

Cognitive Behavior Therapy: A Potential Treatment for Depression among Asian Indian Immigrant Women in the United States

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The changing demographic profile of populations in the United States creates dilemmas and challenges for social work practitioners to provide culturally appropriate mental health services. Previous research on mental health of ethnic minorities suggests that acculturative stress and differential migration experiences account for symptoms of depression, a major public health issue among Asian Indian immigrant women (AIIW). Practice interventions suggest that cognitive behavior therapy is beneficial in treating depression among minority populations. Limited information exists if the AIIW benefit from this treatment. Based on the review of pertinent literature, the authors argue that cognitive behavior therapy combined with other therapeutic approaches can be helpful to treat depression among AIIW. Multicultural training for social workers can also improve cultural competence and help tailor the therapeutic process according to the individual needs.

KEYWORDS *Asian Indian, depression, cognitive behavior therapy, women*

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BACKGROUND

Asian populations alone in the United States account for 4.8% of the population (U.S. Census, 2010). This population increased by 43 % between 2000 and 2010 (U.S. Census, 2010). Ethnic minorities for the most part have been left behind in recent initiatives to develop an evidence-based platform. Treating mood disorders of AIIW including depression is less likely to receive comparable services and quality outcomes with their White counterparts (McGuire & Miranda, 2008; New York City Department of Health and Mental Hygiene [NYC], 2005; U.S. Department of Health and Human Services [USDHHS], 2001). This critical lacuna in our knowledge along with our under-preparedness to effectively treat ethnic minorities suffering from mental illnesses leaves certain vulnerable ethnic minorities at greater risk of ongoing mental disorders and accompanying disruption in their productive lives (Hwang & Wood, 2007).

Multiple organizations, however, have discussed the needs of minority group members within both mental health treatment and research (NYC, 2005; American Psychological Association [APA], 2003; USDHHS, 2001). Efforts are underway to consider a number of unique cultural factors, including individual immigration history, generational status, language proficiency, level of ethnic identity, acculturation, and cultural orientation for specific ethnic populations (Hwang, 2006; Bedoya & Safren, 2009). This paper will concentrate on the Asian Indian immigrant population in particular.

India is the third largest country of origin within the Asian minority group. The number of Asian Indians will continue to increase more than 2 million by the year 2050 (U.S. Census, 2004; Farver, Narang, & Bhadha, 2002). The impact of migration can pose significant pressures associated with depression as immigrants experience identity crises, isolation from their cultures of origin, and difficulties in psychological adjustments in the host country (Bhugra, 2003; Conrad & Pacquiao, 2005; Inman, Howard, Beumant, & Walker, 2007). With the growing immigrant populations, practitioners should give increased attention to the problems such as depression, which is migration-specific.

The clinical manifestations of depression are universal among all populations, but the origins of depressive symptoms may vary cross-culturally (Kokanovic et al., 2009). Stress associated with cultural change and assimilation into majority culture may also have differential impact on Asian Indian immigrant women (AIIW). Depression among AIIW is often contextualized within the framework of individual's cultural beliefs, acculturative pressures, background, language, education, financial situation, and the family structure (Conrad & Pacquiao, 2005). The AIIW may experience loneliness and stress due to lack of family and kin network, opposing cultural worldviews, conflicting child rearing practices, and pressures of assimilation (Tewary, 2005).

Though the National Institutes of health mandates including ethnic minorities in all federally funded studies, research on their mental health and effective treatment modality is limited. Challenges in conducting research with AIIW may arise due to lack of standardized instruments, cost of translation, and difficulties in conceptualizing the definition of depression (Kokanovic et al., 2009). Findings from the previous works on ethnic minorities are difficult to generalize to all AIIW due to variability in the conceptualization of acculturation and one-dimensional definition of mental health and depression (Kumar & Nevid, 2010; Mehta, 1998). Variable sample size, cultural background, language, age, and education levels are other demographic factors that limit the generalizations of the existing literature (Kumar & Nevid, 2010; Mehta, 1998).

Guided by the limited number of studies, practitioners often experience challenges while formulating treatment plans for AIIW (Conrad & Pacquiao, 2005). This paper will specifically examine depression associated with migration experiences among first-generation AIIW. The review will provide helpful information about the existing conventional and popular treatment approaches for depression including applicability of behavior therapy (BT) among AIIW. Finally, the implications for practice and research needs are discussed.

