Cultural Elements and Hispanic, Latino/a/e Communities

Dr. Haner Hernandez (Speaker 2, S2), Dr. Miguel Gallardo (Speaker 3, S3)

Transcription results:

S2: 01:38	All right. Thank you, Bonnie. Welcome, everyone. My name is Haner Hernandez, and I am happy to be here with you. Welcome back to all of you who came to the first two sessions. If you are new to this session, welcome as well. And you can go and view the prior two sessions. This is Cultural Elements and Hispanic, Latino, Latina, Latinx, Latine Communities. And once again, my name is Haner Hernandez. One thing I want to let you know about myself today is that today is my anniversary, 37 years in continuous recovery. And so I'm happy to be here. I'm happy to be alive. And I can't believe that it's 37 years. And I'm going to kick it to Miguel, my fearless coworker here, presenter, Dr. Gallardo. Anything you want to say before we get into it?
S3: 02:36	No, no. Yeah. Thank you. Thank you. Yeah. Yeah. Felicidades, I think it's the--
S2: 02:40	[crosstalk].
S3: 02:42	I'm so happy we're here. I'm so happy we're doing this together. And I've always said just to folks who are listening and who haven't heard this, but wherever he goes, I'm going to follow. So I'm happy to be here with you. I'm Miguel Gallardo. I'm a faculty member at Pepperdine University in our Graduate School of Psychology, and also run a Latinx-specific training program. Really happy to be here and really happy to be with colleague and friend Dr. Hernandez as well today. So thanks for being here. And as he mentioned, we're sort of building on our first two, and this is number three. So hopefully you'll have a chance to hear the other two if you haven't already, so cumulatively. Thanks.
S2: 03:27	Thank you. And thank you for all the comments there in the chat. We're going to get straight into it. And so this project is supported by a grant from the Bureau of Justice Assistance. And just know that the point of views, opinions in this document and in this presentation are those of the authors and do not necessarily represent the official position or policies of the US Department of Justice. In terms of learning objectives for today, hopefully, by the end of this, you'll be able to describe the cultural elements present among individuals, families, and entire communities, and the relevance for engaging, treating, and improving health outcomes. You'll be able to describe cultural humility as an approach towards improving outcomes and describe at least three strategies and three resources for working with these populations.
S2: 04:30	So let's begin with a little bit of talk on culturally informed care. So why, right, be culturally informed? It is important for many different reasons. And sorry about that. These reasons were embedded in the objectives, right? Having a cultural lens enables us to better understand folk, and it enables them to better understand us as well. For everyone involved, historically, within the field of counseling, we have been taught to focus on the people who are in front of us. And we encourage people to think about ourselves because whenever we're doing any type of interaction, counseling or otherwise, we bring our own cultural elements, beliefs, worldview, histories into those relationships. And they come up and come out in many different ways. And so culturally-centered approaches improve the engagement, the retention of individuals within services, and they provide for positive outcomes.
S2: 05:54	There's a spectrum of attitudes that we will have you think about in terms of approaches to working with individuals, how we view individuals that we work with, as well as families and entire communities. So I'm going to ask you to put in the chat an example or two of how you think our field has historically viewed people as

objects. Give us an example or two of how that has happened, if you can, in the chat. While you're doing that, I'm going to also ask you to put into the chat how people have been viewed as recipients in our field. Different from objects, but viewed as recipients. And then finally, we want to encourage you to put into the chat how you believe people have been viewed as resources. So specific examples will help in this regard. So John, thank you for that. Laborers, the very specific title. Other folk who want to come in and chime in on this--

S3: 07:05 Jen mentioned slavery.

S2: 07:07 Yeah. Slavery, laborers. Thank you for that. I missed that one. I'm going to have you think about this. When we think about people as objects within the field of counseling and many health and human service organizations, we're talking about people by way of numbers. So 30% of this, 40% of that. Talking about people as if they were their diagnoses. So schizophrenics, bipolars. We treat people as objects when we call people by other derogatory terms. Homeless. We call people bipolar, schizophrenic, addicts, people in resistance, in denial, all of those things, right?

S2: 08:01 And in the chat, a whole bunch of things are coming in. Right? People who can only do direct services. That's Judith probably alluding to the workforce. Predetermined idea of what recovery is and what it looks like. Exactly. Right? Cleaning, landscaping. Right? So again, back to jobs that are important jobs, but focusing on very specific types of jobs. Receiving benefits not earned. So takers, moochers, leeches, all of those things. Right? Very derogatory. Different skin tone. They are taught of not-- they are taught of not human. They are thought of as not human, a thing I hate typing out. Right?

S2: 08:46 Spanish-speaking employees need to step in to assist Spanish-only clients. Again, some people are alluding to how we treat even people within the workforce. Right? Naming them by their illness. Omar, thank you for that. Now that I'm a social worker, some people resent that we get a little more. All of those things are alive and well. So, in terms of viewing people as recipients, I'll say that many times, instead of engaging with people and teaching them how to access services and building on that, we provide services in a way that creates dependency and not interdependence. And when we create dependency, people come back and back and back and back as opposed to further developing the self-advocacy, the ability to advocate for themselves, all of that stuff. I'm able to advocate for myself as a person in long-term recovery because people taught me that. And it began with people who work in the field. Right? And so--

S3: 09:47 [inaudible].

S2: 09:49 Go ahead, Dr. Gallardo.

S3: 09:52 Oh, oh, sorry. Yeah, I was clearing my throat, but I'll definitely say something here, so. Yeah, no, no. It's okay. Yeah. I was thinking about-- we're talking about labels. I mean, labeling. Labeling really kind of really limits how we see people. It negates the totality of who people are. I think it was Wittgenstein who said, "The limits of my language mean the limits of my world." So it's only what we can describe, and how we see things is as far as we can understand them in some ways. And so I think in many ways, it's really around kind of encouraging us to kind of expand our sort of views and ideas about who people are, who people can be, where people have come from, and not

letting that determine where people go at the end of the day, which I think are so important.

S3: 10:40

And I think it all ties back to kind of where we started our series in some ways around trying to expand this, even just what we mean by Latine, Latinx, Latino, Latina in many ways. And so we also know that when-- it's really interesting because when people get burnt out, when people feel like they're doing too much and they're just stretched thin, we are more likely to begin to objectify the folks that we're working with in some ways. And so it's just this vicious circle sometimes because we know in this work, in this field, it can be very taxing, very heavy, very overload sometimes. And so part of it, what's kind of embedded in this process of how we view people, how we understand ourselves is also self-care, taking care of ourselves in what we're doing so that we're not burning out, we're not getting overwhelmed, and then objectifying how we see people labeling them, etc. So, yeah.

