Understanding the Role of Chaplains in Veteran Suicide Prevention Efforts: A Discussion Paper

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Abstract
In recent years, identifying ways to mitigate the risk of suicidal behavior in Veteran populations has become a major public health challenge of special significance. This has included identifying support options that can be used by Veterans in times of distress or crisis. For example, Veterans at increased risk of suicide will sometimes voice complaints indicative of a need for spiritual and pastoral care support. At U.S. Department of Veterans Affairs Medical Centers, such support is provided to Veterans by clinical chaplains. This discussion paper aims to present the contextual framework in which chaplaincy services are provided to Veterans at increased risk of suicide, better conceptualize the spiritual and pastoral care needs of at-risk Veterans who request chaplaincy services, and offer practical suggestions for framing the provision of spiritual and pastoral care services.

Keywords
spirituality, religion, chaplains, suicide, Veterans

In 2007, the U.S. Department of Veterans Affairs (VA) initiated an intensive effort aimed at reducing suicidal behavior among Veteran populations (Kemp, 2014). At present, the number of Veterans who die by suicide is estimated at 18 to 22 per day, accounting for approximately 18% of all suicide completions in the United States (Centers for Disease Control and Prevention, 2014; Kemp & Bossarte, 2013). These high rates are thought to be due, at least in part, to the increased incidence of diagnosed mental health disorders in this group (LeardMann et al., 2013). Be that as it may, suicide is much more than just a mental health issue (Department of Health and Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention, 2012). Research finds that more than 50% of those who die by suicide do not have a psychiatric diagnosis (Bertolote & Fleischmann, 2002). This highlights the need for novel support options, not limited only to formal mental health services, which can be accessed by at-risk populations.

All VA Medical Centers (VAMCs) staff clinical chaplains who provide spiritual and pastoral care services when requested by the Veteran. Pastoral care is sometimes defined as “a therapeutic modality distinguished by the dialogue of caregiver and careseeker that explores the possibility and implications of a religious definition of the latter’s situation” (Furniss, 1994, p. 177). Spiritual care relates to “an appreciation of presence and purpose that includes a sense of meaning” and is inclusive of pastoral care (VandeCreek & Burton, 2001, p. 2). Most chaplains also provide a number of services not directly affiliated with any faith tradition, such as crisis intervention, emotional enabling, ethical consultation, deliberation, life review, patient advocacy, counseling, bereavement, and empathetic listening (Handzo et al., 2008).

VA chaplains have assumed a unique place within the structure of services provided at VAMCs. As a matter of policy, the comprehensive health package offered to Veterans is expected to include spiritual and pastoral care (i.e., when so requested by the patient; Department of Veterans Affairs, 2008a). Many Veterans will look to

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chaplains for support in times of distress (Besterman-Dahan, Gibbons, Barnett, & Hickling, 2012; Bonner et al., 2013; Iversen et al., 2010; Kirchner, Farmer, Shue, Blevins, & Sullivan, 2011; Kopacz & Karras, 2014; Sullivan, 2007). Considering the broad cross-section of patients who seek health care through VAMCs, most chaplains can also be expected to have contact with Veterans considered to be at increased risk of suicide (Kopacz, 2013). VA chaplains who report such contact estimate that at-risk Veterans account for upward of 10% of their total patient population (Kopacz, McCarten, & Pollitt, in press).

Recent findings in prevalence, risk factor, and intervention studies suggest that Veteran populations exhibit unique health care needs and practices, including unique spiritual and pastoral care needs among at-risk populations (Kopacz, 2013; Rice & Sher, 2012). Yet, examining how to most effectively meet the spiritual and pastoral care needs of at-risk Veterans is without precedent in the literature. Furthermore, a paucity of literature exists describing the potential applicability of chaplaincy services to at-risk Veteran populations. This discussion paper aims to present the contextual framework in which chaplaincy services are provided to Veterans at increased risk of suicide, better conceptualize the spiritual and pastoral care needs of at-risk Veterans who request chaplaincy services, and offer practical suggestions for framing the provision of spiritual and pastoral care services.

