VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

PTSD/Suicide: Conceptualization and Assessment

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Synopsis of Presentation

- The scope of Veteran suicide
- PTSD/Suicide
- Conceptual model of suicide
- Suicide risk assessment
- Questions and Comments

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The Scope of Veteran Suicide

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Suicide in the Veteran Population

- Approximately 20% of all suicides are identified as current or former military
  (National Violent Death Reporting System)

- About 5 deaths from suicide per day among Veterans receiving care in VHA
  (VA Serious Mental Illness Treatment, Research and Evaluation Center)

- About 33% of Veterans who die by suicide have a history of previous attempts
  (VA National Suicide Prevention Coordinator reports)

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Sources of Increased Suicide Risk

- Increased risk for suicide has been noted in the following
  - Those receiving outpatient mental health services (Desai et al 2008)
  - Those who have received psychiatric discharge (Desai et al 2005)
  - Patients receiving depression treatment (Ziven et al 2007)
  - Men with bipolar disorder and women with substance use disorders (Ilgen et al 2010)

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Risk of Suicide Attempt

- Increased risk for suicide attempts has been noted in the following
  - Those with psychiatric conditions (e.g., PTSD, Depression), prior suicide attempt, alcohol misuse, and history of sexual abuse

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Suicidal Ideation

- 21.6% of OEF/OIF Veterans with psychiatric disorders reported having had suicidal ideation in the past two weeks

Pietrzak et al, 2010

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PTSD/Suicide

What do we know about PTSD/Suicide?

- Explosion of research in this area in the last ~5-10 years
- The relationship is complicated

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A meta-analysis of the association between posttraumatic stress disorder and suicidality: the role of comorbid depression

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Abstract

Objective: A considerable number of studies have reported an increased frequency of suicidal behaviors among individuals diagnosed with posttraumatic stress disorder (PTSD). This study aims, first, to provide a comprehensive systematic review and meta-analysis of the association between a PTSD diagnosis and frequency of suicidality and, second, to examine the role of comorbid depression in the association between suicidality and PTSD.
Methods: Searches of Medline (June 2010), EMBASE (June 2010), PsycINFO (June 2010), PILOTS (June 2010), and Web of Science (June 2010) were conducted to identify studies that examined the association between PTSD and suicidality. The studies had to include an effect size of the association between PTSD and suicidality to be included in the meta-analysis. Sixty-three studies were eligible for inclusion in the meta-analysis. Overall and subgroup effect sizes were examined.
Results: A highly significant positive association between a PTSD diagnosis and suicidality was found. The PTSD-suicidality association persisted across studies using different measures of suicidality, current and lifetime PTSD, psychiatric and nonpsychiatric samples, and PTSD populations exposed to different types of traumas. Comorbid major depression significantly compounded the risk for suicide in PTSD populations.
Conclusion: The current meta-analysis provides strong evidence that a PTSD diagnosis is associated with increased suicidality. The crucial role of comorbid major depression in the etiology of suicidality in PTSD is also supported.
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Panagioti et al, 2012

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Routledge
Taylor & Francis Group

Post-Traumatic Stress Disorder and Suicide Risk: A Systematic Review

Karolina Krysinska and David Lester

There is a gap in the literature regarding suicide risk among traumatized individuals with post-traumatic stress disorder (PTSD) and this article aims to systematically review literature on the relationship between PTSD and suicidal behavior and ideation. A meta-analysis of 50 articles that examined the association between PTSD and past and current suicidal ideation and behavior was conducted. There was no evidence for an increased risk of completed suicide in individuals with PTSD. PTSD was associated with an increased incidence of prior attempted suicide and prior and current suicidal ideation. Controlling for other psychiatric disorders (including depression) weakened, but did not eliminate, this association. The evidence indicates that there is an association between PTSD and suicidality with several factors, such as concurrent depression and the pre-trauma psychiatric condition, possibly mediating this relationship. There are significant clinical implications of the reported relationship for suicide risk assessment and therapy, and further studies might help to understand the mediating pathways between PTSD and increased suicide risk.

Keywords post-traumatic stress disorder, psychiatric comorbidity, suicide risk, trauma

Krysinska & Lester, 2010

Subthreshold PTSD matters, too

- It's not just PTSD – those with subthreshold PTSD are 3x more likely to report suicidal ideation compared to healthy controls

Jakupcak et al, 2011

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Factors contributing to risk in this population

- Comorbid disorders, especially depression
- Impulsive behavior
- Feelings of guilt/shame
- Pre-deployment traumatic experiences
- Re-experiencing symptoms
- Combat exposure

Tarrier et al, 2004; Bell & Nye, 2007; Kramer et al, 1994; Ferrada-Noli et al, 1998; Tiet et al, 2006

