Promoting LatinX Generativity: Cultural Humility and Transformative Complicity Through Geriatric Teams

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In honor of Mr. Kevin Vail, US Veteran Medic
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His call to action is in the Acknowledgements (p.11).

Abstract

This article highlights social work, critical thinking, and an ethic of care in geriatric teamwork to promote generativity and the well-being of LatinX elderly. We offer the tripartite paradigm of cultural humility, transformative complicity, and empowerment to reduce power imbalances between service providers, elderly persons, and their communities. A force field analysis considers the Patient Protection and Affordable Care Act (PPAC) and Accountable Care Organizations (ACO) to understand the restraining and driving forces affecting the institutionalization of inter/transdisciplinary teams. Effective evidence-based models that humanize geriatric services are offered to counter the current biomedical emphasis of Medicare/Medicaid policies and less-than-responsive geriatric institutional and educational systems. We highlight Bloom and Farragher’s Sanctuary Model of compassionate and democratic practices to address the negative effects of moral entrepreneurship and ageism. The case of Florence, an LGBTQ grandparent with multiple health issues, is analyzed from biomedical, person in the environment, and a strength-based perspective.

Keywords

critical social work, anti-oppressive social work practice, geriatric social work, colorism/heterosexism, aging and the life course, socio-cultural anthropology, sociology of health and illness, social psychology, and communication.

Florence, a Latinx elderly patient, is grieving the recent loss of her husband. She is taking care of her teenage grandchild, identifies herself as a member of the LGBTQ (lesbian, gay, bisexual, trans, and questioning) community, suffers from numerous health challenges, is economically vulnerable, lives in an increasingly gentrified multi-ethnic neighborhood, and is in the early stages of dementia.

More than likely, even the best health care professional will not be able to fully meet Florence’s multiple needs. Limited resources exacerbated by the restrictions of overly specialized knowledge, fragmented services, compounded social stigma, underprepared and culturally unresponsive health professionals, and confounding Medicare and Medicaid policy directives make effective treatment under these circumstances nearly impossible (Hill, 2015; Turner, Hinton, Gallagher-Thompson et al., 2015; Urbanska, Szczesniak, & Rymaszewska, 2015). In the case of an economically vulnerable elder like Florence, the marginalizing effects of compounded stigma are known to have serious consequences, especially when her sexually underrepresented identity is considered (Jones, 2002; Merton, 1968; Robinson-Wood & Weber, 2016). Marginalization leads to depression and depression may increase suicide ideation (Almeida, Flicker, & Rees, 2014; see also Collier, 2005; Robinson-Wood & Weber, 2016).

Less than responsive social service environments, permeated by ageism and discrimination based on sexual orientation, are known to further exacerbate the hardships of elderly
persons and their families (Bloom & Farragher, 2013; Hodgins & Greve, 2004; Pasupathi, Carstensen, Tsai, Lott, & Maluso, 1995). These circumstances often foster increased misunderstanding, neglect, and elder abuse in the home and in social service agencies more generally (Phelan, 2008). Florence, in effect, experiences cumulative disadvantage which, if not dealt with systemically, can lead to deeper and highly serious repercussions (Merton, 1968).

To effectively address these concerns, we discuss the need for cultural humility (Ortega & Duntley-Matos, 2014; Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998), transformative complicity (Duntley-Matos, 2014; Newberry, Duntley-Matos, Shiry, Brass, & Beu, 2014), and a system-based empowerment approach (Gutiérrez & Ortega, 1991). We review the changing age-based demographics of LGBTQ and Latinx elderly populations, the history and present circumstances of geriatric teams from a force field analytical perspective, the shift in cost as we move to team-based home care, the relevance of the Patient Protection and Affordable Care Act (PPAC), and its policy of Accountable Care Organizations (ACO). Finally, we discuss Bloom and Farragher’s (2013) Sanctuary Model to reframe Florence’s journey with a strength’s based, person in the environment (PIE) perspective that is caring, democratic, and culturally responsive. The STAR-VA, Mount Sinai Visiting Doctors (MSVD) community-based inter/transdisciplinary dementia-focused programs, and the Los Angeles Gay and Lesbian Center’s Senior Services Program are discussed as cost- and clinically-effective examples of culturally responsive and empowering care for Latinx LGBTQ elderly persons.

The Elderly: National Demographics and Changing Health Care Needs

The current and future influx of Baby Boomers (babies born after World War II, approximately between 1946 and 1964, continues to impose new challenges and changes in health care services. According to Szewabo (2012),

[T]he frail elderly [are] growing the fastest. In the United States, the 85+ age group will triple to 19 million by 2050. Worldwide, the World Health Organization (WHO) estimates that . . . there are 4 million elders over the age of 85 years. (p. 44)

Within this population, Latinx elderly are of special concern, given their rapid growth and the heightened rate of dementia. Turner et al. (2015) alert us to these concerning trends:

Latinx elderly patients are particularly vulnerable . . . as they are 1.5 times more likely than non-Hispanic [European Americans] to be diagnosed.

LGBTQ elderly are known to suffer additional social stigma, health disparities, and human rights violations. There are 2,000,000 older adults in the United States that self-identify as LGBTQ, and 4.3% of them are Latinxs (Harley, 2016). They are expected to reach 4,000,000 by 2030 (Zelle & Arms, 2015). From a social exchange perspective (Sabatelli & Shehan, 1993), the value and worth of this population is underappreciated and often leads to a breakdown in self-esteem exacerbated by unresponsive elder care.

As demonstrated in the case of Florence, symptoms and conditions exhibited by Latinx elderly are multiple, co-morbid, and require an exhaustive assessment of medical, behavioral, and social supports. Some of the physiological and social symptoms experienced by persons like her include visual, auditory, physical, cognitive, and/or financial difficulties that can significantly affect quality of life. Latinx elderly are predisposed to diabetes. In addition, they can experience environmentally induced illnesses and disabilities from dehumanizing labor conditions such as excessive noise and chemical toxicity from inhumane work environments that may have promoted hearing loss and other problems (Hong, Chin, & Kerr, 2015).