As the largest integrated health care system in the United States (Department of Veterans Affairs, 2013b), VA programs reach Veteran populations recognized as being at increased risk of suicide (Blow et al., 2012; McCarthy et al., 2009). The experiences of VA chaplains included in this article are meant to offer a degree of practical insight into at-risk Veteran spiritual and pastoral care needs, which may also serve to better inform the provision of such services in other clinical and community settings.

**A Contextual Framework for Chaplaincy Services**

Available literature and anecdotal evidence suggest that many Veterans ascribe a degree of importance to religion and spirituality (Chang et al., 2012; Goertz et al., 2013; House Committee on Veterans’ Affairs, 2012; LaPierre, 1994; Pew Social and Demographic Trends, 2011). While “religion” and “spirituality” are frequently used interchangeably, these terms actually represent two distinct domains. Religion refers to “the outwards and often social articulation of belief in higher powers, often practiced in a community setting” (p. 345) and spirituality is thought to refer to “an individual’s quest for understanding the true meaning of life and the desire to integrate with the transcendent or sacred” (Jonas, 2005, p. 380). A sense of well-being in either domain implies having achieved “a positive outcome that is meaningful for people and for many sectors of society” (Centers for Disease Control and Prevention, 2013).

Achieving a sense of religious and/or spiritual well-being is of practical significance to suicide prevention efforts as these domains are thought to cut across the various behavioral, physical, psychological, and social factors which might lead one to suicidal behavior (Brown, Carney, Parrish, & Klem, 2013; Koenig, King, & Carson, 2012). Such well-being is considered protective against suicidal behavior (The Assessment and Management of Risk for Suicide Working Group, 2013; Department of Health and Human Services et al., 2012; Simon, 2011; World Health Organization, 2012). Available research suggests that some at-risk Veteran populations have a diminished sense of self-reported spiritual well-being (Kopacz, 2014), highlighting the relevance of these domains to Veteran suicide prevention efforts.

VA chaplaincy services draw on the principles of meaning-making and look to enhance religious and/or spiritual well-being by developing a sense of meaning and purpose in the lives of Veterans (Department of Veterans Affairs, 2008a). VA chaplaincy services are meant to uncover meaning and purpose in one’s relationships with self, others, ideas, nature, and, when relevant for the Veteran, with a higher power, benevolent deity, or God. This is done by examining one’s relationships in the context of their spiritual and/or religious values. Meaning and purpose are considered vital for ensuring a variety of positive physical and psychological health outcomes (Schulenberg, Hutzell, Nassif, & Rogina, 2008; Stillman et al., 2009; Reker, Peacock, & Wong, 1987). As suggested by Frankl (1984), “If therapists wish to foster their patients’ mental health, they should not be afraid to create a sound amount of tension through a reorientation toward the meaning of one’s life” (p. 128).

Chaplains focus on relationships because they are thought to form an intra-, inter-, and trans-relational web that houses a person’s sense of meaning and purpose (Snyder, Lopez, & Pedrotti, 2011). A degree of distress, inclusive of spiritual distress, may arise when one or more of these relationships are threatened or broken. Table 1 presents examples of what many chaplains understand to be indicative of spiritual distress. The more significant a particular relationship is, the greater the spiritual distress. Spiritual wholeness is restored when that which threatens or breaks the patient’s relational web of meaning is removed, transformed, integrated, or transcended.

**Veteran Spiritual Needs**

VA chaplains will oftentimes provide care to at-risk Veterans dealing with spiritual or moral injury arising from past military experiences as well as a variety of life circumstances not necessarily related to military service. These circumstances challenge the Veteran’s existing relationships, forcing him or her to redefine their existing sense of meaning and purpose. Just as the process of human development affords stages of growth, so too does spiritual development afford the opportunity for living a life of integrity in which life experiences


Table 1. Examples of Spiritual Distress.

| Questions about reality | An altered sense of meaning in/of life |
|-------------------------|---------------------------------------|
| Needing reassurance of a benevolent deity or power | Feeling the need to be punished |
| Questioning core faith and spiritual values | Needing acts/rituals of purification |
| Asking “core questions” (e.g., “Why me?” or “Why would God . . .?”) | Questions of personhood (e.g., “Who am I?” or “Who am I in relation to . . .?”) |

reflect a deepening of one’s spiritual development. It is expected that one’s adulthood experiences will instill change and transformation within one’s spiritual journey. The process of transformation reflects these experiences, experiences that are not childhood experiences but, rather, those of an adult. VA chaplains support the Veteran in his or her own search for meaning as well as determination of what these experiences may have contributed to their spiritual journey.