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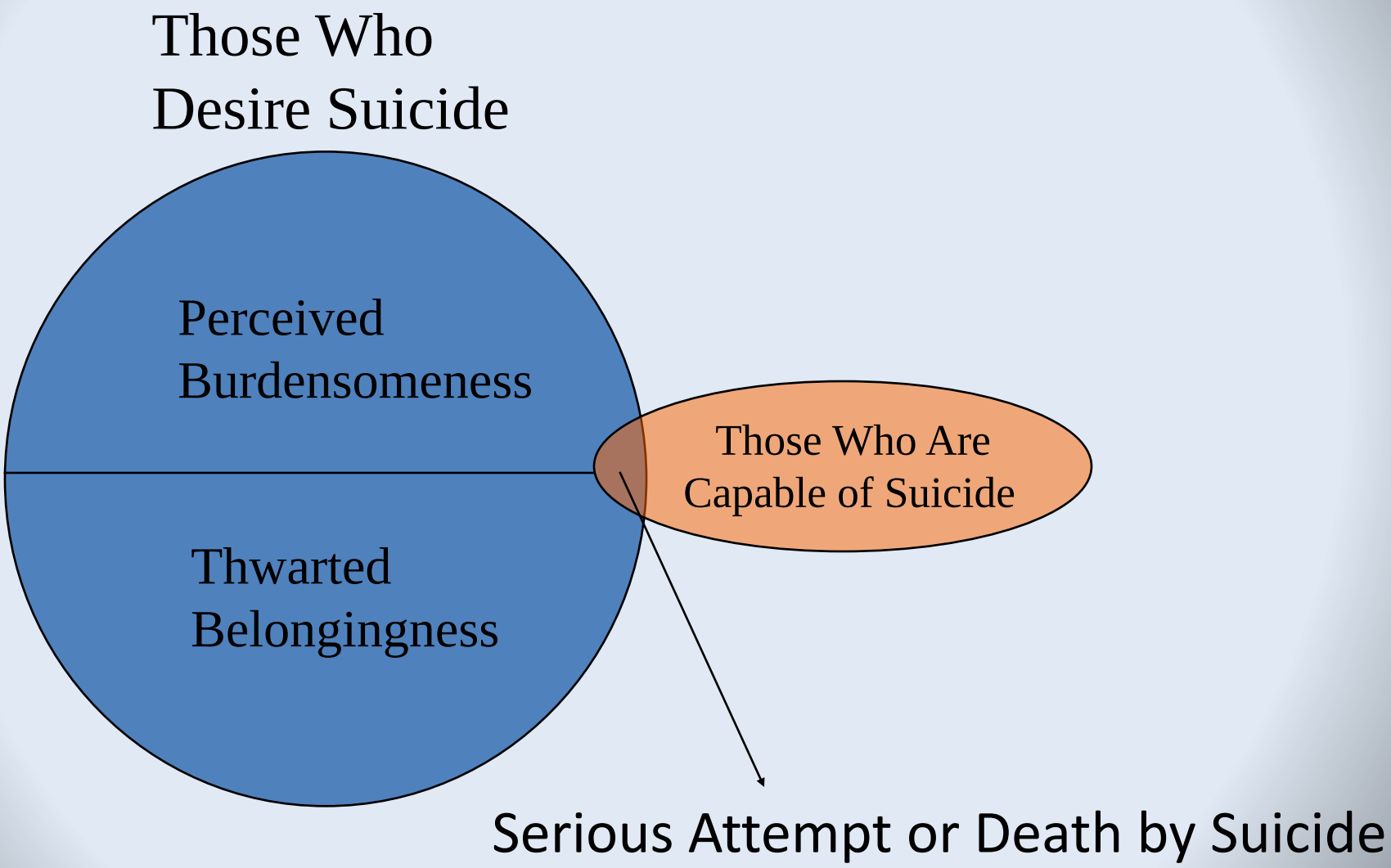
Conceptual Model of Suicide in the Context of PTSD

Interpersonal Theory of Suicide



Joiner, 2005

Perceived Burdensomeness

"My death is worth more than my life to my loved ones/family/society."

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Thwarted Belongingness

"No one cares. I'm all alone."

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Those Capable of Suicide

- Habituation to painful stimuli (e.g., suicide attempts, child abuse, exposure to violence/aggression, combat)
  - Habituation functions to lower the fear of death AND ALSO elevate tolerance for pain
    - (A lethal or near-lethal suicide attempt is fear-inducing and often pain-inducing, therefore, habituation to the fear/pain involved is a prerequisite for serious suicidal behavior)
- Capability develops as a function of repeated exposure to painful stimuli, through which the individual habituates to previously aversive stimuli