Because of society’s emphasis on status, economic independence, and employability, the elderly are often victims of discrimination, invisibility, and dependence within a national culture that ignores the social cohesion and collective wisdom they offer the community and younger generations (Butler, 2013; Carr, Fried, & Rowe, 2015). Although Latinxs tend to experience greater longevity due to strong family and community networks of support, their use of health services often occurs in contexts of marginalization and disregard compounded by provider-induced ageism and ethnocentrism. Ill-informed and deficit-based policies negatively target Latinxs, and minimize their sense of worth, normalcy, and “productivity” (Abela, 2015; Bullock, 2004; Carr et al., 2015; Hayslip, Maiden, & Dolbin-MacNab, 2015; Hayslip & Smith, 2013; Hou, 2015; Kelly & Damato, 1995; Turner et al., 2015).

Humanizing social and health care services implies addressing the needs of elderly patients from their perspective (and that of their loved ones) in a kinder and more responsive way (Newberry et al., 2014). Given the complexity of their socio-psychological and health profiles, health care teams are crucial to elderly well-being. Despite the long history of such arrangements, however, instituting inter/transdisciplinary teams has yet to become standard practice.

History of Geriatric Teams

In the United States, the use of geriatric health care teams dates back to WWII (Behm & Gray, 2011). These teams gained prominence in the 1970s and 1980s as a response to the bed blockages that transpired in hospitals. Large numbers of debilitated elderly patients, who no longer required acute care, remained awaiting nursing home placements (Wieland, Kramer, Waite, & Rubenstein, 1996). Common geriatric teams of that era arose in Veterans Administration facilities, teaching hospitals, and later in skilled nursing arenas. Known as Geriatric Consultation Teams or Geriatric Evaluation and Management Teams, they evolved as a response to the
incapacity of hospitals to address the rapidly growing elderly population.

Different models of geriatric teamwork have developed that vary in organizational structure and roles, levels of communication, and interaction between members. The models used for teamwork are important as they can make a substantial difference in how care is approached and administered and how it can affect the overall outcome of treatment for older adults. Treatment teams of any sort are commonly referred to as multidisciplinary or interdisciplinary, but these are two among several approaches used in geriatric care. A multidisciplinary team, for example, is composed of different professionals that work independently conducting discipline-specific assessments, plans of care, and goals (Behm & Gray, 2011; Galvin, Valois, & Zweig, 2014). Team members have limited communication with each other, share findings, and progress with other members in formal team meetings or in writing (Behm & Gray, 2011; Galvin et al., 2014; Wieland et al., 1996).

Interdisciplinary teams, however, are more common in rehabilitation settings where various professionals are on staff and come together on predetermined dates to discuss the case of a client from each perspective. Team members inform each other about how they are addressing an issue while minimizing overlap. The level of client engagement within team decisions varies from context to context, and collaborative efforts are more common when there is a need to agree on behavioral interventions across professional/client interactions. In both multidisciplinary and interdisciplinary team approaches, hierarchies between professionals can be more or less evident through the differential use of titles, predominance/privilege of voice of some professionals over others, and the ultimate power over treatment decisions (ethnographic data, Duntley-Matos, 2014).

A more recent team approach is referred to as transdisciplinary. This model offers a more integrated and ideal collaborative structure. (Behm & Gray, 2011; Galvin et al., 2014; Wieland et al., 1996). In transdisciplinary teams, professional boundaries flow together to share goals and discuss client progress (Ellington, 2002; Galvin et al., 2014). Some team functions may be shared with others, but the ultimate responsibility belongs to the members with the specialization needed to address the primary concern (Wieland et al., 1996). This approach allows independent and collaborative assessments to work in conjunction, while sharing formal and informal information. Treatment plans are developed together to address all areas and diagnoses. These teams require much trust, respect, and confidence in all participants to be effective. Relationships between members develop over time from well-functioning and mature practitioners and represent the most patient-centered, integrated, culturally responsive, and transformative of the three geriatric approaches. At times, however, the overlapping roles may become a source of conflict (Ellington, 2002), especially when there is a discrepancy between the team and broader institutional philosophies. It is important to note, however, that although the team types seem to be distinguished by clear definitions, the concepts are sometimes used interchangeably.

**Force Field Analysis: Exploring the Driving and Restraining Forces of Health Care Teams**

Using the Force Field Analysis Framework developed by Kurt Lewin in the 1940s, H. M. Young et al. (2011) list several factors that drive and restrain the effective implementation of interdisciplinary and transdisciplinary teams. In their discussion, the elderly, their families, “sub-groups [who share] complexity and risk,” and professional organizations are primary driving forces. In an effort to control costs, business and political interests have begun to promote inter/transdisciplinary health teams in this manner. The PPAC of 2010 is an example of this effort in the political arena. PPAC emphasizes quality care at reduced cost but, ironically, reimbursement restrictions have tended to hinder team creativity by denying payment for the coordination of services and communication expectations required in these models. The Affordable Care Act has established beginning attempts to integrate hospital services in its efforts to reduce costs. It has instituted disciplinary measures in Medicare reimbursement through its Accountable Care Organizations to promote proactive prevention of ailments such as falls, bedsores, and urinary tract infections in hospitals and long-term care facilities.