S2: 11:41

Thank you. And Jen, thank you for your comment in the chat as viewing people as resources. I'm going to come back to that in a moment. And then Omar provides a very specific example of how someone came in, and the counselor out loud said, "Our new LRO is here." So, talk to me about people and acronyms. That's really objectifying and not treating people as resources. And so I'll come to that piece on treating people as resources. And I'll say this. If we're looking for broken people, that's what we're going to find. If we come to this work with the mentality of, "I'm here to save lives," then that's what we're going to do. Lead with that approach, which is really condescending, by the way. No one saved my life. People put resources, information, and supported me. And I took on all of that work, and I took back control over my life. All of the people who we come in contact with have a lot of resiliency, strength. They're alive, and they have resisted systems of oppression.

S2: 12:40

And so some of us wouldn't last one day in a prison cell. Some of these folks have been 25, 15, 20 years, 5 years in solitary confinement. They've experienced homelessness. They have experienced what it means to be hungry, what it means to be abused. They have experienced trauma. And we can view that as broken, but I choose to view that as people with strength, resiliency, and the ability to get better. And the fact that they're in front of us, we should embrace the strengths that they bring and build on that, as opposed to, "I am here to serve a person's life," because I don't do that. The only time that I've saved a person's life, I administered Narcan on a few people who were overdosing. Other than that, I walk side-by-side people. We need to lead with strengths, and we need to do away with this language that further stigmatizes and doesn't do well for people. So thank for everything that you're putting into the chat in this regard.

S2: 13:41

I'm going to continue along here and talk a little bit more in this realm about how we claim we treat people. The "we" here is Health and Human Services, and all of us are a part of that, right? So that's the "we" that we're talking about here. So have you ever heard the people who say, "I'm non-biased?" I used to say this a great deal. I don't say it anymore. Have you heard the people who say, "I am non-judgmental?" I used to say this a great deal. I don't say it anymore. As they come, I treat people as they come. The more current term is, "I meet people where they're at." I used to say these things a great deal. I don't say them anymore. Another one is-- this is the golden rule. I treat people the way that I want to be treated. Sounds good, right? The platinum rule is, "I treat people the way they want to be treated," right? I used to say these a great deal. I don't say them anymore. And then my personal favorite is when people go around

saying, "I treat everybody the same. I treat everybody the same." I used to say these are a great deal. I don't say them anymore.

S2: 14:43

Why the mantra, "I don't say them anymore, and I used to say them a great deal"? Because first and foremost, I need to own, right, my biases, my judgments, and all of that. And so why the mantra? Because all of this is a huge crock of shit. Forgive the non-politically correct language. Are human beings biased? Of course, we are. We're not born biased, but we learn bias through family, places of worship, places of education, through media, social media, places of employment. You're learning bias right now because what I'm presenting is highly biased based on my own biases, worldview, and experiences, right? Are we judgmental? Human beings are, and I am too. All of the research in the world points to that. Now, if you're sitting here saying, "I'm not judgmental. You are, Haner, because as soon as you open your mouth, you judged a whole bunch of things," then welcome to the crowd because that's a judgment, right?

S2: 15:41

Treating people as they come, I get where that comes from. But we are treatment professionals, prevention professionals. We do interventions. We do a whole bunch of stuff. And we're funded, and we have an agenda. So that comes with a huge caveat. Meeting people where they're at, our entire system is designed so that you come to me. You make an appointment. You wait in the waiting area. You shut off your phone. You don't come with huge people making a lot of noise. And then you wait till I call you in. So meeting people where they are, unless you're visiting people in their communities and their homes in a consistent way - and some people are doing that - we don't meet people where they're at. And then as I want to be treated, I'm going to ask you to think about. Raise your hand if you are a 58-year-old Puerto Rican male. You don't want to be treated the way that I want to be treated. And even if this room was filled with 58-year-old Puerto Rican males, we're not all the same, which brings me to the latter point, right? Now, it's interesting when people say, "I treat everybody the same." And immediately after that, some people say, "I don't see color." So why are you mentioning color if you don't see color?

S2: 16:52

And I have no business treating everybody the same. Dr. Gallardo is different from Bonnie. It's different from Juan. It's different from Jose. It's different from me. It's different from other people. So what's the bottom line? We should treat people with dignity and respect. We should tailor our approaches with this cultural lens of who people are, who we are, and engage with them in conversations that enable us to get to know them and who they are and what they bring to this endeavor, including and especially leading with their strengths, right? So this is a piece about what? About looking inward. Each and every one of you here have a job. And I want to ask you to remember when you went to the interview for your job. I'm sure you didn't go into that interview and said, "I'm highly biased. I judge things. I don't treat people as they come. And I don't treat people the way that I want to be treated. And I don't treat everybody the same." Because if you would have said that, you wouldn't be here. They wouldn't have given you the job. We don't value honesty. We need to value honesty. And if you are a supervisor, a coworker, whoever is here, and anyone says out loud in front of you, "I'm non-biased. I'm non-judgmental," don't beat them up. But have a conversation. What does being non-biased mean to you? What does being non-judgmental mean to you? Let's engage in that conversation, which I believe helps people to do what? To look inward, to look inward.

S3: 18:24

Dr. Hernandez, I just want to follow up with something you said around someone coming to the office, turning off their phone, waiting for you to call them in. I mean, the other piece of that too, it's like how many of you-- when you think about what we provide and our expectations, we expect someone to show up to a place they've never been to before, to talk to someone they've never met before, to disclose personal issues to someone that maybe they don't even disclose their personal issues to in their own private life. I mean, when you think about it from that perspective, it's like, "Is it really accessible? Is it really appealing from those views?" And the answer is, "No, it's not." And so I think I wanted to add that a little bit in there too because our sort of service delivery system, I think, in some ways, when we sort of try to match that up against a lot of the communities that many folks are trying to serve, there's a huge gap there. There's a mismatch in so many ways when we really think about it from that perspective. So I just wanted to add that there.