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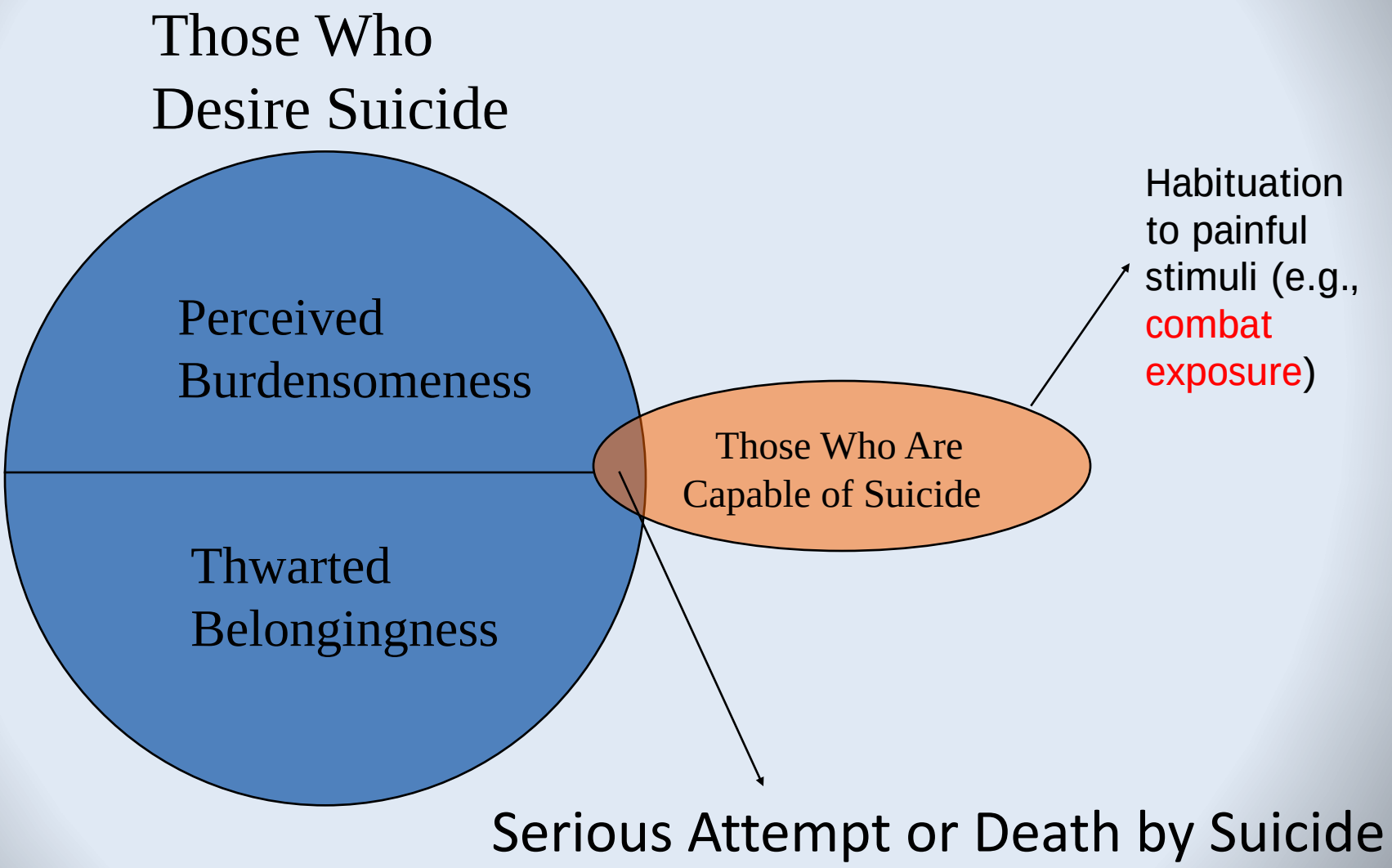
Interpersonal Theory of Suicide



Joiner, 2005

The Role of Combat Exposure

- Exposure to painful and provocative experiences such as combat contribute to fearlessness about death and increased pain tolerance, which serve to enhance the individual's capability to attempt suicide
  - Violent and aggressive combat experiences, in particular, should demonstrate relatively stronger associations to this capability.
    - In a sample of deployed active duty combatants, combat characterized by violence and high levels of injury were associated with relatively stronger associations of the acquired capability for suicide

Craig et al, 2011

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Not all combat experiences are equal

- Level of violence
  - Firefights vs. nonhostile, routine patrols
- Proximity
  - Hand-to-hand combat vs. artillery fire at a distance
- Personal responsibility
  - Killing an enemy combatant vs. witnessing others engaged in combat

Craig et al, 2011

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Combat experiences are influenced by:

- Occupation
  - Medics vs. infantrymen
- Location of deployment
  - Relatively well-controlled areas vs hostile areas with high combat operations

Craig et al, 2011

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Additionally

- Combat experiences marked by initiation of violence toward others (e.g., firing upon the enemy) are more strongly associated with suicide attempts than combat experiences without active initiation of violence.

Fontana et al, 1992

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What does all this mean?

- Viewed from the perspective of Joiner's theory, the findings regarding violent and aggressive combat experiences could be explained by differing levels of acquired ability (i.e., fearlessness about death and pain tolerance) associated with these different types of combat.