Given this, these quality control measures have led to important improvements in hospital care and cost reduction (Casalino, Erb, Joshi, & Shortell, 2015; Ellison, White, & Farrar, 2015; Kessell, Pegany, Keolanui, et al., 2015). More research is needed, however, to assess their financial and other consequences on elderly who do not have access to higher quality hospitals. According to recent qualitative and focus group-based research, a person such as Florence, due to her low socioeconomic status (SES), might fall into this category. Latinx focus group participants have described how dismissed they can feel by medical practitioners and health professionals when seeking services for their elderly family members. In addition, compounded stigma resulting from ethnic and LGBTQ identity is often sufficient to keep the clients themselves from seeking medical attention. Their difficulties are further exacerbated when health care professionals are ignorant about the complex needs of multiple subjugated identities (Gratwick, Jihanian, Holloway, Sanchez, & Sullivan, 2014; Oswald, & Masciadrelli, 2008; Pasupathi et al., 1995; Turner et al., 2015). It is for this reason that the Partnership for Health and Aging sponsored by the American Geriatric Society (Young et al., 2011) has convened 20 participating organizations to improve elder care. They hope to “coordinate (end-of-life care), interdisciplinary team care; caregiver support; and healthcare systems and benefits” (Young, et al., 2011, Driving and Restraining Forces in Interdisciplinary Collaboration, Chart).
Addressing Cost by Shifting to Interdisciplinary and Transdisciplinary Teams

When implemented appropriately, teams have been found to have the potential for being more cost-effective (Little, 2010). At this time, however, given the disparate fee-for-service reimbursement structure of Medicare and Medicaid, and the high cost of medical treatment and supplies, team interventions have not reached broad implementation. For this reason the Center for Medicare and Medicaid Innovation (CCMI) has been seeking strategies to offer bundled payments that will support interdisciplinary and transdisciplinary teams to improve cost and clinical effectiveness with elderly patients who remain in their homes (Davis et al., 2015). However, at this point, the bundled payments are often not sufficient to cover the costs of the specialists (Newberry, ethnographic interview, June 13, 2016). In spite of this, well-coordinated client-centered home care, based on interdisciplinary treatment, is beginning to reveal positive results that move away from the less effective biomedical model.

The Bio-Psycho-Social and PIE Approaches

As is apparent, collaborative teams contrast dramatically with the traditional physician directed model where doctors are considered the primary “experts” (Ellington, 2002; Little, 2010) and where the costs of care become a substantial stressor. In the medical field, the biopsychosocial psychiatric model (Engel, 1977) has been an effective alternative to the biomedical model (Carr et al., 2012). Its integrated focus allows for a holistic understanding of the physiological and environmental variables affecting a person’s health. From a social work perspective, the PIE approach is rooted in systems theory and promotes the integration of paradigms from several disciplines. Role theory, an important component of PIE, addresses the person’s behavior, interpersonal relationships, sense of self, the impact of social norms, structures, and the broader environment in an ongoing process of mutual transaction and influence (Granucci Lesser, 2011). In this sense, moving away from a focus on isolated ailments (generally within the context of fragmented services) improves client care through a team of professionals who address the whole person in an integrated fashion.

Evidence-Based Interdisciplinary Programs That Work

As in the 1940s, there is presently a renewed awareness of veteran needs that has led to an expanded support for interdisciplinary teamwork specifically related to geriatric dementia. A recent study with positive results is the STAR-VA multisite and multicomponent psychosocial program for managing the challenging behaviors associated with this illness (Karel, Teri, McConnell, Visnic, & Karlin, 2016). This interdisciplinary team-based program has proven to reduce behaviors such as “resistance to care, agitation, violence/aggression, vocalization, wandering . . . depression, anxiety,” and others (Karel et al., 2016, Abstract). STAR-VA attributes part of its success to its use of a simultaneous top-down and bottom-up approach. The top-down approach includes “high level organizational and interdisciplinary program leadership support . . . ” The bottom-up mechanism involves “local facility, [community living center] leadership support, interest and [aid] from frontline staff and local champions” (Karel et al., 2016). In effect, this program reduces the need for dangerous and often lethal antipsychotic medications among elderly veteran patients.

Another successful example is the MSVD program. The MSVD is composed of physicians, nurse practitioners, social workers, and administrative assistants. Its interventions have increased the physician’s capacity to see patients by 40%, leading to an estimated revenue increase of $46,000 that, with the regular charges of the nurse practitioner, offsets the latter’s salary. Here, the nurse practitioner manages complex cases proactively with home visits. The social worker, because of increases in caseload, handles part of the intake visits via phone. Weekly team meetings enable members to address program difficulties and to make changes leading to better communication and structural support.

MSVD program researchers observed that satisfaction with the team approach has remained equally positive despite the increase in client load per physician. Nonclinical staff members were able to address concerns that did not require physician intervention and which were welcomed by patients. Due to its success, the MSVD is in the process of adopting this model for its entire practice (Reckrey, Soriano, Hernández et al., 2015). These incipient efforts, however, do not offset, at this time, the significant and broader systemic forces that restrain or prevent the effective implementation of transdisciplinary teams on a larger scale or in the micropractices of individual institutions.

Common and powerfully insidious dynamics within teams often include turmoil among specialists who are uncomfortable with blurring professional boundaries, a lack of communication skills, ineffective teamwork, lack of conflict resolution skills, and a dearth of training in geriatrics. Such difficulties not only affect the climate of health care facilities but also negatively affect the training of students and future professionals in their higher education institutions (Duntley-Matos & Newberry, ethnographic data 2013-2016). An additional problem addressing the needs of the elderly is the dearth of geriatric concentrations in professional development programs. According to Young et al., in 2011, only 4% of health service practitioners held certificates in this field. At the present time, there continues to be a substantial shortage, although there is an increasing number of advertisements in social work associations and social work programs offering certificates in geriatrics. However, the gap between the curricula, educational climate, and system restructuring priorities continues to be of serious concern.
Important barriers to promoting inter/transdisciplinary teams include inadequate academic infrastructures, disparate curricula, and schedules characterized by varying student levels in clinical training. Parallel rather than integrated curricular formats, and budget and building constraints, have also preemted integrated teaching. Currently, a culture of traditional values that reward individual exceptionality, competition, and distrust, rather than openness, dialog, problem-based learning, and collaborative teaching, is most common in health service provision (Young, 1998, Duntley-Matos, 2013-2016 ethnographic data). Thus, in the United States, the use of geriatric interdisciplinary and transdisciplinary teams has been slow to evolve. Today, with short hospital stays, there is an increasing need for outpatient clinics and care in home settings. This has led to the development of outpatient teams that provide nonacute care (Burns, Nichols, Graney, & Cloar, 1995; Donald, Baldwin, & Bannerjee, 1995; Wieland et al., 1996), but which require a collaborative emphasis to be effective. Such options continue to be explored and, in some cases, mandated to address the restraining forces discussed thus far.