Advances in the organization and delivery of battlefield health care mean that many service personnel are surviving trauma, which would have otherwise proven fatal in combat theaters from earlier eras (Beekley, 2006; Gawande, 2004; Manring, Hawk, Calhoun, & Andersen, 2009). While bodily wounds may heal, this has led to an increase in the number of Veterans dealing with otherwise “invisible wounds.” Individuals with a history of military service in times of war frequently suffer from psychological distress at varying degrees of severity (Gray, Kaiser, Hawksworth, Hall, & Barrett-Connor, 1999). The diagnostic status of Veterans who served following September 11, 2001, may also be significantly influenced by trauma exposure outside of warzone traumatic stress (Dedert et al., 2009; Hankin, Spiro, Miller, & Kazis, 1999). The VA expects that the number of Veterans requiring mental health services will continue to increase in the coming years (Department of Veterans Affairs, 2013a).

The conflicts in Iraq and Afghanistan differ from those of past wars, among others, based on the all-volunteer force as well as the types of warfare conducted in these regions (Hoge et al., 2004). The unique nature of these conflicts—reflective of theater-specific duties and experiences—could influence symptom presentation and treatment (Tuerk, Grubaugh, Hamner, & Foa, 2009). Besides experiencing situations which may pose a threat to the life of the service member or those close to them, the experience of active duty may also include witnessing violence, experiencing a painful loss, or having one’s ethical or moral standards contravened (Nash et al., 2013; Stein et al., 2012).

This has given way to the idea of spiritual or moral injury in Veteran populations, conceptually defined as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p. 700). Moral injury is representative of the challenge of having to reconcile certain wartime experiences with individual interpretations of right and wrong and is purported to increase the risk of suicide in some Veteran populations (Kohlberg, 1973; Litz et al., 2009; Maguen et al., 2012). Interpretations of right and wrong may draw on individual experiences related to religion and/or spirituality. In attempting to deal with different types of trauma, some Veterans might turn to spiritual and pastoral care for support (Greenawalt et al., 2011; Mihaljević, Aukst-Margetić, Vuksan-Ćusa, Kođ, & Milošević, 2012).

Chaplains frequently also encounter at-risk Veterans dealing with a variety of life events (e.g., divorce, illness, relationships), not necessarily related to military service. In keeping with pastoral practice, VA chaplains help the Veteran uncover a religious and/or spiritual definition in the difficult circumstances they may be experiencing. In doing so, the aim is to elicit an enhanced sense of meaning and purpose in the life of the Veteran which can be used to better deal with turbulent emotions (e.g., loss and grief, hope and despair, joy and sadness) arising in the course of these life events as well as help reaffirm the Veteran’s understanding of self/personhood.

Emotions frequently encountered in these life circumstances include guilt, sadness, and grief (Berg, 2011; Owens, Steger, Whitesell, & Herrera, 2009; Urić & Šimunić, 2009). Guilt is conceptualized as a sense of remorse, regret, or self-condemnation, most often linked to a concrete event (Bryan, Ray-Sannerud, Morrow, & Etienne, 2013; Henning & Frueh, 1997; Marx et al., 2010). In Veteran populations, thoughts of self-harm (i.e., suicide ideation) may serve as an expression of remorse for past actions (Bryan, Morrow, Etienne, & Ray-Sannerud, 2013; Singer, 2004). Conceptually, crisis situations may arise if a Veteran is unable to express his or her guilt in a healthy manner or if he or she rejects social support, leading to feelings of helplessness and isolation (Singer, 2004; Wellen, 2010).

Sadness and grief are emotional reactions to loss that are typically time-limited (Wellen, 2010). For some Veterans, grief-specific symptoms are distinct from symptoms related to war trauma (Pivar & Field, 2004). Nevertheless, if not dealt with in a manner appropriate for the individual, grief can become pathological or chronic, adding to one’s emotional burden (Aloi, 2011; Gort, 1984). To date, however, only a small body of literature has directly examined the relationship between Veteran experiences of grief and different health outcomes.