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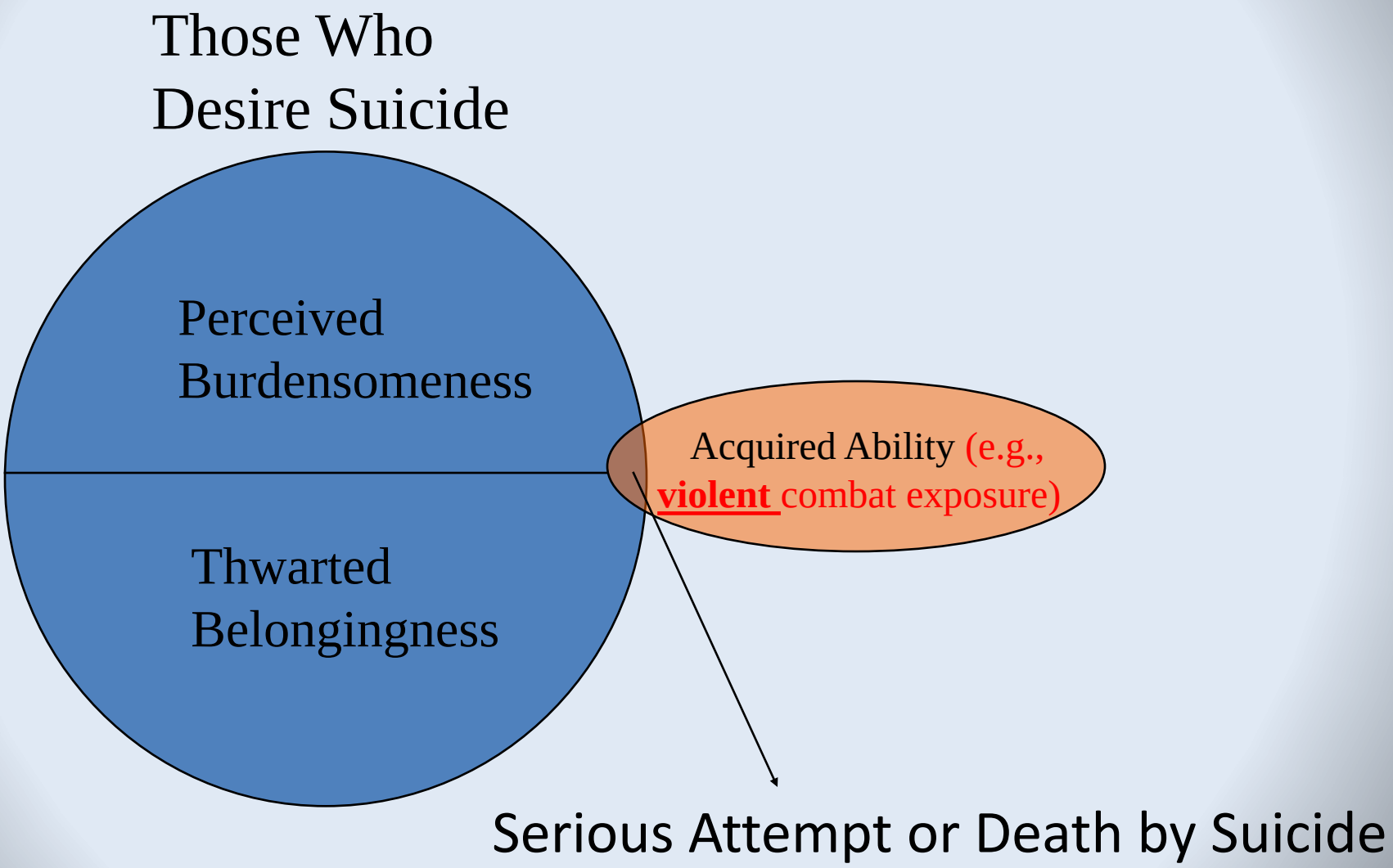
Interpersonal Theory of Suicide



Joiner, 2005

Treatment Implications

- Joiner's model posits that prevention of "acquired ability" OR of "burdensomeness" OR of "thwarted belongingness" will mitigate serious suicidality.
- Belongingness may be the most malleable and most powerful.

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Suicide Risk Assessment

We assess risk to…

- Take good care of our patients and to guide our interventions
- The purpose of systematic suicide risk assessment is to identify modifiable and treatable risk factors that inform the patient's overall treatment and management requirements (Simon 2001)
- Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)

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Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR

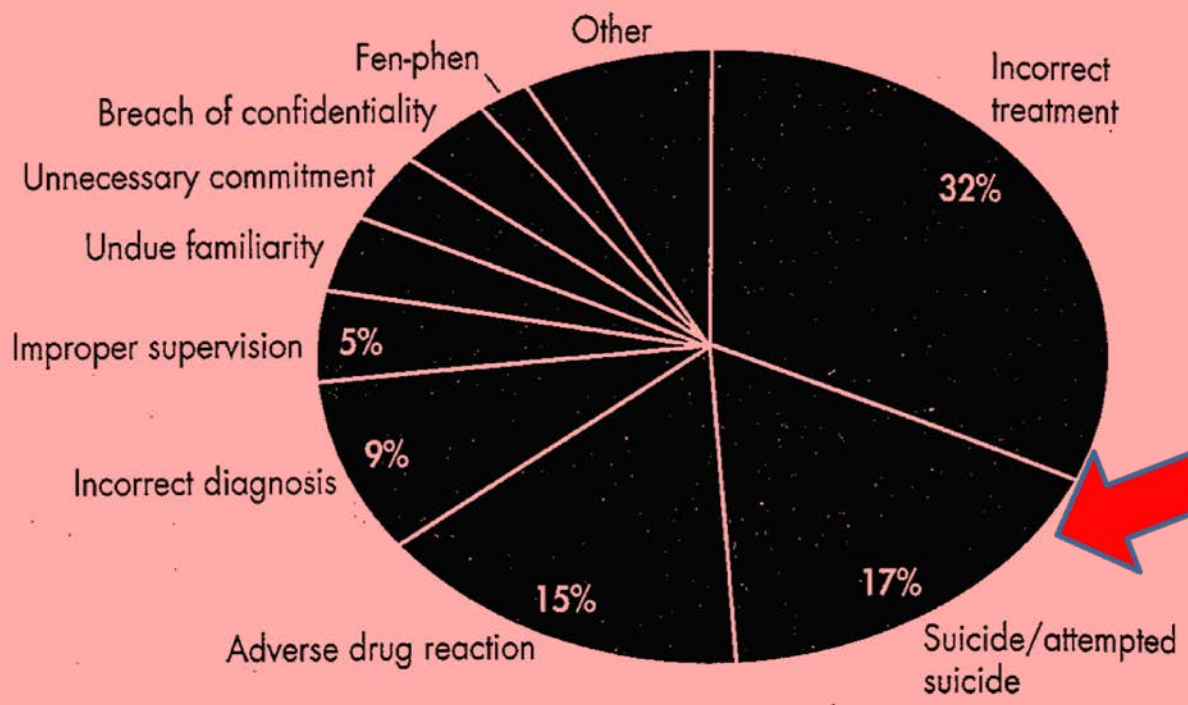

FIGURE 28–1. Most common malpractice claims against psychiatrists: United States, 1999–2003.
Source. The Psychiatrist's Program, the APA-Endorsed Psychiatrists' Liability Insurance Program, 2004.

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Clinically Based Risk Management

- Clinically based risk management is patient centered
- Supports treatment process and therapeutic alliance
- Good clinical care = best risk management

Simon 2006

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Suicide Risk Assessment

- Refers to the establishment of a
  - clinical judgment of risk in the near future,
  - based on the weighing of a very large amount of available clinical detail.

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Good Clinical Practice is the Best Medicine

- Evaluation
  - Accurate diagnosis
  - Systematic suicide risk assessment
  - Get/review prior treatment records
- Treatment
  - Formulate, document, and implement a cogent treatment plan
  - Continually assess risk
- Management
  - Safety management (hospitalize, safety plans, precautions, etc)
  - Communicate and enlist support of others for patient's suicide crisis

"Never worry alone." (Gutheil 2002)

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Suicide Risk Assessment

- No standard of care for the prediction of suicide
- Suicide is a rare event
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment
- Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients

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Suicide Risk Assessment

- Standard of care does require suicide risk assessment whenever indicated
- Best assessments will attend to both risk and protective factors
- Risk assessment is not an event, it is a process
- Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
- Research identifying risk and protective factors enables evidence-based treatment and safety management decision making

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APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors

http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_14.aspx

- Quick Reference Guide
- Indications
- Risk/protective factors
- Helpful questions to uncover suicidality
- And more

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Important Domains of a Suicide-Focused Psychiatric Interview

- Psychiatric Illness
- History
- Psychosocial situation
- Individual strengths and vulnerabilities
- Current presentation of suicidality
  - Specifically inquire about suicidal thoughts, plans and behaviors

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Thorough Psychiatric Evaluation

- Identify psychiatric signs and symptoms
  - In particular, sx's that might influence risk: aggression, violence, impulsivity, insomnia, hopelessness, etc.
- Assess past suicidal and self-injurious behavior
  - For each attempt document details: precipitant, timing, intent, consequences, and medical severity
  - Substances involved?
  - Investigate pt's thoughts about attempt: perception of lethality, ambivalence about living, degree of premeditation, rehearsal
- Review past treatment history and relationships
  - Gauge strength of therapeutic alliance

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Thorough Psychiatric Evaluation

- Indentify family history of suicide, mental illness, and dysfunction
- Investigate current psychosocial situation and nature of any current crisis
  - Acute crisis or chronic stressors may augment risk: financial, legal, interpersonal conflict or loss, housing, employment, etc.
- Investigate strengths!
  - Coping skills, personality traits, thinking style, supportive relationships, etc

