a common type of professional development activity for clinicians, have been found to be most effective when they are sustained and intense (30 or more hours) and include follow-up sessions (e.g., Guskey & Yoon, 2009; Wei, Darling-Hammond, Andree, Richardson, & Orphanos, 2009).It seems reasonable to assume this would be applicable to professional development for clinicians. Linking brain research to learning through the use of brain-compatible strategies would be another important consideration in designing effective professional development experiences (Materna, 2007).Such strategies would include having learners question their assumptions related to the focus of new learning, thus tapping into their previous experiences and helping them to make associations with new learning (Knowles, Holton, & Swanson, 1998; Materna. 2007).

Professional development activities that use experiential learning approaches have been specifically recommended for CQ education (Li, 2009; MacNab, 2012; Ng, Van Dyne, &Ang,2009).Experiential learning approaches emphasize the role direct experience plays in learning and change. One example is Kolb's (1984) four-stage experiential learning cycle, which encompasses (a) concrete experience, (b) reflective observation, (c) abstract conceptualization, and (d) active experimentation. Cultural intelligence-building professional development activities based on Kolb's model would actively involve learners in directly experiencing, functioning in, or learning about culturally different situations. A workshop might begin by having participants reflect on previous experiences that relate to the topic at hand. Then simulations and

authentic case studies are learning strategies that could be used to provide new concrete experiences.

Following Kolb's (1984) cycle, the professional development experience would be structured so the participants use the concrete experiences that are culturally different as a basis reflection and observation (accommodation). Strategies to encourage reflection might include open-ended questioning and discussion techniques aimed at making meaning of the experiences and developing shared understanding. Addressing the third stage in Kolb's experiential learning model, abstract conceptualization, the workshop facilitator would present the abstract concepts, or theories, behind the new learning or ideas. Clinicians would be encouraged to think about how the concepts apply to the concrete experiences. Additional opportunities would be provided for workshop participants to actively experiment with the new information, including activities that allow individuals to plan how they might apply concepts in future interactions with clients in culturally different situations. In keeping with best practice in professional development, follow-up activities that require participants to apply the new learning to in the interactions with clients should be included.

While the cost of comprehensive professional development process, in which outside experts and prepackaged training are used, might prove prohibitive, especially given the current state of agency budgets, there are other ways to structure professional development that can lessen costs considerably. Technology-based mediums, such as Webinars, wikis, and online forums, provide a venue for learning. Other low-cost vehicles for professional development include communities of practice (Wegner, 1998) and professional learning communities. Communities of learners can be self-organizing or facilitated. In either case, individuals come together over a shared interest in a particular domain of learning. They provide mutual support for learning and performance and engage in sharing expertise and resources.

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