We get some great discussions on our CLAS-talk email discussion list and occasionally we share them here. They have been edited for brevity and clarity.

Questions

What are the differences between diversity training and education in cultural competency? How are these terms used and why does it matter?

Answers

Recently there have been a number of posts about diversity, cultural sensitivity, etc. Along with others immersed in this field I see it as important to stress the difference between diversity and cultural competency. We can value difference immensely and still never reach the critical components of culturally responsive care or recognizing the difference between these two. Diversity means differences, and any diversity training I have been to has been aimed at simply that — acknowledging and valuing differences. But that is not enough when you are a health care or human services provider. Awareness and sensitivity has to be followed by expanding the knowledge of the cultures you serve or you have to be given the tools to enable you to gain more insight into their cultural values. (The explanatory model is one such tool.) This will enable you to have information about the patient and skills to negotiate a treatment plan with the underlying goal of a good health outcome.

As long as training stay at a simple diversity level, I don't see much that can be gained. Communicating Across Boundaries [2] developed by NAWHO [3] stresses that cultural competency is a field of study, a series of behavioral changes, and a strategy for reaching diverse communities. This suggests that the field is ongoing, requires commitment, and is not static like culture itself.

The excellent article Cross-Cultural Primary Care: A Patient Based Approach [4] ends with a discussion of what the authors believe to be imperative for every cross-cultural encounter. They describe this as the triad of empathy, curiosity, and respect.

I believe if we stick to teaching concrete skills that will work in every cross-cultural situation we will avoid the pitfalls of stereotyping. We can, and should, intersperse our teaching with carefully thought out examples from our own work and lives.

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Thanks for this terrifically thoughtful post. In the past, we started doing something called diversity training. This was well established by the 60s, and was (and still is) primarily devoted to
training how diverse groups (especially whites, African Americans, Hispanics/Latinos, and later — Asians) can get along in the workplace. Diversity training is well known for its activities that expose our unconscious assumptions, attitudes, and biases. It dedicates relatively little time to provide explicite knowledge or teach communication skills.

Beginning in the 1990s, we witnessed the beginnings of cultural awareness, cultural sensitivity, and ultimately — cultural competence training, where the focus was on providing quality services to diverse populations. Much of this teaching targeted services to immigrants and refugees, native-born populations and began to encompass an even broader vision of diversity that includes persons with disabilities or mental illness, the homeless, specific regional populations like Appalachians and native Americans, GLBT and so forth. Historically, this type of training has been strong on expanding students knowledge and somethimes their skills. However — and this is my very personal observation and perhaps is an overgeneralization — the cultural competence training field as a whole appears weaker than diversity training in the ways that it challenges our assumptions and unconscious biases.

Standards for cultural competence training, by the way, suggest that we should spend equal time on all three areas: attitudes, knowledge and skills. These are likened to the three legs of a stool. They need to be balanced because if one leg is too long or too short the stool gets wobbly.

In the last few years, a number of workplaces seem confused between the two types of training (diversity training and cultural competence training), and have requested something called "cultural diversity training." This may turn out to be a request for diversity training, cultural competence training, or both. The requestors may seem to want one thing but when you explain both types of training, they decide which one they want, but with components of both. Most training organizations that specialize in diversity training are not well equipped to perform cultural competence training, and vice versa, I believe this situation has led to a great deal of misunderstanding in the field at large. None of this history contradicts anything you say, but it may help to shed some light on your remarks.

Marjory Bancroft, MA
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As an anthropologist, let me say that your comments and concerns are certainly on target in many respects. However, I am compelled to point out that culture is not static. The marvelous thing about culture is its inherent flexibility. Culture is always adapting, allowing humans to succeed in ever-changing environments - whether physical or social. Therefore, in learning about cultural sensitivity (and, you're right, not necessarily in diversity training), we learn not only about the values and beliefs of various cultures, but also how these elements influence one's expectations and behavior. And, as you are probably aware in your work as you engage clients from a multitude of cultural backgrounds, knowing this helps you serve the needs of those clients better — precisely because you understand how to approach the client and his or her family and deliver the care required. So, now you are not fighting against established beliefs and values, but are using those to bolster support for your work.