S2: 19:25

Yeah. Thank you. And we're going to come to cultural elements in a moment or two. And the cultural elements help us to understand what's there for people and what is acceptable, what is not acceptable. And we're going to come back into that in a moment. Now, again, this is all about the look inward. So resource in terms of how do we do that, right? There are such a thing as cultural self-assessments. They were developed for individuals and organizations that were researched. We have a resource for you. Sorry, because I jumped the gun. That slide is going to come a little bit later. I had it in a different sequence in a prior presentation. So I'm going to come back to the resource for looking inward a little bit later on. So I apologize for that.

S2: 20:15

In terms of challenges - and these are connected to what Dr. Gallardo was talking about, right? - so many Latine people only go to a doctor when something is wrong and it's unbearable. So think about it this way. When people come to us, they've seen other folk in community. That might be a spiritual healer. That might be a doctor-- not a doctor, but that might be a pastor, a priest, someone whom they have developed trust with. And so when they come to us as providers, we might think that that's the first stop, but it's not. They might not mention that they have seen these other people, and they might not mention what they've done as a result of seeing those other people. But those things are clearly there. Latine people are more likely to seek help from medical professionals than a psychologist or a psychiatrist due to the stigma associated with what we're talking about, right? Substance use, mental health, those sorts of things. Now, that doesn't mean that some don't, right? So be careful to understand this.

S2: 21:16

Latine people are more likely to see medical professionals as authority figures. I can't tell you how many times - and I was in my early 20s; I've been at this for a while - and older people would come to me and say, "Doctor, this," and I didn't even have a doctorate degree at that time. But this issue on viewing medical professionals as authority figures, they are less likely to overtly disagree or express discomfort. I know a lot of people who sit in front of us, and they do this when we're talking with them, and they smile, and they nod their heads up and down. That doesn't necessarily mean that they understand or that they're going to do whatever it is that we're talking with them about. They understand that there's a power imbalance. And the culture dictates that you are respectful of the position and who's in that position. As many Latino people hold the cultural ideal of personalismo - and we're going to get into personalismo a little bit later on - they expect personal contact with the provider who is diagnosing and treating their condition. Think about this. I have been to

appointments and meetings with a doc who's never laid their hand on me, and that comes across in a very specific way. Personalismo is a central cultural element that we'll come into.

S3: 22:38 I would say, too, just really quickly. You mentioned dignity a second ago on the previous slide and a lot of what you're talking about here, and I always think about this acronym DEI. We talk a lot about DEI right now. And I think what I'd like for DEI to stand for, [as?] you think about work, is dignity, empathy, and integrity. We think about how to sort of respond and treat folks in these ways. And so we need a new-- we need to switch the acronym a little bit to match what we're trying to do, so yeah.

S2: 23:11 Thank you. And in the chat, thank you, Jean - or is it Jen? - for adding this, right? That you've changed the culture in your office. We used to say, "Meet them where they come and treat them the way we want to be treated." We say, "We will actively listen, be compassionate, understanding, and professional." You speak very nicely to the fact that we need to look inward into ourselves as individuals, but also into the culture of the organizations in which we work because there is a culture operating, right? And we fall in line with that culture, many times without even questioning it, because of what came before us. So thank you for adding that.

S2: 24:01 So there's many different challenges, right, that people show up with. It is our responsibility to better understand. And that's what, in part, what we're doing here. So to the cultural values present in the Hispanic, Latino, Latina populations that we're talking about, familia, familismo, respeto or respect, personalismo or personal relationships, confianza or trust, spirituality or espiritualidad. For some people, it's religion. And for some people, they separate out spirituality from religion. And for some people, it's one and the same. So we're going to go a little bit deeper into one of these-- each and every one of these, so that we can better understand these issue [inaudible] areas.

S2: 24:55 So the first one is familismo, right? It comes from the word familia, family. And so familismo describes the client's focus on family and their community group as a source of identity and support. Have you think about that many times, the way that in mainstream US, we think about the definition of family. For many Hispanic, Latino, Latina folks, that definition is different. In my family, we have people who are not blood relatives who are part of the family. So comadres, compadres, neighbors, friends, and they're very much a part of the family. And so we are family-oriented always in terms of our approach and what we do.

S2: 25:36 Boundaries, you might experience that they may be more flexible between family members. And we need not to pathologize that, right, when we see folks expressing boundaries in different ways. Clinicians, providers must avoid, again, pathologizing and may be supportive and to understand that this might be different from your own practice, but it doesn't make it bad. It's just different, right? The importance of family may result in some individuals putting family needs before their own. Again, the emphasis on the collective. But that can also be a strength. If there's something going on, particularly with children in the family, that might motivate change because we're focused on the collective as opposed to the individual focus on the family.

S2: 26:25 But for some people, that could be viewed as detrimental. And there's a lot of research about the family approach. Many of you have had the experience that you're treating somebody, and they come to your office with a lot of people in toll. And in the US, that has been criticized by providers who don't understand that that is not a

sign of weakness. That is a sign of strength. People brought people with them. We know a great deal about family systems theory. The culture for Hispanic, Latino, Latina folks is very much in line with family systems theory. And we need to be able to incorporate family members into the process without getting bent out of shape because people showed up with other people. If people show up alone, we're going to constantly ask them, "So who's in your family? Who's your support network?" Many people bring those folks in toll, right? And again, you need to understand that the definition of family is somewhat different. Dr. Gallardo, anything you want to add here?

S3: 27:27

Just that I would say that I think what you're speaking to, what we're talking to is just the collectivistic nature of our communities. And we know that we get worse in isolation, and we heal in community. And so I think even as we think about ourselves, it's impossible for me to think about myself as an individual without considering and thinking about my family and what that means to me and in my own identity and who I am. And so it's like even if I come alone to an appointment, I bring my family and my community with me. So even if they're not all there at that moment physically, they're always present in some ways, and they may be there.

S3: 28:09

The other thing I would say too is I think historically, we talk about being non-pathologizing. I think one of the terms that we've used in our sort of treatment models is this term of enmeshed in some ways. And I always just, for years, when I would do presentations and travel, sometimes I'd take my parents with me, and I'd always joke, and I'd say, "Yeah. My parents are here, and no, we're not enmeshed. We're a family coming together as a support." And so I think even the terms that I think historically we've used to sort of identify and talk about family constellation, family structures, those kinds of things, I'd like for us to kind of think about how we can begin to question those and think about the utility of those with different cultural communities, different contexts, etc. "Enmeshed" is just one example that I'm using based on this particular information here. But there's a number of others that we use that are just sort of automatic in some ways without even thinking about the implications, the origins of those terms, and the implications of those terms in any given context. So I would just challenge us to think about how we can begin to think about a language and terminology and way of understanding who we're working with in a way that is more compassionate, contextually, culturally attuned, and respectful, so.