The Spiritual Dimension of Suicide

Religion and suicide have been inextricably linked ever since Durkheim’s (1897/1997) seminal study. Consequently, most clinicians see religion and spirituality as important to understanding suicidal behavior (Colucci & Martin, 2008). While an extensive literature exists expounding on the many
biological, social, and environmental factors increasing one’s risk of suicide, a paucity of empirical literature exists describing the religious and/or spiritual risk factors for suicide (Sanchez, 2007). Religion and spirituality serve as examples of “common, culturally generated personal traits, social relationships, lifestyles, representations of illness and treatments, and/or approaches to planning for prevention and management of illness and illness risks” (Leventhal, Weinman, Leventhal, & Phillips, 2008, p. 492). As such, better understanding the relationship between religion, spirituality, and suicidal behavior should remain a focus of future research.

Engel (1977) proposed a biopsychosocial model of medicine to serve as a conceptual basis for applying the scientific method to better understand health and illness. This model posits that health and illness are dependent upon an interaction between biological, psychological, and social systems (Engel, 1980). Spirituality is thought to fall under the social domain of this model (Smith, 2002). Accordingly, an enhanced sense of religious and/or spiritual well-being may exact health benefits across all three of these systems (Schaefer et al., 2013). For example, individuals who ascribe a high degree of importance to religion and spirituality may be more resilient against depression due to anatomical changes in their central nervous system (Miller et al., 2014). Meaning and purpose have also consistently been cited as influencing psychological well-being (Błazek, Kaźmierczak, & Besta, 2014; Schütte et al., 2014). Finally, positive social relationships, such as those leading to higher social support, less loneliness, and less conflict, can be built by applying interpersonal constructs frequently associated with spiritual and religious tenets, such as gratitude and compassion (Jordan, Masters, Hooker, Ruiz, & Smith, 2014).

Chaplaincy Services Applied

Frankl (1984) suggests uncovering meaning and purpose “(1) by creating a work or doing a deed; (2) by experiencing something or encountering someone; and (3) by the attitude we take toward unavoidable suffering” (p. 133). In the same vein, VA chaplains are able to offer spiritual and pastoral care services aimed at uncovering meaning and purpose in the life of the at-risk Veteran. All such services are provided on a strictly voluntary basis (i.e., based entirely on the private choice of the patient; Department of Veterans Affairs, 2008b). The work done by chaplains typically involves first meeting with the Veteran, assessing their religious and/or spiritual needs, and proposing a pastoral care plan that can be adapted based on the Veteran’s changing needs. VA chaplaincy services do not include a religious component unless expressly requested by the patient (Department of Veterans Affairs, 2008b). Patients are at liberty to discontinue any or all services, at any time, and for any reason.

Ministry of Presence

The Ministry of Presence serves to facilitate spiritual healing. “Ministry of presence in the pastoral office means vulnerability to and participation in the life-world of those served” (Hunter, 1990, p. 950). In simple terms, it describes the physical presence of a chaplain and their willingness to meet without preconditions (W. F. Sullivan, 2014). The primary goal of the Ministry of Presence is to reestablish a sense of trust, safety, and consistency for the at-risk Veteran. Chaplains frequently see those who experience spiritual distress as also losing a sense of hope in establishing meaningful relationships. Having felt abandon, such Veterans may also have issues with trust and safety. Ministry of Presence is meant to establish rapport with the individual, leading to a relationship based on consistency. In the context of clinical chaplaincy, this involves following the patient’s treatment agenda and, when appropriate, being pro-active in his or her provision of spiritual care (e.g., offering support after hearing a diagnosis; being consistent and following through with promises made; Fontana & Rosenheck, 2004, 2005; Hughes & Handzo, 2010; Shaw, Joseph, & Linley, 2005).

Trauma Recovery

The search for meaning motivates many Veterans to look for support from pastoral care providers and VA mental health professionals (Fontana & Rosenheck, 2005; Hughes & Handzo, 2010). Those presenting for VA chaplaincy services oftentimes look for the restoration of meaning specifically related to their trauma, which may “refer both to the negative events that produce distress and to the distress itself” (Briere & Scott, 2006, p. 3). VA chaplains frequently help Veterans diagnosed with posttraumatic stress disorder (PTSD) or those dealing with different types of trauma. A diagnosis of PTSD has been significantly associated with suicidal behavior (Sareen, Houlahan, Cox, & Asmundson, 2005).