MIGRATION EXPERIENCES OF AIIW

The impact of migration among immigrants differs and in some cases increases the biological, psychological, and sociological vulnerability towards depression (Bhugra, 2003). Immigrants may leave their country due to multiple social, political, and economic factors, and understanding depression among AIIW is beyond one theoretical framework. Specifically, AIIW migrate due to job opportunities, higher standards of living, better working conditions, and education opportunities. Migration may also be a reason to reunite with families and join the extended network for economic and social support. AIIW may also migrate as dependents on their spouses to maintain marriage and family (Conrad & Pacquiao, 2005). Considering differential purposes for migration, a holistic perspective integrating, multiple psychosocial factors can be helpful to understand the stress associated with migration experiences (Ying, Ivey, & Kramer, 1999).

DEPRESSION AMONG AIIW: POSSIBLE EXPLANATIONS

The biological theories argue that depression is either a disease or a physical defect in the brain or body (Schwartz, 1999). A review of family, twin, and adoption studies explains that depression is hereditary and can be

easily transmitted in families (Sullivan, Neale, & Kendler, 2000). Although the family, twin, and adoption studies provide relevant information to understand the genetics of depression, they do not account for the environmental factors that increase the risk for depression among the AIIW (Sullivan et al., 2000).

The psychological approaches for understanding depression initially originated from Sigmund Freud's psychoanalytical model in the 1920s. Freud emphasized that events during childhood can affect adult functioning. In the latter half of the twentieth century, behavior modification emphasizing behavior deficits and cognitive behavior approaches provided broader perspective on abnormality. Behavior deficit, a symptom of emotional disorder, arises if the behavior of an individual does not meet the society's norm (Bandura, 1969). These deficits become apparent once the minimum standards of competence are varied in any situation and can lead to depressed behavior. For AIIW, depression can be a result of behavior deficit resulting from inability to balance conflicting family hierarchy, gender, roles, and high academic standards in the dominant culture (Conrad & Pacquiao, 2005). Experiences of migration, loss of family, social support, barriers to communication, and difficulties in changing value and belief system can also lower self-esteem among AIIW and may further account for depression (Srinivasan, 2001).

Cognitive theories propose that depression is a product of irrational thoughts. Thoughts are based on one's values and belief systems and may vary based on education, religion, cultural occupation, upbringing, socio-economic status, age, gender, and the like (Dattilio & Bahudur, 2005). The cognitive schema of AIIW is constructed based on values and belief system embedded in their collectivistic cultural orientation. Cultural conflict due to constant struggle in maintaining a balance between the dominant individualistic culture and the parent collectivistic culture can induce stress, create distorted thought processes, trigger irrational thoughts, impact the decision-making abilities, and cause severe depressive symptoms among this minority population (Dattilio & Bahudur, 2004).

Acculturation theory explains that depressive symptoms can trigger if immigrants of a minority culture are unable to adapt in the majority culture (Berry, Kim, & Boski, 1988). Bicultural socialization or adapting selectively to both host culture and parent culture results in less acculturative stress and anxiety (Berry et al., 1988). Many AIIW may totally acculturate in the majority culture, but some women may not give up their cultural identity and experience pressures to assimilate (Tewary, 2005). Others may be a carrier of cultural tradition and experience difficulties in changing their belief and value system. Cultural conflict may induce emotional stress that can have multiple implications such as acceptance of the majority culture, rejection of the same, or adopting and maintaining both cultures at the same time that are essential for development of self-esteem and identity (Berry, Kim, Minde, & Mok, 1987).

Understanding psychological stressors associated with cultural changes is important as they may affect the mental health of AIIW (Peterson, 1999; Mehta, 1998). In one study, narratives of AIIW explained the ambivalence they experienced in the process of creating a physical and psychological home in the host country (Poulsen, Karuppaswamy, & Natrajan, 2005). Findings also suggest that the AIIW felt insecure and unsafe in the country of immigration. Voluntary immigration, level of control over one's decisions, day to day social network, and level of emotional investment in the host country are other attributes that can be associated with acculturative stress and mental health issues (Poulsen, Karuppaswamy, & Natrajan, 2005).