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Elicit any suicidal ideation
  - Focus on nature, frequency, extent, timing
  - Assess feelings about living
- Presence or Absence of Plan
  - What are plans, what steps have been taken
  - Investigate patient's belief regarding lethality
  - Ask what circumstances might lead them to enact plan
  - Ask about GUNS and address the issue

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Assess patient's degree of suicidality, including intent and lethality of the plan
  - Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  - Realize that suicide assessment scales have low predictive values
- ***Strive to know your patient and their specific or idiosyncratic warning signs***

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Identify Suicide Risk Factors

- Specific factors that may generally increase risk for suicide or other self-directed violent behaviors
- A major focus of research for past 30 years
- Categories of risk factors
  - Demographic
  - Psychiatric
  - Psychosocial stressors
  - Past history

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Warning Signs

- Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior
- Proximal to the suicidal behavior and imply imminent risk
- The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment

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Risk Factors vs. Warning Signs

Characteristic Feature	Risk Factor	Warning Sign
Relationship to Suicide	Distal	Proximal
Empirical Support	Evidence-base	Clinically derived
Timeframe	Enduring	Imminent
Nature of Occurrence	Relatively stable	Transient
Implications for Clinical Practice	At times limited	Demands intervention

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Risk Factors vs. Warning Signs

Risk Factors	Warning Signs
•Suicidal ideas/behaviors •Psychiatric diagnoses •Physical illness •Childhood trauma •Genetic/family effects •Psychological features (i.e. hopelessness) •Cognitive features •Demographic features •Access to means •Substance intoxication •Poor therapeutic relationship	•Threatening to hurt or kill self or talking of wanting to hurt or kill him/herself • Seeking access to lethal means •Talking or writing about death, dying or suicide •Increased substance (alcohol or drug) use •No reason for living; no sense of purpose in life •Feeling trapped - like there's no way out •Anxiety, agitation, unable to sleep • Hopelessness •Withdrawal, isolation

Determine if factors are modifiable

Non-modifiable Risk Factors

- Family History
- Past history
- Demographics

Modifiable Risk Factors

- Treat psychiatric symptoms
- Increase social support
- Remove access to lethal means

Don’t Neglect Modifiable Protective Factors

- These are often key to addressing long-term or chronic risk
- Sense of responsibility to family
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Enhanced social support
- Positive therapeutic relationships

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Establish Diagnosis and Risk

- Axis I, II, III, and IV all extremely pertinent to informed determination of risk
- In estimating risk, combine all elements:
  - Psychiatric illness
  - Medical illness
  - Acute stressors
  - Risk factors and patient-specific warning signs
  - Protective factors
  - Nature, intensity, frequency of suicidal thoughts, plans, and behaviors
  - Veteran specific considerations (i.e., combat exposure, agent of killing)

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Acute v. Chronic Risk

- These are very different, and each carry there own specific treatment/safety

  A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

- Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk

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Acute v. Chronic Risk

- Acute and chronic risk are dissociable
- Document estimation for each

"Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior."

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Psychiatric Management

- Establish/Maintain therapeutic alliance
  - Taking responsibility for patient's care is not the same as taking responsibility for the patient's life
- Attend to safety and determine treatment setting
  - Level of observation, frequency of sessions
  - Restricting access to means
  - Consider safety needs, optimal treatment setting, and patient's ability to benefit from such

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Develop a Treatment Plan

- For the suicidal patient, particular attention should be paid to modifiable risk and protective factors
- Static risk factors help stratify level of risk, but are typically of little use in treatment; can't change age, gender, or history
- Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc
- Augment protective factors (i.e. enhance sense of belonging)

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VA National Initiatives that Address the Risk of Suicide

- Annual depression and PTSD screens
- Suicide Prevention Coordinators and teams
- Veterans Crisis Line
  - VA Crisis Line (1-800-273-TALK)
  - Online chat (www.veteranscrisisline.net/chat)
  - Text option (838255)
- VA ACE Cards
- Resources for family members
- VA Safety Planning Manual
- Hubs of expertise in suicide prevention (VISNs 2 and 19)