From a Force Field Analysis then, it has become evident that there continue to be more restraining than driving forces geared toward change. This explains why transdisciplinary teamwork is struggling to take hold on a broad scale. Working in collaborative teams to improve geriatric care requires a willingness to leave egos at the door, to be open to continuous learning, to focus on trust building, and to develop the ability to adapt and compromise. Above all, however, it requires the political prioritization of our elderly, the validation of their different cultural and identity needs, a change in health service provision values, and creative institutional funding and support.

It is in this context, where most health and social service agencies experience difficulty serving someone like Florence, that the paradigms of cultural humility, transformative complicity, and systems-based empowerment become relevant.

**Cultural Humility, Transformative Complicity, and Empowerment in Interdisciplinary Teams**

The implementation of the team approach in medical care takes effort and time, but is highly effective in the long run for the institution and the client. Although the transdisciplinary team is the ideal model for working with a geriatric population (Little, 2010), our previous discussion on driving and restraining forces, considered in the context of pervasive discriminatory ideologies, reveals why actual implementation is difficult. It is clear that interdisciplinary teams (Behm & Gray, 2011; Wieland et al., 1996) are the most common and closest model to transdisciplinarity under current biomedical institutional, structural, and ideological constraints. Effectiveness with Latinx geriatric patients can be improved substantially, however, if a cultural humility approach (Duntley-Matos et al., 2015; Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998) becomes the guiding framework.
practices. Team members are able to detect harmful discourses and to address them proactively and reactively rather than remaining silent to appease institutional authoritarianism that perpetuates ignorance. Ongoing open dialog is more likely to reduce institutional harms and promote positive client- and family-centered adaptations. As a result, empowerment at the personal, interpersonal, and political levels, within and beyond the institution, is more probable (Gutiérrez & Ortega, 1991).

The Social Worker Role in Transdisciplinary Teams

Each discipline participating in a health care team has a specific role to fulfill even when boundaries are more fluid in nature. According to the National Association of Social Workers (2013, as defined by Barker, 2003),

Social workers help people increase their capacities for problem solving and coping . . . [to] obtain needed resources, facilitate interactions between individuals . . . people and their environments . . . [T]hey may work at a systems level on regulations and policy development, or as administrators and planners of large social service systems. (http://www.naswdc.org/practice/intl/definitions.asp)

Social workers, ideally, work to humanize all needed aspects of treatment by helping individual clients and communities maintain an acceptable quality of life through the reduction of oppression, marginalization, and social injustice.

The reality, however, is that the shortage of health care providers who possess geriatric training and the concerning deficit-based views held by many professionals about the elderly, Latinx, and LGBTQ populations plague the social work field. For example, ageist attitudes of social work students, faculty, and practitioners are not uncommon. A study by Allen, Cherry, and Palmore (2009) found that “undergraduate and graduate social work students and practicing social service providers in the nursing home and mental health setting . . . readily admit[ed] to positive ageist behaviors” (Abstract). Similarly, Woodford, Brennan, Gutiérrez, and Luke (2013) discussed patterns of behavior seen in graduate social work faculty that may have “negative, positive, but not very positive” attitudes toward LGBTQ populations. Patterns of not including LGBTQ content in the curriculum, and treating students and colleagues as invisible or in verbally hostile ways, are all examples of how health service and social work attitudes can influence professional practice and client treatment (Woodford et al., 2013).

These hidden negative attitudes must be considered along with the primary functions and roles of social workers in interdisciplinary and transdisciplinary teams as their influence can be insidious and seriously harmful (Hafferty & O’Donnell, 2015). Social workers commonly provide diagnosis and assessment (bio-psycho-social), care/case management, individual counseling, group work in psychotherapy and psychoeducation, liaison services (patient/family/professional community), and advocacy. They also serve as community resource guides (Mellor & Lindeman, 1999). Social workers also play a role in interdisciplinary teams:

[They focus] on memory loss and caregiver issues . . . referrals for concrete services (transportation services, assistance in the home, meal delivery and adult day programs) . . . assistance with transition to alternate care settings . . . psychotherapy and counseling services (billable services) . . . support programs for patients and/or caregivers, [collaboration] with local agencies and organizations, [and provision of] educational resources and materials. (Galvin et al., 2014, p. 459)

The consequences of not taking a culturally responsive approach seriously can be devastating for elderly Latinx and their caregivers when social workers are not appropriately educated to develop a culturally humble approach. This is more so the case when the stigma toward LGBTQ identities plays a role in institutional discrimination and when social workers are not taught to think critically about their work. In fact, Dr. Jean Anastas (2012), former President of the National Association of Social Workers, published her grave concerns over the lack of critical thinking skills promoted in the professional curriculum. A case in point is the stirring account of Latinx caregivers who have felt neglected by social workers and other health service professionals (Turner et al., 2015). The following quote by a focus group participant reveals detriment to family well-being due to undereducated and experientially underexposed social workers, and to the lack of critical thinking skills that are necessary to obtain information for effective care.

“I’ve told you about the experiences with social workers . . . I’ve felt that they know nothing of the illness. They don’t get training [about Alzheimer’s disease] . . . they fill out a paper and they do this and that and then they make notes and comments . . . one [even] said to me ‘look I know nothing about [Alzheimer’s disease]. The same caregiver added[,] ‘I feel [that] they don’t even take the trouble to train the social workers’” (p. 458).