A review of the structural strain theory that originated in the 1930s suggests that depression is a sociological phenomenon (Thoits, 1999). Structural strain theory explains that the origin of stress and disorder is in the broader organization of the society, where some social groups are more disadvantaged than others. AIIW may experience discrimination and challenges in the immigrant country. Even though college-educated, some AIIW may be financially dependent due to restrictive work laws in the United States (Tewary, 2005). Immigration laws may also restrict entry of friends and families that can provide support to AIIW during stressful events, including pregnancy. AIIW often report postpartum depression and encounter difficulties in pregnancy and child rearing due to limited social support (Goyal, Murphy, & Cohen, 2005; Conrad & Pacquiao, 2005; Fisher, Bowman, & Thomas, 2003; Schumacher, 2001).

Micro-issues such as marital discord, relationship problems, and family responsibility and structural issues including poverty, racism, and migration experiences can contribute to depression among AIIW. As depression among the AIIW is multifactorial, the treatment approach requires a comprehensive evaluation of biological, psychological, and structural stressors associated with migration experiences (Peterson, 1999; Khanna, McDowell, Perumbilly, & Titus, 2009).

Treatments for Depression

Treatment perspectives for depression may also vary among the AIIW. In one study with AIIW, findings discussed that some AIIW women interpret mental illness as a personal problem that can be treated with family support and traditional Indian medicine; whereas others view it as a hereditary problem that requires psychiatric evaluation (Suthahar & Elliot, 2004). Practitioners often discuss their challenges while working with Asian Indians as clients are ashamed of discussing their depressed behaviors (Conrad & Pacquiao, 2005).

Conventional therapeutic treatments for depression include pharmacological treatment, electroconvulsive therapy, and psychotherapy. Although medication and shock therapy are helpful in treating depression, a combina-

tion of drugs and psychotherapy can help improve the treatment outcomes and reduce the side effects of long-term medication use (Baldauf, 2009).

Psychotherapy such as behavior modification focuses on the environmental approaches triggering depressive symptoms. The development of the behavior theory from identifying fault in the individual to an awareness of the systemic forces makes it appropriate for treating depression among ethnic minorities. Modeling based on principles of social learning helps treating behavior deficits and improves behavior responses to meet social, marital, and vocational tasks. Programs such as assertion training, self-control, problem-solving training, and marital skills training are specific interventions in reducing depression (Hollon, 1981).

Newer treatments for depression such as behavior activation aim at understanding the functional aspects of behavior (Hopko, Lejuez, Ruggiero, & Eifert, 2003). Models of behavior activation are also used in cognitive therapy for purposes of behavioral change. These models do not aim at interpretation of beliefs and values that are integral part of AIIW (Hollon, 2001).

Cognitive Behavior Therapy: Past and Present

The idea of cognitive development was initially originated in the 1970s (Beck, 1970, 1976). Cognitive behavior therapy (CBT) is widely used for treating depression among women. Cognitive therapy is identified as a short-term, problem-oriented therapy that focuses on both behavioral and cognitive change as main strategies for alleviating distress and improving the coping capacity of a patient (Beck, 1970). Cognitions can lead to setting unrealistic standards for the future that are difficult to meet (Bandura, 1969). The high standards set by an individual can lead to few successes, which will further result in limited positive reinforcements. Limited positive reinforcement may lead to cognitive and emotional loss resulting in depression. During the 1960s and 1970s, various clinicians validated the importance of cognitions in the interventions (Vera, Vila, & Alegria, 2003). Beck (1970, 1976), Dobson and Shaw (1995), and Bandura (1969) are a few of the important people in the field of cognitive behavior, and their works have described the importance of cognitions in understanding and treating depression.

Beck's work is considered important in the initial development of CBT. His work drew ideas from Albert Ellis's rational emotive therapy (RET). Ellis explained that cognitive constructs such as irrational beliefs and negative thinking are the basis of psychological disturbance. The main theme that RET advocated is that change could be attained only if the irrational beliefs responsible for depression can be modified (Ellis).

Another pioneer in cognitive behavior development, Dobson and Shaw (1995), explained that cognitive therapy is based in a "diathesis-stress" (p. 161) conceptualization. The concept behind this framework is that the

patient who suffers from an emotional disorder has some dysfunctional, self-defeating cognitive structures that trigger distorted thoughts in certain situations. Theoretically, CBT involves making patients aware of their biased perceptions and distorted thoughts and helping them to cope with the problems more realistically (Dobson & Shaw).