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STAND BY THEM

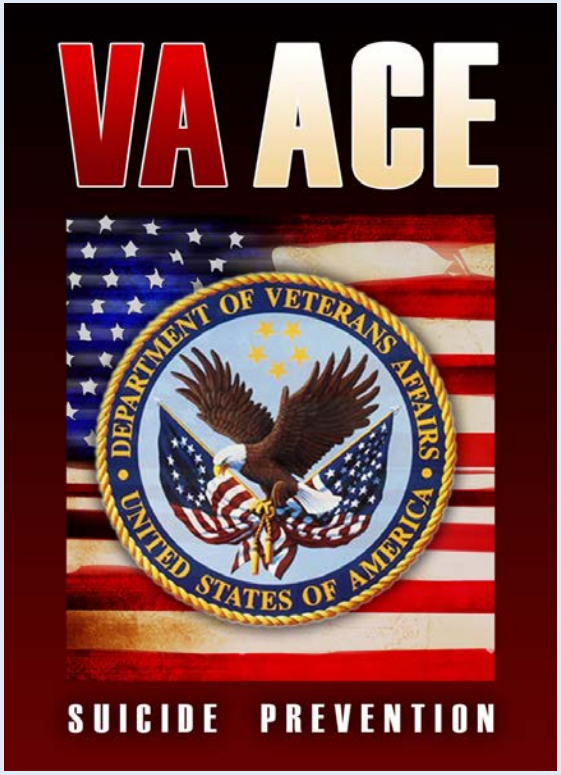
Act Now

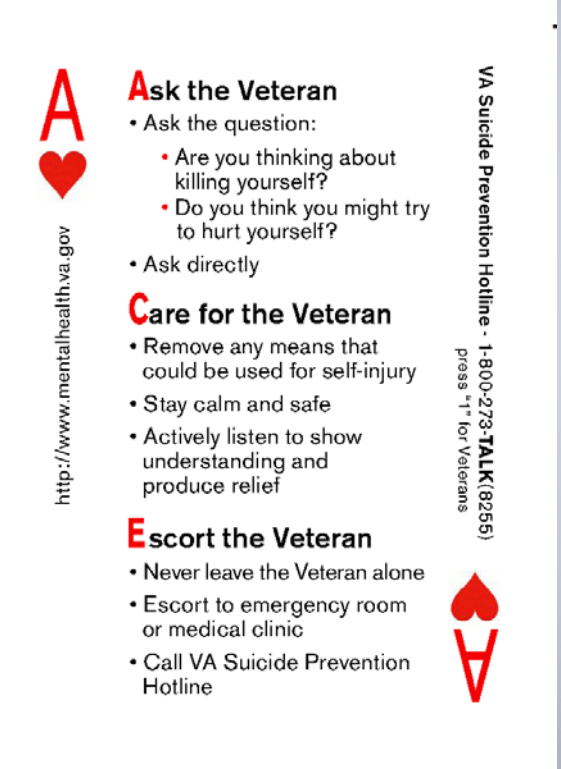
Dial **1-800-273-8255** **PRESS 1**
to talk to someone NOW

- **Confidential Veterans Chat**
- **Text to 838255 to Get Help NOW**
- **Take a Self-Check Quiz**
- **Confidential Homeless Veterans Chat**
- **Support for Deaf and Hard of Hearing**

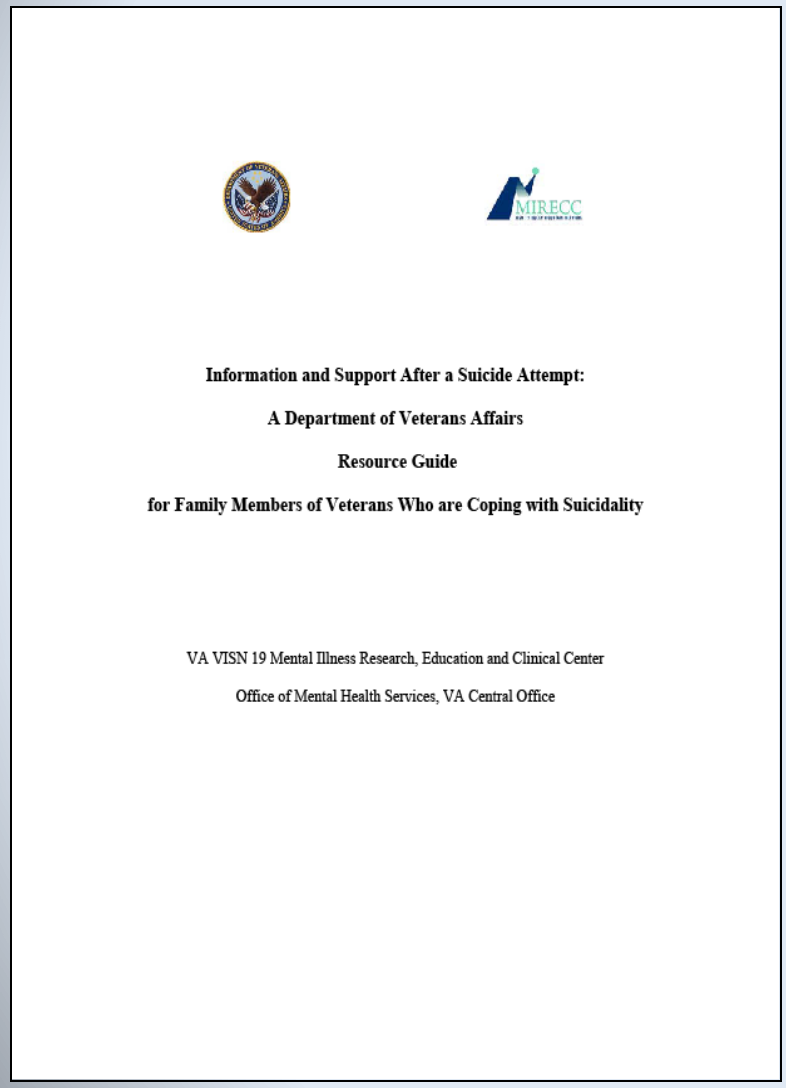
VA ACE Cards

- These are wallet-sized, easily-accessible, and portable tools on which the steps for being an active and valuable participant in suicide prevention are summarized
- The accompanying brochure discusses warning signs of suicide, and provides safety guidelines for each step