As revealed in this quote, in addition to developing the ability to problem solve, it is important that health service professionals explore their own values as well as those presented by their clients. The research of Turner et al. (2015) revealed a focus on family, patience, tolerance, and love as common values in the narratives of their focus group participants. These caregiving priorities are relevant to altruism and the transgenerational sharing of history in broader LGBTQ elderly community family networks (Oswald & Masciadrelli, 2008). Interestingly, however, Turner et al. point to a positive role of the often-criticized biomedical model. In essence, by separating the illness from the person, the cultural emphasis on patience, tolerance, and love can remain a strong unifying caregiving force in the family and community system.
At least one social work program responds to these values to address the specific needs of LGBTQ Latinx elderly by promoting political advocacy and addressing heterosexist discourses in social service intake forms. The Los Angeles Gay and Lesbian Center’s Senior Service Department is advocating for a change in SB 1729 to include provisions that will ensure that health professionals working with sexual and gender minority elders comply with training expectations to promote a discrimination-free environment (Gratwick et al., 2014).

The program is based on a three-pronged approach: socialization activities, case management, and cultural safe spaces training. The activities incorporate shared meals, computer classes, and social media. They include fall prevention and stress management (yoga, dance, chair Tai Chi), storytelling and writing, and art and theater. Case management includes behavioral management, housing assistance, food security, referrals, end-of-life planning, and mental health and legal resources. The program works creatively to lower costs for this population. It is partnering with the University of California, Los Angeles, and other California-based universities to provide energetic and creative social work intern experiences with LGBTQ populations while enhancing the Center’s LatinX programming for their Comunidad Latinx group (p. 896). Finally, their cultural safe spaces training addresses history, barriers to service, challenges in aging, and practical steps to promote responsiveness (Gratwick et al., 2014).

With the aid of programs like the Los Angeles Gay and Lesbian Center’s Senior Services, in collaboration with programs such as MSVD and STAR-VA, Florence, her family, and her chosen LGBTQ community can have a stronger recourse for political advocacy and become active participants in collective well-being. This increased social capital can promote empowerment at the personal, interpersonal, and political levels (Gutiérrez & Ortega, 1991). This is more likely to reduce the elderly’s propensity for isolation and depression, enhancing, in this way, cognitive abilities while limiting the need for pharmacological interventions.

Unfortunately, the present reality is that few programs effectively address the cultural needs of Latinx LGBTQ elders. This highlights the importance of culturally responsive communication requiring transdisciplinary engagement with the democratic and empathic emphasis of the Sanctuary Model (Bloom & Farragher, 2013). This model enables social workers to be critically aware of pejorative preconceptions and discriminatory structural barriers that undermine their professional values of emancipation and ethics of care (Hamington, 2001).

**Bloom and Farragher’s Trauma Informed System Sanctuary Model**

Bloom and Farragher’s (2013) Sanctuary Model of organizational behavior is based on an extrapolation of clinical work with patients who suffered institutionally inflicted emotional trauma. Through ongoing exploration, the researchers discovered that rather than helping patients, the institutional assumptions about oppositional patient behavior, the punitive interventions, and the isolation of clients from their natural social networks were, in fact, retraumatizing. This led them to help clients build networks of support through democratic, transparent, and caring interactions.

The relevance of the Sanctuary Model to geriatric care is its humanizing and collaborative intent. It addresses organizational climate difficulties and focuses on stronger caring social networks to promote bio-psychosocial well-being. The Sanctuary Model is a powerful way to decrease beliefs and behaviors that stigmatize older adults. It offers a basis for preventing the abuse, neglect, and fragmented services that often compromise the health of elderly patients. More importantly, however, this model strives to include, in every way possible, the equal and central participation of clients in their own care.

The goal of the Sanctuary Model is to define stress as a public health issue and to reduce toxic dynamics within institutions (Bloom & Farragher, 2013). In this context, interpersonal defense mechanisms characterized by “denial, coercion, avoidance of conflict, and scapegoating” (p. 16) parallel equally traumatizing dynamics that cause harmful climates with serious repercussions on staff relationships and client care.

A perceived lack of safety erodes trust relationships. Under these conditions health service organizations see threat rather than opportunity, pathology rather than strength, and risk rather than reward. (p. 16)

The Model highlights the difficulty experienced by professionals in managing emotions due to constant demands of empathy, concern, caring, and tolerance resulting from excessive emotional labor. These are the circumstances that more likely lead to poor or negligent services. Organizational toxicity promotes organizational amnesia (p. 17), fragmented service delivery, reactive decision making, silencing of dissent, administrative abuse, lowering of morale, increased miscommunication, and overall conflict (p. 17).

An empowering organizational culture, on the contrary, parallels the attachment relationships exhibited in healthy human development where mental and social well-being are the rule, not the exception (Bloom & Farragher, 2013). Well-being implies resilience and the ability to adapt to changing circumstances while maintaining a purpose that is significant to the person and their social/institutional context. Healthy organizations use risk when necessary to promote changes that benefit workers and clients. They address feelings of grief and loss openly and empathically while embracing the real need for growth, change, and creativity. In the case of the elderly and their staff, they promote well-being while valuing diversity through democratic interactions. Trust is promoted through transparency, collaborative decision
making, an ethic of care, and an alignment between stated values, procedures, and practices. Psychological, moral, and physical safety are prioritized in the process of building community. Power is used to advance collective and client goals rather than to promote personal administrative desires.

Healthy organizations create space to discuss and manage emotions on a regular basis. They value continued knowledge development gained from open communication. Finally, healthy organizations emphasize social responsibility, forgiveness, and social justice. The STAR-VA, MSVD programs, and the Los Angeles Gay and Lesbian Center’s Senior Services are good examples of a Sanctuary Model approach that uses cultural humility, transformative complicity, and system’s based empowerment.