S2: 29:33

Thank you for that. And I'll say this. In the previous session, we were talking about migration and immigration and the impacts of that on families. So imagine this tight family unit as defined by the people in that family and then people having to immigrate or migrate into another space where many of their family members are not present. And what does that do to the individual. Physically, psychologically, spiritually, all of those things, right, are in play. So we need to think about that. The other thing is that many Latinos value family in a way, especially elders. And so we're not necessarily going to move people away and send them away. As a matter of fact, you see families who bring people in. "No, no. Now it's our turn to take care of them. It is my responsibility." And it is an expectation of the culture. All of this is grounded in issues of culture. In the interest of time, we're going to move on. We teach this stuff over semesters long, right, and we're forever learners in this stuff. So this is basically meant as an introduction.

S2: 30:40 Respeto, respect, right? Respeto refers to the respect given to a professional based on their position. Remember what I said earlier, right? Again, depends on what your position is and that sort of thing. But I've heard people call me licenciado, doctor, right, even when I didn't have those titles, right? Providers are seen as authority figures. Therefore, individuals may struggle to question or express concerns about recommendations. I tell people all this time, "Just because you see people smiling and waving their head up and down or shaking their head up and down doesn't necessarily mean that they understand and/or agree."

S2: 31:23 But respeto requires that you treat the position with respect and the person within it. Healthcare professionals should demonstrate respect to the use of titles so that we should have some reciprocity or exhibit reciprocity in terms of utilizing titles just to recognize and to validate those experiences for people. Again, this is in the research, and we know this. We know that you know this. Respeto is not a given. It is earned, right? So I will show respect to the person in front of me, but I really want to get to know you, right? As a person in the receiving end of services, I will demonstrate respect for your position, for who you are as a human being, all of that. But then I want to really understand where you're coming from. And depending on how that relationship develops, I will either gain greater respect for you, or I will say, "This is not for me," based on what those views are, how you're treating me, what you call me, all of those stuff that-- all of those things that we discussed earlier by way of objectifying people or humanizing people and everything in between them.

S2: 32:40 Let me move into personal relationships, or personalismo. This has been called a type or form of friendliness, referring to how one behaves within relationships. So we're talking about sincerity, authenticity, and warmth, right? Latin people may expect providers-- we do expect providers to demonstrate small talk, physical contact, sharing of personal information. I'm going to give you an example. For the most part, in our field, historically, we've been taught to answer personal questions in very detrimental ways. So think about this. Think about what you have in your office. Many people have pictures of themselves and their families, or maybe they went on vacation. They have something in their office that they can identify with, right? So then I come into your office. And I'm going to ask you about that, because I am Latino and because my culture, we don't get to the serious stuff right away. We're going to do some small talk at the beginning of it. So I go, "Dr. Gallardo, are those your kids?" And if Dr. Gallardo doesn't understand the meaning of that question, he might say, "This is not about me. This is about you. Keep the focus on yourself, and we're going to be fine."

S2: 33:53 And what that does is shuts people down completely, because what people need is some type of personal connection in order to be able to move forward. Now, there's all types of personal questions that people ask, and we are aware that your agency has policies on what you can answer, what you can't answer. But we're going to ask you to think about what those policies are. And we're also going to ask you to think about, how do you respond to personal questions? So I'll give you an example. Someone asked me, "Do you have any kids?" One end of the spectrum, "This is not about me. This is about you. Keep the focus on yourself." Another end of the spectrum is someone who says, "Yeah, I have two kids, Jose and Maria, three and eight. They go to the Milton Valley school. They drive me crazy." Blah, blah, blah. That's way too much information, right? And so I think about personal questions along a continuum. And I'm going to have you think about what that looks like for

you. So for me, answering a personal question depends on the context, who's asking, what is it that they're there for. It depends on many different things, but I'm never going to go to the extremes. The extremes are giving way too much information or shutting people down completely. Because when people ask me a personal question, it's because they're interested in engaging in a conversation that leads with personalismo. Dr. Gallardo.

S3: 35:19

Yeah, yeah. Thank you. Yeah, you know what? Just another way to think about this too, just to kind of hit home what you're saying. It's like, I think in US-based kind of more traditional Western culture, being time- and task-oriented is really the priority oftentimes. And in many of our communities, time is much more fluid, and time looks differently. And there's this sort of joke. It's like, "Yeah, people of color time." We're always a few minutes late somewhere, or we're always sort of showing up-- and there's sort of kind of a running joke about that. But in some ways, it's not that that's an-- it's just sort of our concept of what those things mean for us in some ways. For many of us, not all, but for many, may look a little bit differently. So the relationship is always more important than the task at hand. And I think that's really what Dr. Hernandez is really referring to. It's like the relationship is always more important than the task at hand as a starting point.

S3: 36:19

And then, I always think of when this topic comes up, I always think of a friend, colleague of mine, Dr. Melba Vasquez, who was president of APA and done a lot of stuff. And one time, we were doing a presentation together, and it was an ethics presentation. And we were talking about this issue of self-disclosure, and etc. And she said, "Sometimes a taco is just a taco." I don't need to figure out, is it made of flour tortilla, corn tortilla? It's like I don't need to-- I don't need to-- sometimes it's just like when someone asks the question, it's like I don't need to break it down, or when someone tries to gift-give you a resource, it's like, I don't need to understand why are you giving this to me? What does this mean? And all these kind of-- again, I think what Dr. Hernandez said is so important, around if we're thinking about what's in the best interest of who we're trying to best walk with and walk alongside in their process, and we keep it there, then I think we're going to be on the right track in some ways.

S3: 37:21

But I think self-disclosure actually can be an intervention, if done well, a very effective intervention. And sometimes, you don't have to break it down and ask why people are asking those questions or why they're important. Sometimes maybe it depends on the nature of the context, the relationship. Maybe we might kind of reflect on that a little bit more. So I guess, in some ways, what I would encourage is to not think in absolutes. I think, in some ways, what many of you have probably learned along the way are before you learned about human relationships and yourself in the context of providing services and resources to other human beings, you learned about rules and regulations and limitations. And I think we have to sort of reverse that. I would like to see us reverse that. What does it mean to be in the context of a human being serving other human beings and walking alongside human beings? And it's not that we're advocating for being unethical or lacking integrity, throwing out rules and regulations. No. But if we're starting there, if that's our starting place, then that's going to limit us inevitably in terms of the effectiveness of some of the services and the work that we're trying to do. So I think just as we think about that, I think that's another important point I wanted to make sure we covered today, so.