From a treatment perspective, CBT is extensively used to treat depression among women. In a review of 12 different studies, CBT helped in treating depression and improving social functioning among ethnic minorities (Voss Horrell, 2008). Effectiveness of CBT treatment for depression among minority clients including Hispanics and African Americans is also encouraging (Green et al., 2006; Miranda et al., 2003; Revicki et al., 2005). Even though CBT is mainly a European American therapy, it can be modified as a useful tool for practitioners who work with AIIW.

In psychotherapy in general, it is important to consider the saliency of issues pertinent to a subgroup when conceptualizing a case for both ethnic and racial minority groups. Practitioners of cognitive-behavioral CBT are often called on to adapt interventions for use with their diverse clients, yet few tools and limited resources are currently available to guide what steps are needed to culturally adapt interventions (Hays & Iwamasa, 2006). As the U.S. population continues to increase in diversity (U.S. Census Bureau, 2006), the field of CBT would benefit from clinical research and practice that better understands what aspects of CBT are appropriate for use with specific minority groups.

Cognitive Behavior Therapy: Strengths

For AIIW, depression can be a product of systemic forces affecting individual development. Coping mechanisms and expression of emotions may also vary depending upon the intensity, beliefs, and significant life events within the framework of cultural values of this population. AIIW cope with situations better when they can fulfill their responsibilities toward husband and children (Anand & Cochrane, 2005; Hussain & Cochrane, 2003). CBT working on a constructivist model helps explore the subjective framework and interpretations of a client rather than the objective foundation of faulty beliefs (Corey, 1996). The reality presented by the client is accepted without any questioning whether it is rational or is not. Examining these beliefs also helps in developing specific interventions and exploring helpful coping strategies.

With regard to therapy, AIIW can benefit from a directive style of therapy. This approach is more suited as AIIW are comfortable with hierarchical authorities (Khanna et al., 2009). AIIW will expect the therapist to do something concrete and visible instead of listening passively to their issues. CBT, being direct and action-oriented, offers this opportunity through

the relaxation training and visual-auditory feedback aspect of biofeedback (Casas, 1995).

Cognitive Behavior Therapy: Limitations

Although CBT offers a promising path for treating AIIW, some limitations may act as barriers in maximizing the treatment outcomes of AIIW. During the therapy sessions, the therapist forms the model of care, and the client is supposed to accept the external narrative of the therapist. There is an expectation that the individual should change his or her views of reality (Corey, 1996). Sometimes, the emphasis is on individual change, ignoring the systemic issues. For instance, in treating depression among AIIW, there is an expectation that clients may totally acculturate and assimilate in the American system, thereby suspending their beliefs and attitudes for adaptation in the American society. The therapist may also overlook the values of the AIIW such as the construction of self. For AIIW, self is constructed on the basis of healthy marital and family relationships, obedient children, and support of the extended family. AIIW hardly think of their personal needs. Self-satisfaction is more in terms of fulfilling family roles and responsibilities.

The theoretical construct of CBT describes that individuals have the ability to control their thoughts and emotions (Vera et al., 2003). The ability of controlling thoughts and emotions and skills of coping may differ in the case of ethnic minorities. Ethnic minorities may suffer discrimination and develop a cognitive set such as external locus of control or external locus of responsibility and learned helplessness. It is difficult for these individuals to develop coping mechanisms and acquire the psychological and sociological skills to overcome depression (Casas, 1988). Variable skills and unreasonable coping mechanisms to deal with discrimination and conflict might cause depression and at the same time deter the treatment process for AIIW. AIIW who are affected by any event of discrimination cannot be expected to simply develop self-control or coping mechanisms to overcome depressed feelings. Heavy counselor-controlled procedure is recommended in such situations (Casas, 1988). AIIW might be passive and reluctant to participate in the initial part of the therapeutic relationship, because they may view the therapist as a part of the system that has caused their misery.

Case conceptualization for AIIW in CBT may also take longer time as the bulk of the session focus is on accepting the disorder rather than the treatment. CBT is a short-term treatment. On average, a client receives 16 sessions (National Association of Cognitive Behavior Therapists [NACBT], 2007). Long-term follow-up sessions, although desired, may not be possible due to administrative or financial reasons on part of the client, and this may affect the desired measurement of the treatment. Other limitations include minimal emphasis on gender, race, and class issues during case conceptualization, an important relationship building session in the therapy (Casas, 1995).