Now that we have addressed the implications of organizational culture, transdisciplinary teamwork, and the greater good for Latinx geriatric LGBTQ populations, it is important to revisit and deconstruct Florence’s initial biomedically centered representation. This enables us to appreciate the value of a PIE perspective and helps us demonstrate how healthy organizational culture is of essence in the promotion of teamwork that leads to system’s based empowerment for the elderly.

First, we offer a more detailed description of Florence from a biomedical perspective, then, as a contrast, we offer a cultural humility and transformative complicity perspective.

Florence’s life is based on a reformulated/composite representation based on Wieland et al.’s (1996) work influenced by the experiences of our co-authors’ in geriatric scholarship, care, and minimalist social work curricula and educational expectations.

Florence, Transformative Treatment, and Client Engagement Through Transdisciplinary Teams

Florence is an 86-year-old Latinx diagnosed with macular degeneration, heart disease, neuropathy, depression, limited mobility, dementia, and anxiety. Her husband of 62 years died 6 months ago. Her only child passed away. She is the caregiver of her teenage grandchild and is currently living independently. She has recently disclosed to her neighbors that she is a member of the LGBTQ community. She is experiencing increasing challenges as time progresses that include physical limitations, adverse medical conditions, a psychiatric disorder, and loss and grief issues. In addition, she has experienced ridicule and marginalization from acquaintances due to her sexual identity.

Florence’s team is composed of a nurse, physician, geriatrician, psychologist, psychiatrist, pharmacist, occupational therapist, physical therapist, chaplain, dietician, and social worker, which receive “cultural competency” continuing education credits once a year. Their training is composed of vignettes of “racially ascribed” ethnic, class, and gender differences within geriatric populations. Practitioners are told that they may encounter variations, but knowledge of cultural consistency is nevertheless emphasized, expected, and evaluated in training assessments.

Of Florence’s team members, the nurse has the most contact with her. She is kind and responsive toward her needs given her multiple health concerns. Her other therapists see her once or twice a week with the exception of the pharmacist and dietician whose communication is more sparse. The pharmacist does not see Florence in person, and the dietician does an assessment once a month unless otherwise needed. Florence’s cultural preferences are addressed by providing services that respond to her family-reported religious affiliation. The chaplain, who speaks with her in Spanish, visits her once a week unless her family requests additional visits.

Florence’s concerns and progress are noted by each specialist and placed in her electronic file for her various service providers to prescribe treatment. Despite this communication, and the group recreational activities offered by her geriatric services, Florence continues to exhibit depression, lack of motivation, and isolationist behavior. All of Florence’s health care professionals describe her care as “client centered” and believe that they are being responsive to her cultural, medical, and emotional needs despite her apparent inability to thrive . . .

Florence’s lack of communication is attributed to her incipient dementia. In the meantime, the standard professional hierarchy takes place with the physician having primary voice in her assessment. Disagreements between practitioners, due to communication difficulties and areas of expertise, occur repeatedly and resentment between professionals is sometimes noticeable even when not stated directly. Power differentials become evident as medical decisions are made.

In the biomedical multidisciplinary team model depicted in this description, it is clear that Florence’s experience of pathology and medical interventions take a primary role in her care. Her cultural needs are peripherally addressed through secondary sources such as family members, cultural competence trainings, or through the cultural assumptions of the institution.

Her sexual identity is mentioned in the case notes, but not addressed as an area of importance to Florence. In fact, her lack of communication is defined as a cognitive deficit rather than explored as an effect of staff and institutional cultural assumptions. Now, let us view her case via the lens of the Sanctuary Model, an ethic of care, and the PIE approach.
is a primary goal for the team. The practitioners are taught to question their biases and assumptions about their clients and about each other, to use exploratory communication strategies from a position of openness, critical self-awareness, active and empathic listening, and from an understanding that they know very little about all that there is to be known about Florence, her history, and social circumstances.

From a cultural humility perspective, Florence is defined primarily by her strengths and her abilities are prioritized to better address her bio-psychosocial concerns. Team members, including Florence and her family, meet weekly to communicate and problem solve collaboratively with the goal of moving toward a transdisciplinary model of intervention where professional boundaries are intentionally crossed to address all diagnoses more effectively. The social worker is a crucial liaison. She regularly meets with Florence to gain a deeper appreciation of her cultural ancestry, family history, community support network, socio-cultural multidimensionalities, cultural preferences, and personal strengths. Because Florence is considered the central source of information about herself, she is the primary reporter of her experience: her needs, desires, and social reality. The social work team member participates as an advocate to strengthen Florence’s problem-solving abilities and to reduce anxiety and depression related to her incipient dementia, grief, and health care needs. She also helps her obtain needed resources by facilitating mutual aid community and health networks given Florence’s grandparenting responsibilities and sexual identity.

Team members contextualize all of Florence’s treatment from multi-cultural and intersectional perspectives based on how she understands her economic, ethnic, gender, sexual, spiritual and political orientations, as well as her class ascriptions (among other identities) in relation to each other and to her needs at the time of each meeting. Her team members actively struggle to transcend their own epistemic privilege to validate her self-worth and to accept that they play a small, but important part in her universe.

During this process, the practitioners will use transformative complicity by continuously analyzing how institutional protocols, policies, and practices hinder or promote effective and responsive care for Florence. They analyze structural, behavioral, and ideological barriers by considering assumptions of privilege that may go unnoticed when consciously focused critical reflection is not part of the teamwork process. Team members continuously assess their own communication patterns to ensure empathy and a reduction of power imbalances between them, between them and the institution, and between them and Florence.

For instance, if Florence has a desire to remain independent, team members who succumb to restrictive risk management processes exacerbate complicity in Florence’s failure to thrive. To promote positive transformation in her life, calculated shared risks must be taken to reduce restrictive interactions, structures, and policies at the interpersonal, organizational, and broader political levels. Concrete examples include offering fall prevention programs that increase independence, providing dementia informed education for Florence, her loved ones, and the wider community, facilitating access to more responsive living options, teaching communication techniques to help redirect Florence when she experiences confusion and anxiety, including her in advocacy that supports payment for holistic and integrated services, and identifying collaborative community activities for her and her grandchild.