S2: 38:45

So let me give you an example of personalismo with my doctor, who's been my doctor for over 30 years. So when I first met him, he introduced himself. And he knew my name. He put his hand on my shoulder. There's the first thing, right? He touched me. And then he touched my belly. He is my doctor. And he said, "Oh, you must like Alcapurrias." And I went, "Holy shit. He knows Alcapurrias." Forgive my language there. But in my head, that's what I said. And that's the food that we eat in my country. But he knew I was Puerto Rican before I got there. And so you know what I said? "This is the best doctor in the world." I didn't say it out loud, but I said it in my head. I didn't know where he went to medical school. I don't know if he was at the top of his class, at the bottom of his class. But I knew he was really good because he said one word in Spanish. He knew where I was from, and he touched me.

S2: 39:40

And you know what? It happens that he is the best doctor in the world, and I've had him for over 30 years. But you can see how he knew personalismo, right? And before I knew personalismo. I just lived within that space. I didn't knew it intellectually, but he knew enough about it. And I'm sure that each and every one of you here has had the experience of someone asking you something. And I also believe that small self-disclosures are important. The question that we need to answer is, "Why am I self-disclosing this? Is it for the benefit of the relationship, or is it because I just like to talk about myself?" If it's for the benefit of the relationship and it growing, then we are on the right track. So trust and confianza, all of these things go hand in hand, right?

S2: 40:32

Again, confianza, trust is not a given. It's something that's earned over time with practice and with repeated interactions with people. A form of mutual reciprocity, having faith that that individual will help you to the best of their ability based on the relationship. Again, it takes time to develop trust with people. And many times, our systems are set up that we have these assessment tools and a whole bunch of questions that are highly personal. They're really direct. And many of them are embarrassing to the folks who are in front of us. And they might not have experience with those tools or that language or even engaging in those conversations.

S2: 41:20

I did a lot of HIV work, and those assessments, "How many times did you have sex? Was it anal sex? Was it oral sex? Was it unprotected sex? Was it this? Was it that? Blah, blah, blah," and a whole bunch of-- a barrage of questions to people, right? And so what does that do to that relationship? What does that do to that person who's on the receiving end of that, who is at their most vulnerable, right? Mutual reciprocity in the relationship may be emphasized and expected. It has to be earned, as I said before. Small self-disclosures may be helpful in establishing trust. This is what Dr. Gallardo and I were talking about a while ago, right? And so this is also connected to the language that we were talking about earlier. How we engage with individuals. Is it a strength-based language? Is it pathologizing language? All of that leads to either the development of trust or the lack thereof in these relationships.

S2: 42:23

I'm going to move us to the next one, which is religion, espiritualidad. Again, some of these things are used interchangeably. And for some people, religion is espiritualidad. And for some people, those are two separate things, right? But in terms of thinking about religion and espiritualidad, they may offer meaning to existential, transcendental aspects of life. So how people view themselves and what they do, their relationship with others, right? Illness can be viewed as a spiritual punishment. So think about that, right? A lack of understanding of, for example, mental health issues as a mental illness or an addictions issue as an illness, right? Many of us come to this work with that understanding because we've been trained. Many people in the

community, it's about something else. "This is happening to me," the use of substances, right, "and it's because there's bad spirits," or "[foreign], mal de ojo, right, when I was a kid." Or, "There are other explanations as to why bad spirits are in my life, and they're manifesting themselves in hearing voices or the use of substances," and all of those things.

S2: 43:48

And those are not necessarily, right, what everyone presents with in terms of their views, but we do best to understand that not everyone understands mental health or substance use disorders and those conditions that's illnesses that are in the DSM. And many of those people don't even know what the DSM is, right? Spirituality can be very powerful and helpful as religious leaders tend to also be community leaders. Again, before people come to us-- and most Hispanic, Latino, Latine identify as being religious. And most of those folks identify with the Catholic religion. It doesn't mean that they're necessarily practicing Catholics, but they identify that way. So before people come to us, as we said before, they will have seen other people in the communities, right?

S2: 44:46

If you go into any Latino community and spend some time there-- in the community where I'm sitting right now, across the street, there's a botanica. And in that botanica, there's a spiritual healer. And it's not advertised that way, but you go in there, you'll have access to speaking with someone, and they have all sorts of things that they will tell you to do, from baths to oils, to things to wear, to rituals that are spiritual in nature, religious in nature; all of those things. And so I have seen people coming to our offices wearing things that most people who don't understand what they're wearing would brush it off as, "Yeah, that person is wearing white after labor day because they don't get the US rules around attire," or "They're wearing those beads, and those beads look really nice." They don't see what's behind those beads and how that is connected to spiritual practices at the community level. And so those things can and have been really helpful for people. When providers better understand that, then we can better incorporate those practices, in terms of validation of what they are, into our conversations and relationship-developing with people. Dr. Gallardo, anything you want to add here?

S3: 46:05

Yeah, just quickly. I think when you look at spirituality and religion over a timeline in our communities, and specifically, more recent sort of data across the country shows that we're not adhering to sort of more religious-- we're not retaining those religious sort of foundations as much as we are moving towards more spirituality foundations in many ways. So when you look at the next generation of folks, younger generation, they're sort of, quote-unquote, "less religious than their parents and grandparents, but more spiritual." And just really briefly, that sort of religion is sort of those sort of organized beliefs and practices that are shared by a particular community. Whereas spirituality is sort of this individual practice of meaning-making and knowing that there's something more powerful than myself, but it doesn't have to do with sort of an organized set of rituals and beliefs and practices with a particular community.

S3: 47:10

And so a lot of younger generation Latinx community members are sort of identifying more spiritually than with any kind of organized religion in many ways. And so what I think all that sort of says, and often does-- because religion, historically, for many of us, spirituality has been part of a connection to our communities, our families, our culture in some ways oftentimes, and yet there's this sort of, I think, gap and this clash that happens around organized religion and sort of the changing world. And there's a gap for some people in that. But I think it's important enough for us to know

that those foundations oftentimes keep us connected to the things that matter most to us in our lives. And that's our communities in some form or another, our families or those relationships. And so we're moving towards-- many of the younger generations identify more spiritually than religiously, just as a side note.