Hughes and Handzo (2010) suggest,

as the person with PTSD is seeking to reframe his or her assumptions that were held prior to the trauma to accommodate the experience of that trauma, so grief is about redefining one’s understanding of the world, oneself, and others. (p. 56)

Chaplains assist individuals with PTSD to work through their grief by identifying specific losses, providing a safe place to grieve, providing grief education to normalize emotional responses, and identifying coping strategies (Hughes & Handzo, 2010). Fontana and Rosenheck (2005) conclude that greater consideration should be given to addressing existential questions in the treatment of PTSD, stating “that resolution of existential questions requires an examination of the bases for moral judgments” (p. 135). VA chaplains help facilitate an examination of morality in the context of the Veteran’s own religious and/or spiritual background.
Hughes and Handzo (2010) also propose eight specific spiritual care interventions for those dealing with PTSD: clinical use of prayer, healing rituals, confession (i.e., as a means for guilt resolution and forgiveness work), percentage of guilt distribution, life review/spiritual autobiography work, scripture paralleling/education, reframing God assumptions/examining harmful spiritual attributions, and encouraging connection with a spiritual community. Prayer has been widely utilized as a coping strategy in clinical settings (R. M. Brown & Niebuhr, 1987; Foster, 1992). Healing rituals can also help one find a renewed sense of meaning (Fontana & Rosenheck, 2005; Hughes & Handzo, 2010). Confession helps with the release of feelings of guilt and refocuses the individual on healing through the seeking and giving of forgiveness and pardon (Drescher, Smith, & Foy, 2007; Grossman, 1996). Discussing the percentage of guilt distribution helps one reappraise and reframe his or her feelings of guilt by differentiating appropriate from inappropriate guilt. This facilitates a greater ease in dealing with and ultimately resolving guilt (Scurfield, 2006).

**Life Review**

Life review is defined as “the process of facilitation of the life review experience or mental process of reviewing one’s life” (Butler, 1963, p. 66). Life review enables one to narrate his or her spiritual autobiography. In doing so, one can rediscover insights, strengths, themes, and so on, and possibly find resonance with his or her current situation following traumatic stress (Fowler, 1995, 2001). Such integration of experiences and understanding facilitates a deeper sense of meaning-making. With scripture parallel, one finds scripture passages that resonate with or parallel his or her own experiences. This is expected to facilitate meaning, hope, and healing (Hughes & Handzo, 2010; Landau, Mittal, & Wieling, 2008). By reframing God assumptions, one reexamines their own assumptions about God and God’s character. This includes reframing harmful spiritual attributions that may contribute to spiritual distress (Harris et al., 2008; Shaw et al., 2005). Finally, a chaplain can encourage connection with a spiritual community. This is expected to facilitate healing through connection with a healthy supportive community (Hautamäki & Coleman, 2001; Walsh, 2007).

**Other Services**

Mantra repetition is considered a spiritual care specialty intervention (Hughes & Handzo, 2010). A mantra represents a word, thought, or sensation—of religious or spiritual significance or with no particular meaning—repeated by the individual (Chan, 2014). A spiritual care provider can utilize mantra repetition as a way to focus the patient’s attention and to bring clarity of the mind. Such an intervention can be particularly helpful with intrusive recollection, avoidance/numbing, and hyper-vigilance (Bormann et al., 2005). Creative writing is another specialty intervention for spiritual care providers (Hughes & Handzo, 2010). Through this intervention, at-risk individuals can discover insights, process grief, and loss, and get in touch with difficult emotions. Moreover, such interventions afford the opportunity to integrate life experiences over time into a deeper understanding of self and relationship to one’s environment. The spiritual care provider can facilitate a process in which the patient creatively expresses his or her feelings about the trauma, describing how it has affected his or her life. This may also include exploration of the Veteran’s feelings in the context of religious and/or spiritual distress (Knaevelsrud & Maercker, 2007).