### Shattering Ageist Stereotypes: The Importance of Generativity and Altruism

There is a growing body of literature emphasizing the life-enhancing effects of pro-social activities for the elderly that improve quality of life, positive affect, and longevity (Kahana, Bhata, Lovegreen, 2013). Silverstein, Conroy, and Gans (2012) emphasized moral capital as transgenerationally transmitted altruistic values through social institutions such as schools, churches, and social service agencies. These can help children and family members develop norms of filial responsibility (p. 1259). Similarly, Oswald and Masiadrelli (2008) provide an insightful discussion of Erik Erikson’s work on generativity and ritual in extended rural LGBTQ families. Their work stresses the empowering effect of generativity through extended/fictive kin relationship in reenacted or newly created rituals. These strengthen community ties while defying the sometimes marginalizing effects of biol egal kinship expectations.

Studying lesbian or gay (LG) generativity may facilitate theory development by bringing our attention to human caring that is not expected within a normative life course. It is common for adult lesbians and gay men to define their families by received support and chosen obligation rather than normative roles within biologic kinship systems. (Oswald, 2002, p. 1061, column 1, para. 2)

This is an area where transdisciplinary teamwork can have positive effects for someone like Florence through advocacy efforts that bridge the community/social service divide.

Generativity and altruistic activities can help the elderly support others as they strengthen their own networks and areas of influence. Such integrative community-based strategies decrease the highly concerning effects of isolation such as feelings of victimization, marginalization, and psychological vulnerability (Morley & Tumosa, 2012). They increase independence by fostering personal, family, and community dignity and worth. Even in cases of beginning dementia, it has been found that increasing validating networks may reverse or reduce cognitive deterioration, especially when accompanied by consistent physical activity that is motivating and life enhancing. According to Fiatarone Singh and Morley (2012),
Physical activity, is “associated with more positive psychological attributes and a lower prevalence and incidence of depressive symptoms (p. 110) . . . Walking significantly reduce[s] the risk of dementia . . . Exercise also protects against the neurotoxicity of ageing stress (p. 111) . . .

Szabo (2012) informs us that “[I]nformation processing and motivation are [positively] affected by the mood of the individual” and promote healthy risk taking (p. 43). Sachs-Ericsson and Blazer (2012) add that; “Social support may serve as a buffer against disability while social disengagement may be a risk factor for [increased] cognitive impairment” (p. 1005). By emphasizing the social needs of a patient like Florence, team members are better able to provide life-enhancing supports while tracking and preventing institutional and service provider harms. Institutions also profit by managing client time and resources more effectively while improving the working environment.

A Community-Based Strength’s Perspective: Reframing Florence’s Initial Biomedical Representation

Florence is a warm and friendly 86-year-old woman who, prior to her family losses, was described by her community members as having a lively sense of humor, sharing with others and loving her grandchild. Although she has experienced increased marginalization after losing her only child and husband of 62 years, and after identifying with the LGBTQ community, her church members, niece and nephew have come to her support. They have identified themselves as extended family members who are willing to be educated in cultural humility and dementia reductive approaches. Florence’s niece and nephew value her as the family historian who, prior to her depression, actively sought to share her long-term memories. During times of lucidity, Florence states that she is eager to maintain as much of an active lifestyle as possible and that she is enthusiastic about her energetic past. She is able to ambulate on a walker, she likes the company of others, and she is proud of being described as having a heart of gold. Her strong values of caring for others and her own challenges finding acceptance for her sexual orientation facilitate her willingness to forgive and be accepting of others.

It is apparent that, although living independently, Florence has networks in her community and her extended family that are willing to be supportive. Several are validating of her grief and journey of self-discovery and are able to buffer counteracting ideological, behavioral, and structural forces that negatively affect her well-being and social integration. The process of gentrification affecting her neighborhood, ironically, has spurred community organization activities that can benefit from Florence’s keen historical knowledge of the area. It is in this context that Florence meets younger members who identify as LGBTQ for mutual support.

Her interdisciplinary team, trained in active listening skills, an ethic of care, and critical self-reflection at the individual and institutional levels, consistently practices power reduction strategies with its members, Florence, and the institution. The difficult challenges of promoting a democratic and community-centered agency environment are embraced in a structured and consistent manner. This effort enables team members to improve their understanding of how best to respond to Florence’s multidimensional needs while helping her understand the benefits of her existing and burgeoning support networks.

Florence’s health challenges, physical limitations, and mood difficulties are prioritized, but reframed by including her in altruistic and generative community engagement that is protective of her energy and physical and cognitive abilities. Her dignity and worth are emphasized even when these seem to counter the cultural preconceptions enforced by the institution charged with her care. Thus, the geriatric center and team provide her with the dignity of risk to counter protocols that augment her alienation and depression, but which due to being the norm, often go unperceived.

To address her cultural and sexual identity preferences, after consulting with her, her team makes an effort to include decor of Latinx LGBTQ families among those of other groups. Through humor and the inclusion of topics that are pleasing to Florence, the team encourages her to expand her social relationships and to offer her talents and services to her community. Her communication needs are monitored more carefully and addressed more effectively. The team members are careful to respond to her use of English and more limited use of Spanish from context to context rather than assuming that they must speak to her in formal Spanish. In essence, Florence and her transdisciplinary team have been able to co-develop strategies that address her cognitive, physical, emotional, and social health in ways that enable her to contribute to herself, to her family, to the greater good of the agency, and to her community.