S2: 48:20

And in terms of recovery and recovery processes, both from mental health and substance use disorders, when you are within those recovery circles speaking with people, you will see that they talk about spirituality and what that means for them and how spirituality has been a strength in terms of their recovery processes and how they define for themselves what spirituality is, as opposed to us thinking that we have the definition and are going to impose that on folk. That's why I said earlier, for some people, spirituality and religion is [here?], and for some people, right, they are two different things, and the practice of those things are different.

S2: 49:02

And always remember what we talked about in previous sessions. These acculturation gaps. This is the piece that Dr. Gallardo was talking about, right? The differences between people who are recent arrivals into the US and different from people who have been here for a while, the acculturation gaps between the younger folks and the older folks in terms of practices and that sort of thing. And depending on who you speak to within the family, there are people who are responsible for maintaining this within familismo, right, that teach these practices to other people. Whether they accept them or practice them or not, that's a different thing. But there's usually people within family who their role is a spiritual role or religious role in terms of passing things down from one generation to the next.

S2: 49:49

So gender roles and expectations. These are huge within Latino communities. And some of you, when you hear this stuff, will say, "Well, they're present in other communities as well." Yeah, they are. But we're talking here within the context of the Latino, Hispanic, or Latinx community. So there's something called Marianismo. Right off the rip, I'm going to point out to the fact that this is talking about Maria. And very specifically, this alludes to the Virgin Mary. So have that in mind as you think about this. It's the female equivalent of machismo, which incorporates the concepts of saintliness, submissiveness, humility, and vulnerability. It may also include the role as a provider and having strength to raise children, right?

S2: 50:38

So when you think about that Virgin Mary aspect and what that entails, and you think about someone who is there for their family and put themselves last, right? In this case, a female who puts themselves last behind everybody else. So I'm here to serve my husband, my children, my family, right, all of those things. To serve family is not a bad thing. That is a strength, right? But to put yourself last constantly is a huge challenge. And then when you think about the fact that many females with this value are more likely to minimize symptoms or neglect treatment to care for family, there's also values that are embedded in this related to double and triple standards, right? So if a man uses substances in society, it's one thing. But if a female uses substances in the same society, it is a different thing. And we, as a society, have those double, triple, quadruple standards in the Latino community that exist as well, right, and they're pronounced. They are pronounced.

S2: 51:59

And so the equivalent of that for males is machismo. I usually ask people in training, "So what's the English word for machismo?" And people go, "Macho." And I go, "No, that's a Spanish word." We're talking about male chauvinism here, right? It's a form of masculinity that involves having pride, being courageous, and valorous, but also

promotes male dominance and superiority. So let's break these things apart, right? Because first and foremost, when people hear machismo, what they think, "Oh, that's all bad." The first part of the sentence is what? To be a provider for the family, to be there, to be a caretaker for the family. Those are not bad things. Those are actually good things, right? This whole piece on dominance and superiority, that's another aspect of it.

S2: 52:51

I'll give you examples in terms of how I have experienced and continue to experience machismo within communities, but in my life. When I was growing up, young boys don't cry. [foreign]. So boys cry when chickens pee. And if you know anything about chickens, is that they don't pee. So the expectation is you never show vulnerability, that you never show feelings, right? That you never, right, express those feelings in front of other people, right? And that you always have to be in charge. Imagine what that does to a young boy growing up, to a young man growing up, to a man who is now in need of substance use or mental health services when you're taught that you don't show feelings. And that if you do, be careful with whom you show them in front of.

S2: 53:51

So depending on who you're working with, if they're a male, and you identify as male, they might show some things but not others. But if you're a female, they might choose to show some things and not others. This is huge, right? Men with this value may struggle to accept appropriate emotions and vulnerability. That's what we're talking about. In treatment, machismo may lead men to minimizing symptoms, not using familiar support or stopping treatment prematurely. When I went from prison to treatment, not because I wanted to go to treatment, but because I wanted to get out of jail, one of the first things that I was introduced to was groups. And when I walked into that group, men were talking about their feelings, and some of them were crying. And for me, they were weak and could not be trusted because they were doing that. And there was something wrong with them, not with me. Because my cultural values clashed with the cultural values of recovery and treatment. So we must understand that the culture of what we're setting up in order for people to heal might not be in line with the cultural values of the folks who are coming into those spaces and places. That doesn't mean that they will not come around to understand healing and getting better because I did. But in the beginning, it's a cultural clash for many. Dr. Gallardo.

S3: 55:15

Yeah, thank you. Going back to what you mentioned on the previous slide around just always kind of thinking about levels of acculturation, educational levels, just sort of identity, and how one sees oneself, where one sort of identifies and in what ways. I think all those things really come together with all these different cultural values and costumbres that we're talking a little bit about here today. So some of the-- when we look at the younger sort of next generation of Latinos, Latinas, Latinx community members, Latine community members, we see some of this shifting a little bit where some of those really strong adherence to women do this and men do this starts to evolve a little. Some of that intersects with acculturation status, education status. So there's some literature that's talked about the more educated folks attain at the end of the day, the less maybe they adhere to some of these more traditional kind of gender roles and expectations at the end of the day. So I think some of that's important to kind of think about as you're working with folks.

S3: 56:38

And then I see more recent folks who've come to the United States and our communities. And I see a shift happening in both the dads and the moms and the

parents and their families in many ways. And so there are, I think, some shifts happening. I hope it continues to shift. There's also another term too, caballerismo, which is another term around kind of thinking about Latino men in many ways. It tends to be a little bit more of a positive sort of perspective around respect for family, care for family. Also, there's been some literature done looking at endorsement of more traditional machismo sort of values versus those caballerismo values in some ways. And the men who rate themselves and who are rated higher on caballerismo also are rated higher on social connectedness scales in some way. So maybe a little bit more likely to maybe express the emotions that Dr. Hernandez was talking about and maybe be okay with kind of being more open about how they might be feeling.