**From Theory to Practice**

There are certain common threads which link at-risk Veterans who engage in chaplaincy services. VA chaplains note that many at-risk Veterans report a history of abuse prior to their time in the military. This would include emotional/psychological, physical, or sexual abuse, or frequently a combination of all three. Oftentimes, the Veteran’s family of origin was also dysfunctional.

This climate is thought to give way to a degree of negative affect, including feelings of vulnerability, fear, self-image issues, and an inability to trust. The Veteran’s emotional response to their circumstances typically includes anger, shame/blame, or guilt. They adapt to this climate by developing several protective responses. What emerges is an inability to be vulnerable after so many years of having one’s vulnerability violated. Chaplains observe that such individuals will actively seek out and pursue control whenever stressed or placed in a trying situation. Security and protection are gained through manipulation. Many of these Veterans will then begin to contemplate suicidal behavior after finding themselves in circumstances devoid of the possibility of control, security, and/or protection.

A typical case will involve a VA chaplain responding to a request for services made by a patient in a locked-down psychiatric ward. The patient will most likely have a long history of suicide ideation, usually with at least one suicide attempt. As related to his or her experiences of religion and/or spirituality, the patient will typically profess anger with and confusion about God, feelings of rejection by God, and ambivalence toward life and living. They have skeptically searched for some form of meaning in their lives and perhaps tried to establish some type of relationship with a higher power. The end result is that the idea of a loving God, who is all-powerful, does not make sense to them. Either God does not love him or her, or God is not all-powerful. Some will move toward an atheistic or agnostic worldview as a means of lessening their religious and/or spiritual pain.

An addictive cycle might develop as other coping skills diminish and fail to provide relief. However, this cycle fails to restore the sense of meaning and purpose that they seek
(Allen, Nieuwsma, Pollitt, & Blazer, 2014). For some, their failed search for meaning and purpose proves intolerable, even more so than before their addictive disorder began. At this stage, many patients will report contemplating suicidal behavior.

In collaboration with other clinical mental health providers, VA chaplains help the patient rediscover the meaning and purpose otherwise missing in his or her lives. A newfound sense of religious and/or spiritual well-being, based on a renewed sense of meaning and purpose, may help the at-risk Veteran to better deal with his or her difficult circumstances (Baumeister, 1990). Select outcomes for spiritual and pastoral care include increased self-acceptance, better connecting with others, and, when appropriate for the Veteran, reestablishing a relationship with a higher power, benevolent deity, or God.

**Conclusion**

The aim of this discussion paper was to provide practical insight into the spiritual and pastoral care needs of Veterans at increased risk of suicide and present the framework in which VA chaplains attempt to address those needs. As research examining the different correlates of suicidal behavior among Veteran populations continues to develop, increasing attention will most likely be drawn to the spiritual and pastoral care needs of at-risk Veterans. Clinical chaplains represent a professional group qualified to address these needs in health care settings.

Making chaplaincy services the focus of empirical research would invariably help provide an evidence base for applying these services to at-risk populations. At present, spiritual care constitutes a complementary and alternative medicine modality (Barrett et al., 2003). However, no studies or clinical trials have taken place to assess the clinical usefulness or applicability of spiritual care as part of suicide prevention efforts. Of note is that chaplaincy services are rarely provided as a stand-alone service, but rather as part of an interdisciplinary team. Most individuals who seek pastoral care support will also access clinical providers specially trained to formally diagnose and treat mental health disorders (Schindler, Berren, Hannah, Beigel, & Santiago, 1987).

Health care professionals are becoming increasingly mindful of religious sensitivities among their patients, the salutary benefits associated with religion and spirituality, that most Americans and clinicians hold some type of religious beliefs, and the influence of such beliefs on the lives of those who espouse them (Budd, 1999). As these professional groups look to be more attentive to the needs of the at-risk Veterans under their care, they should remain mindful that some of the complaints voiced by at-risk Veterans may be indicative of a need for religious and/or spiritual support (Kopacz, Silver, & Bossarte, 2014). To this end, in collaboration with other health care providers, clinical chaplains are able to offer an added degree of support to at-risk Veterans in times of distress and crisis.

**Authors’ Note**

The findings, conclusions, and opinions expressed in this work are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs nor should they be construed as the official position of the U.S. Government.

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