Conclusion

Geriatric patients will soon make up the majority of the U.S. population and are in dire need of policies, institutional, and integrated team-based health care services that focus on their needs from a cultural humility, transformative complicity, and empowerment perspective. In geriatric care, the strengthening of socio-cultural networks through altruistic and generative activities is offered as a necessary means to address elderly clients, family systems, and community-relevant needs. From a political empowerment perspective, we advocate for the deconstruction of moral entrepreneurship (Cousins, 2009) and the reduction of marginalizing social values that stigmatize vulnerable populations for the purpose of political and economic gain. Policies that promote ageism (Morley & Tumosa, 2012), enforce normative cultural mores to the exclusion of diversity, and which permeate our health
care system, are examples of areas that need rapid redress through transdisciplinary team advocacy. The Los Angeles Gay and Lesbian Center’s Senior Services, the MSVD, and STAR-VA models have shown that this approach is not only more therapeutic for the patient but also more cost- and goal-effective for the institution.

Transforming deficit-based representations of our ageing populations to portrayals of wisdom, productivity, strength, and mutual nurturance can help decrease national patterns of social marginalization (Kahana et al., 2013). The potential and actual contributions of our elderly are many.

One positive example is the Hope Clinic in Ypsilanti, Michigan, which uses volunteer services carried out by caring retired physicians who provide free medical treatment to low-income and indigent community members. This is an example of how practice contradicts political mystification. Definitions of human disposability are socially constructed, disseminated, and embraced to fulfill the needs of, often-times, unscrupulous market priorities. However, volunteer clinics and related social services demonstrate how altruism and social connectivity are promoters of continued physical activity and community inclusion that are often ignored. Not only do altruistic and culturally relevant generative activities improve the health of the general population, but they also enhance the overall quality of life of our culturally varied geriatric patients (Fiatarone et al., 2012; Morley & Tumosa, 2012).

Thus, the call for inter/transdisciplinary teamwork in health care is crucial from a transformative complicity perspective that hopes to reduce our participation in the marginalization of our aging populations. As stated by Cousins’s (2009) in “It Ain’t as Simple as it Seems . . .”

[O]ppressions and inequalities are [often] stealthily built into our therapies, interventions, programs, and procedures—activities we feel certain are necessary and fair representations of our good will, humanity, and sense of social justice . . . people labeled as “risks” [however] too often bear the burden of this reproduction of inequality . . . Legislative acts and policies founded on simplistic, stigmatizing, or inaccurate assumptions shape the social services that flow from them (p. 96) . . . [As social workers and health service providers] we must identify, challenge, question, and otherwise expose the incomplete, narrow, and harmful logic and reasoning that mystify too many of us into lockstep formations on behalf of a common moral definition of, and answer to, social problems. (p. 106)

Carefully considering the needs of our growing Latinx elderly populations, their rich national and ethnic diversity and, within that, their complex multidimensional embodiment of sexual orientation, class, gender, abilities, and other identities, will not only help us promote longevity, but greater health and spiritual fulfillment for those who came before us and continue to offer us the wisdom of their histories, experiences, and cultural insight.

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Through the observance of transformative complicity and cultural humility, this veteran found “hope” through their own moral reparative work, the moral healing began and the answer to “what can I do to find it?’ was [found]. “Who can help me?” You can; I can; society can; when the roles and responsibilities of interprofessional teams are established…With a rate of 22 veteran suicides per day, and after a decade of war, it is time for the healing to begin… (2015, accepted ABSAME presentation Abstract) ...Together, hopefully, we can put an end to veteran homelessness, undereducated & underskilled veterans to work to empower this generation’s greatest asset, to help rebuild this beloved country of ours!... I’ll take all the help we can get!! (Vail, LinkedIn, Retrieved July 17, 2015).
WMU ABSAME Rogues 2014:
Front Row (left to right): Jenna Losey, Kevin Vail, Daniel Alejandro Cubero-Matos
Back Row (Left to right): Marialicia Garza, Mark Duffy, Cindy Newberry, Alexandra Isabel Cubero-Matos

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**Marrit Shiery** is a licensed master of clinical social work. She is an experienced hospice bereavement coordinator, and senior center specialist. She has an associate’s degree in business administration from Lake Superior State University in Sault Ste. Marie, Michigan. She is employed as renal/medical social worker at Fresenius Kidney Care and is a social worker at Comforts of Home Counseling and Care Management in Battle Creek, Michigan. She co-presented a preliminary version of this paper at the 2013 ABSAME National Conference on Humanizing Health Care through Inter-Professional Teams and at the University of Michigan School Of Social Work, Ann Arbor.

**Maria M. Matos Serrano** holds a master’s degree from Harvard University. Her doctoral research focused on the uses of time in William Faulkner’s short stories. She was the president of the Middle States Commission of Higher Education Evaluation Committee at the University of Puerto Rico, and was responsible for evaluating private colleges throughout the Island. She directed the English Honors Program in the School of General Studies of the University of Puerto Rico, Rio Piedras.

**Robert M. Ortega**’s research and practice interests include a focus on child maltreatment and disproportionality, treatment interventions, and culturally responsive service utilization particularly in the areas of mental health and child welfare. He teaches at the University of Michigan School of Social Work in Ann Arbor. He is the recipient of the Council of Social Work Education’s 2013 Distinguished Recent Contributions in Social Work Education Award for his work on cultural humility and child welfare. He received the social work student sponsored *WMU ABSAME Rogues “Scholarship from the Heart” Jane Adams Award* for outstanding mentorship through scholarship in 2014.

**Cindy Newberry**, LLMSW, holds a master’s degree in social work. She is the recipient of the 2014 Western Michigan University NASW Student of the Year award for her co-authored publication during her WMU ABSAME Rogues membership. She presented at the National Association of Behavioral Science and Medical Education (ABSAME) Conference and at the University of Michigan, Ann Arbor, School of Social Work. She assisted with the creation of ABSAME’s first student chapter. She is currently employed as a renal social worker for Fresenius Kidney Care.

**Mitchell M. Chapman** is an MSW student at Western Michigan University School of Social Work with a concentration in gerontology.