S3: 57:52

It's going to look differently. It's going to look different. Don't get me wrong. We still have ways to go as men, if you will, in most cultures, but particularly in ours. I'm not suggesting that this is night and day, no, but there is some movement. And I think the idea of caballerismo which is this chivalry and nurturing roles, there's an endorsement of those processes as well. And I think I love what Dr. Hernandez said about the term machismo. It's like that was historically not a negative process in many ways for many of our communities. And it was functional. It was meaningful. I think over the years, as people change, so does culture and so does the world around us. And then I think we begin to be inculcated with external ideas and messages and reinforcements that sometimes we internalize that then I think kind of turn these things upside down to a certain degree. And I think that's the concern and that's the danger in some ways. So yeah.

S2: 59:00

So thank you for that because you're calling upon us never to paint with a broad brush, right? And think about that idea of sameness and pathologizing, right? So don't take concepts and think they apply the same way to everybody because they don't is what we're calling upon us to do, right? So when we think about cultural strengths in the Latine populations, right, we have strong support systems, including family, willing to attend relevant appointments and supports all of that. I'm going to move through these very quickly because we're coming up against the timepiece once again. Some Latine people might be open to holistic treatment experiences involving spirituality, physical, right, health treatment, all of those things. If a positive rapport is developed, Latino people are more likely to trust, right. That whole piece of trust comes back into play. And then research has demonstrated that Latine people are more likely to believe in a positive impact of mental health treatment than their White counterparts.

S2: 59:59

So when we think about these populations, just, again, come into the piece, understanding that there's an evolution, right, that things are changing for people in terms of how we view getting better spiritual practices and all of those things. We have moved away from this whole-- or most of us have moved away from this whole experience of talking about cultural competence. Cultural competence denotes that I know everything there is to know about culture. And if there's one thing that I've learned about culture in my journey of doing this work, that I'm culturally incompetent. There's no way that I can know everybody's culture. There's no way that I can know my own culture. So if we're moving away from cultural competency, what are we moving towards? Cultural humility, which is a lifelong commitment to self-evaluation and self-critique. This is the look inward. We're back to the look inward, right? Redressing power imbalances. How do we work with people so that we're not always up here when we view people as resources, with strengths, with the ability to get better, that is us redressing power imbalances. And it's about not being

paternalistic in the field of mental health and substance use disorders. We know best. We tell people what to do, when to do it, how to do it. And then when it doesn't work, we blame them. Cultural humility pushes us to look in the other direction.

S2: 01:01:27

And it's about developing partnerships with. Again, I am not here to save your life. I am here to partner with you, walk beside you, share information and resources, learn from you, and hopefully move the relationship in a way that enables you to get better, right? We're up against time, but this is the slide that I jumped the gun on earlier. It's just cultural self-assessments. So we want you to visit this link. It's out of Georgetown and the National Center for Cultural Competence. Self-assessments, cultural self-assessments developed for organizations and individuals. At the individual level, this resource has many of them. You can choose. I do at least one culture self-assessment annually. This enables me to look inward. They were developed by researchers, people who understand how to develop these things. I cannot rely solely on the feedback that you will give around this presentation to figure out what I do well and why I should improve. So that look inward with a self-assessment helps me to do that. They take about 45 minutes to do. Harvard has one online on implicit bias. If you want to Google that one, it's actually really good as well. And then if you want to do it for your program or for your organization, which we highly recommend, they take a little bit longer because you need to involve everybody from the organization and do it in a formal way, right, so that you better learn about what's going well, what needs to be improved, and what types of changes to the organization need to be made so that they're more welcoming of people from different walks of lives, from different walks of life.

S2: 01:03:18

Again, we're over by two minutes. There are multiple pathways of recovery. And so when you think about how people get better, there are many ways of doing things. And so what is our role? Is to understand that there isn't just one way. There's many different ways. There's 12-step in recovery. There's holistic approaches. There's exercise in recovery. There's yoga, meditation. There's smart recovery, rational recovery. I can go down the list of many and not end by 4 o'clock because there are way too many. So we need to take a page out of the restaurants in this country. When you go into a restaurant this weekend - hopefully, you're going to go to one - they offer you water, they sit you down, and they bring out this revolutionary thing called the menu. They don't tell you you're having hot dogs whether you like it or not. Our role is to provide options in front of people, give them the opportunity for self-determination, for choice, for agency, for them to make choices of what works for them. There's faith-based approaches in recovery. And people combine many of those things together. Again, we need to move away from this thing of only this works. Medication-assisted treatment. Does that work? Of course it works. Is it for everybody? No. All of the pathways that I've mentioned are not for everybody. Our role is to provide options for people. Dr. Gallardo, we are at time. Anything you want to close it up with?

S3: 01:04:43

We actually have until 12:15, by the way.

S2: 01:04:46

Oh, 12:15. So I--

S3: 01:04:50

Yeah. So you can take a couple more minutes if you want to just go back to anything. We have a few more minutes if you want to. It's up to you.

S2: 01:04:55

Okay. So once again, I was tracking time, but I was tracking the wrong amount of time. Thank you for sharing that. So this helps to slow down. Again, the field of

mental health and substance use disorders has been very punitive. Again, we tell people what to do, when to do it, how to do it, and when it doesn't work, we put it on them. The other piece that we've done is that we have criminalized mental health and substance use disorders. And so it behooves us to take a step back to understand what the pathways of recovery are. And as important, that you do the research in your service area to see what's available. You don't want to talk about options that are not available.

S2: 01:05:51

And then the other thing that you want to do is that you want to make sure that the options that are available are accessible, and they provide quality of care for all people. And when we're talking about the Hispanic, Latino, Latine population, we are talking about the fact that many people can get access into something, but that doesn't necessarily mean that you get quality of care. So when you think about the multiple pathways of recovery, think about who's offering them from what perspective. Do the people who are offering this pathway of recovery or your agency, any pathway of recovery, does it include the cultural elements that we have discussed here today? Are those cultural elements taken into account? Are they present, right? So that people, when they walk through the door, they feel welcomed, validated, respected, that they feel that they can come back.

S2: 01:06:48

Many people don't come back, and they vote with their feet. And again, we blame them or they're in denial. They're just not ready for change. And we blame them as opposed to that look inward, which the previous slide around, cultural self-assessments, will help us to get at. Is it something that we are doing or that we're not doing that pushes people out of the door? And I always say this to folk, "Your best outreach workers are not necessarily the people with outreach in their title." All due respect, I was an outreach worker, and I am not disparaging outreach workers. But what I am saying is that the people who walk through the door, at some point, they're going to walk back out of that door. And they're going to talk about us in one of two ways, "That place is really good, and they treated me with decency and respect," and they're going to tell as many people as possible, or, "Don't ever go there because that place did not understand me. They treated me badly and look out and be aware of this and this and this and this. And if you have to go in there, go in and go out in a very careful way because that place will be detrimental to you." And it's unsafe. And it's unsafe.