Resources for Family Members



Information and Support After a Suicide Attempt:

A Department of Veterans Affairs

Resource Guide

for Family Members of Veterans Who are Coping with Suicidality

VA VISN 19 Mental Illness Research, Education and Clinical Center

Office of Mental Health Services, VA Central Office

"Information and Support After a Suicide Attempt: A Department of Veterans Affairs Resource Guide for Family Members of Veterans Who are Coping with Suicidality"

- This is an online resource that provides sources of information and support to Veterans, their family members, and their care providers.

Resources for Family Members

How to Talk to a 9-13 Year-Old Child about a Suicide Attempt in Your Family

This information sheet is intended to serve as a guide for adults to use when talking with a 9-13 year-old child about a suicide attempt in the family. It is not intended to replace the advice of a mental health professional. In fact, it may be best to use this along with professional support if you or your child is struggling with how to talk about this difficult topic. It is important to consider your child's level of development and ability to understand events when deciding how to talk with them about this issue.

Why should I talk to my child about a suicide attempt in the family?

It is important to talk to your child about the suicide attempt to help them understand what has happened. Without support of friends/family, they may try to make sense of this confusing situation themselves. Sometimes children blame themselves for something they may or may not have done. Children ages 9-13 may not want to talk directly about their worries or feelings. Instead, they may express fears, have trouble sleeping, or become anxious when separated from certain adults.

How should I talk to my child?

- Keep your child's daily routine as consistent and predictable as possible, but be flexible.
- Pick a place that is private where your child will feel free to talk. Be aware of what they may overhear from other conversations.
- Keep it simple. Use words your child will understand and avoid too many details. Ask them questions.
- Be aware of your own feelings and how you are coming across. For example, your child could mistake an angry tone of voice to mean that you are angry with them or with the family member who attempted suicide.
- If your family member is in the hospital, talk to your child as soon as possible. Keep checking in with your child. This will help to send the message that you are open to answering questions over time. Be honest.
- Get other support people involved (friends, clergy). This will benefit you and your child.
- Offer extra support, affection, and attention during this time (hugs, time together).

What do I say to my child?

- Start with their understanding of the situation. *"I want to talk to you about what happened to dad. What do you remember from last night?"*
- Describe what has happened using understandable language. *"Mom was feeling very sad and hurt herself."*
- Inform children about emotional struggles. *"Grandpa has been feeling very sad lately."*
- Address guilt, blame, shame, and responsibility. *"I want you to know that this is not your fault."*
- Assure children that their family member is getting treatment/care. *"Dad is in the hospital getting help."*
- Let them know that their daily routine will stay the same. *"Even though it is different that mom is not here, you will still go to school tomorrow."*
- Encourage them to express their feelings. Help them to know that their reactions are normal and expected. Ask if they have questions. *"I wonder what you are thinking about the things I've told you. Sometimes kids feel like it is their fault, or they did something wrong or that it will happen to them or other adults in their life. Do you feel any of these? Sometimes it is easier to draw or write about feelings than say them. Would you like to draw a picture of your feelings? Do you have any questions about grandpa and what happened?"*
- Help create a connection between the child and their family member. Tell them when they can expect to see their family member again. *"Would you like to draw a picture for or write a letter to dad while he's in the hospital? He will be there for a few days."*
- Allow them not to talk if they desire, and to choose who they talk to. Discuss how your child can share this information with family and friends. *"If you don't want to talk about it now, that's ok. We can talk about it later or you can talk to grandma, too. Would you like to talk about this with your friend Jane? What would you like her to know?"*
- Let them know you are getting support, too. *"This is something that makes me sad and I need to get some help, too (from clergy, friends, and/or my doctor)."*
- Reassure them that you are in charge and in control, and that they can come to you with concerns and questions.
- Consider suggesting a special activity to keep them busy, active, or involved with a familiar project; however, it is important not to encourage ongoing distraction or avoidance of feelings.

Guidelines for talking to children (4-8 years, 9-13 years, 14-18 years) about a family member's suicide attempt

- These guides provide an outline of how and what to say to children about the topic of suicide.

VISN 19 MIRECC Website

http://www.mirecc.va.gov/visn19/

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New Service for VA Providers

Thank you!

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