Perhaps the issue isn't so much Cultural Competency v. Diversity as much as it is using each approach to provide solutions to different problems. As Marjory noted in her response — often groups need both sets of information and skills. More training, not necessarily one or the other. Starting with a basic understanding of culture and its components that leads to a skills-based outcome for participants working with multi-cultural clients.

Pamela A De Voe, PhD
Mediation and Cross-Cultural Specialist

Thank you for this very important discussion. I agree with the last couple of statements made that there is a lot of confusion between what is being called "diversity training" and "cultural competence." A lot of perspectives have been expressed in this discussion; my intention is to contribute and not take issue with what has been said.
I think many others would agree that the purpose of our crucial work is to help healthcare providers:

A. Learn more about a range of cultural tendencies encountered in their professional settings, where intercultural training can unfortunately end if the trainers lack the expertise or their clients are afraid of going further for fear of push back and;

B. To begin to see their own and others cultural biases and;

C. To explore their own personal biases — where other forms of diversity training come into play.

We need to blend the strengths and tools offered in a range of the approaches of looking at difference and attitudes about these.

I highly recommend an article by Patti DeRosa entitled "Social Change or Status Quo [5]," in which she identifies six different "forms" of diversity training, Intercultural (IC) being among them. (On the web, see Article 2 [5]) The last one she distinguishes, "Anti-Ism" (AI),** has key applications for why the CLAS standards were created: helping to correct the massive disparities in "access, quality, and outcomes" in health care between racial and ethnic groups in the U.S. Which, as many of us know, is not just due to lack of understanding about other cultures. There is also conscious or unconscious racism, xenophobia, ageism, ableism, heterosexism, etc. in the mix.

Although Ms. DeRosa does not claim that her delineations are written in stone, I find her framework to be an extremely helpful counterbalance to the predominant tendency in HR and related fields to collapse all "diversity training" together into whatever form may have been one's experience with it. She also distinguishes Legal Compliance (LC); Appreciating Difference (AD); Managing Diversity (MD); Reducing Prejudice (RP: looking at our own personal, individual biases) as a step towards acknowledging the (AI) "isms," the (sometimes unintended/unconscious) societal privileges received by some groups: men, whites, heterosexuals, non-disabled, Christians, younger people, etc.

I delivered some introductory six-hour training program over two days that organically blended the Intercultural with shades of Appreciating Difference, Reducing Prejudice, and Anti-Ism, and the case manager nurses I was working with couldn't get enough of it. In closing, although it can be done, I think we do ourselves and our clients a disservice if we offer our CC training as separate from the "ism" context for which the CLAS standards were created. Or, if we distinguish "diversity training" as entirely distinct and fail to draw on the range of tools that it offers.

* My first CC class was in a graduate class in my organizational development program called something like: "Cross-cultural business." We definitely did not delve into our own biases and prejudice. However, I learned a lot about the cultural anthropology categories, which was very interesting and helpful. Point being, CC education can be left at the more "objective" level, and as with the client example Larry pointed to, my sense is that there are many who may be doing just that.

** At the time she wrote the article, Ms. DeRosa identified this form as "Anti-racism" or (AR). She says that now she would broaden the term to "Anti-ism" to include several other forms of systemic bias. Although I do facilitate some specific anti-racism training, I agree that the AI term is more helpful in certain contexts.

Veronica F. Adams
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I, too, agree with this distinction between diversity training and cultural competence - that cultural competence is skill-based. When I conduct training in cultural competence, my objective is to change provider behavior in a way that is discernable to patients. Ideally, patients of diverse cultural backgrounds who are seen by a provider trained in cultural competence would answer affirmatively to: "I believe my provider likes me and is concerned about my well being." "My provider treats me with respect." "My race and/or ethnicity does not affect the quality of care I receive." "When I don't understand what my provider says, I feel comfortable asking questions." Ideally, the data would be stratified by the race and ethnicity of the patient indicate whether it was a racially concordant or
discordant encounter.

Cultural competency training should improve provider behavior and communication skills so that patients answer "yes" or at least "most of the time" to these questions.

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