S2: 01:08:07

So think about the multiple pathways of recovery in that way. When we make recommendations and put a menu of options in front of people, we need to make sure that those options are available, viable, accessible, and that there's quality of care within them. The last thing you want to do is to put your reputation and the trust that you have developed with people on the line by sending them somewhere where they're going to be treated badly because they're going to know that they were treated badly there, but they're going to look back and say, "Well, Haner sent me here." Right? And that has its own weight to it as well, by way of the relationship moving forward.

S3: 01:08:50

Yeah. And I want to just add to this too. I think if we make an assumption that-- and I'm going to talk about this on the liberation psychology side in just a minute. But if we make an assumption that communities have already inherent resources and strengths embedded in their communities, both individually, relationally, communally-wise, etc., you can go back to-- you can go back or either one, Doctor. Yeah. There's some value in potentially also utilizing cultural brokers, cultural health

workers. Some systems call them promotoras. And people from the community who are part of the system to help go back out and assist the systems and the work that's being done and really bridging gaps and disparities in communities.

S3: 01:09:54 We have some promotora models here where I live in some of the communities. And highly effective, it's people from the community going back out. It's like what Dr. Hernandez mentioned. It's like, okay, we have these individuals from the community who we build trust with, build relationships with. We ask them to help us kind of think about what we're doing that works, what we're doing that doesn't work, make some cultural adaptations and adjust what we're doing to a certain degree so that when they go back out, they feel good about what they're going and trying to help people walk into and come into in some ways. And so I do think that really thinking about using community resources and already existing inherent strengths within communities is incredibly important, including individuals in communities that can be helpful in those models. And I think those are other pathways and avenues that allow people to make services more accessible, to hit recovery, and to stay well along the way as well. So I want to just add that, too, in this systemic place as well, so.

S2: 01:11:10 Thank you for that. I will add to that by saying the following. There's a workforce crisis, a documented workforce crisis in behavioral health, specifically mental health and substance use disorders. Primarily white, female, baby boomers, and soon retiring. The people in need of services are younger and more diverse. So that's sort of the workforce crisis. The biggest explosion in the workforce in the last 10, 12 years has been peers in the mental health space and in the substance use disorder space; mentors, recovery coaches--

S3: 01:11:50 Wellness coaches.

S2: 01:11:50 --peer specialists, wellness coaches, all of those things, right? And we are seeing more diversity amongst that cadre of people coming in with that experience from community with the lived experience. And so they are being embedded and integrated into healthcare settings, criminal justice settings, into hospitals, primary care. You name it, there's an explosion of this workforce. And for those of us who don't understand what that workforce does - and many of us don't - they are charged with utilizing lived experience in helping other people, so they are encouraged to do self-disclosures. They are encouraged to do many of the things that clinicians are discouraged from doing.

S2: 01:12:40 And so if you're a clinician, and you have incorporated people with lived experience into your settings, look for ways of supporting and understanding their role. And there's a lot of evidence and research that says that they improve outcomes for people. So that's the other piece that I wanted to add here. And then the final slide, I'm going to kick it to Dr. Gallardo to take us home with the psychology of liberation.

S3: 01:13:04 Yeah. Thank you. Now, we're definitely going to be right at time when we finish, which is perfect timing. I think what Dr. Hernandez said at the beginning today around if you're looking for broken people, you're going to find them, right, in many ways. This is really around - I think I'm going to say it similarly-- a little bit differently, but - we should always identify what's right with people before we find out what's wrong with them. And I think that's sort of an unlearning process that we have to do and kind of a shift. But this idea of psychology and liberation is really a very strength-based systemic perspective in many ways.

S3: 01:13:45	I mean, there's a lot more to this, but I want to just mention a couple things. We know that most of our families and our communities have multi-issues that they're sort of negotiating and trying to deal with - so medical, mental health, substance use, employment, poverty, immigration issues, whatever it may be - and so what we know is that while all of those areas tend to need some attention, most of our traditional forms of providing social substance and mental health services focus almost exclusively on the medical and mental health issues. And I think, not that we don't want to focus there, but I think when we focus primarily there, those systemic possibilities of interacting and understanding-- the contextual issues all become background noise if you will. They become overlooked in some ways. And so when we focus solely on the individual, we're sort of failing to take into consideration-- and we've said this in the past two webinars so we've been consistent pretty much throughout our time together through these three webinars.
S3: 01:14:56	And so ultimately, what Packman says is that the very social issues that are relevant to the health and well-being become background noise and tend to be excluded as legitimate forms of professional intervention. In fact, Packman argues they become second-class interventions. And so I think, "How can we, in some ways, start from those areas to understand what someone might be going through, how they may have landed themselves in the position that they have, their location in the world in which they find themselves in that moment to then kind of inform us how best to serve them, how best to intervene, how best to walk with them?"
S3: 01:15:42	Psychology of liberation is about accompanying people, walking with people, not necessarily being sort of the experts, if you will. It also means around being creative in what we do. And I think sometimes our systems kind of suck out the creativity and the flexibility. And I think it's exactly what we need to do oftentimes when we're working with minoritized, underserved, disenfranchised communities, including our own Latina, Latinx communities that we're talking about today. So education, work, legal issues, violence in communities, ethnic and social disconnect, social networking, or lack thereof. All those factors, I think, should be part of our understanding and really where we start with. Anything out of context is going to look off. Anything out of context is going to look-- so how do we place them in context? So I really want to sort of hit home with that as we wrap up our webinars and think about how best to help you move forward. So yeah, I'll stop there.
S2: 01:16:49	Thank you for that. You remind us of the structural determinants of health, right, and to be comprehensive in our understanding of what's going on for folks. We want to thank you for your participation, for your comments in the chat, for coming back again and again. And we want to wish you happy holidays with you and your family. Stay safe. Be well. We look forward to our paths crossing in the near future. From my family to yours, thank you very much.
S3: 01:17:18	Yeah. Happy New Year. Feliz Año Nuevo. Yeah. Thank you. Thanks, everybody. Thank you.
S2: 01:17:24	Thank you. And in the chat, the evaluation piece was put in. And thank you, Bonnie, for all your behind-the-scenes technical assistance.