In brief, psychotherapy such as CBT holds a valuable option for treatment of depression among AIIW, as many of the symptoms of depression may originate from inability to cope with immigration and culture conflict. However, there is limited knowledge about the treatment outcomes associated with CBT for specific ethnic/racial groups suffering from depression. Applicability of CBT to treat one subgroup may also not be effective for another group. Practitioners argue for modification, flexibility, and creativity in the CBT process while working with the ethnic minorities (Dattilio & Bahudur, 2005; Hays, 1995; Voss Horrell, 2008; Valdez, 2000).

IMPLICATIONS FOR PRACTICE

A review of the therapeutic literature suggests that CBT is helpful in examining depression from a micro-perspective at individual and family levels. CBT is also helpful in accounting for stressors associated with cultural conflicts. However, principals of CBT do not account for the impact of macro-factors such as poverty, racism, oppression, and class issues that can increase family stress and contribute to depression among AIIW. An integrated treatment approach including a combination of psychosocial interventions can help formulate treatment goals for treatment of depression among AIIW (Khanna et al., 2009). Several such theoretical approaches can be incorporated into overall CBT strategies for treating depression in AIIW. Each of these identifies clients' cognitive framework of perceiving themselves in an ecological systems context. Values, beliefs, and perceptions can then be reframed as per CBT.

Narrative therapy can help AIIW narrate their stories of immigration and intergenerational experiences (Tewari, Inman, & Sandhu, 2003). Through narrative stories, therapists can understand the connections among AIIW acculturative experiences associated with depression within the cultural, political, social, and economic framework (Poulsen et al., 2005). Solution focus therapy can help empower AIIW in understanding their personal strengths to overcome discriminatory anti-oppressive behavior.

As family is an integral part of the AIIW's developmental cycle, social work practitioners should involve family in the therapy either individually or with the client to understand family patterns with respect to generational differences regarding religion, culture, language, and parenting styles (Khanna et al., 2009). This will help in understanding the family structure and a client's position in the family. Involving family members in the therapy will also help explore client's beliefs and reinterpretations of significant life events within the framework of cultural values and paradigm of this population.

Social work practitioners should also value AIIW's perception of self, which is developed around the family. This perception of self often conflicts

with the Western concept of individualized self. Understanding perception of self is important as conflict in self-development can affect the psychological well-being of an individual and lead to depression (Furnham & Malik, 1994). Skill training can empower AIIW. The focus should be to address prejudiced and illogical beliefs and to challenge the dominant cultural assumptions and institutions rather than accepting them. Culture-specific strengths, coping strategies, and emphasis on religious and spiritual growth should be discussed as understood by a client. Cognitive behavior analysis of coping can help in understanding how social arrangements such as poverty, racism, discrimination, and the like deter or promote women's thought process and their coping efforts subsequently (Berlin, 1983).

While working with AIIW with depression, social work practitioners can offer assertiveness training for improved treatment outcomes. Assertiveness may not be valued among AIIW, a culture-specific issue; however, not being assertive could also affect communication and expression of emotions that can trigger irrational thoughts (Dattilio & Bahudur, 2005; Hays, 1995). In situations where AIIW are hesitant to accept assertiveness training as it conflicts with their values, beliefs, and tradition, a social work practitioner's goal should be empowerment discussed within the comfort zone of the client. Self-determination would allow clients to analyze and determine when to be assertive.

Developing cultural competence while working with minorities can help develop intimate understanding of client beliefs and values in the mix of treatment choices. One difficulty in illustrating cultural competence in clinical research and practice is that decisions and the decision-making process of ensuring cultural competence are often left unspoken (Rogler, 1989). The first step in any therapy can start with a conceptual framework. Much as one uses a treatment theory (e.g., CBT) to guide assessment, case conceptualization, and therapeutic strategies, there are several general frameworks supported by the best available research that can help clinicians adopt a culturally sensitive perspective (Bedoya & Safren, 2009).

Social workers who treat clients from diverse backgrounds often encounter the problem of how to best understand a client and his or her problems. Specifically, how does one understand whether the client's behaviors and problems originate from individual traits or cultural characteristics? *Dynamic sizing* or the skill of knowing when to generalize and when to flexibly individualize treatments based on the client's characteristics is an important skill to learn if practitioners are to prevent rigid overgeneralizations and increase their cultural competence (Sue, 1998). Similar to dynamic sizing, a common issue that comes up in cultural competency training, supervision, culture, and mental health courses is therapists' desire to separate out the clinical from the cultural. Social workers should make a clinical assessment, understand the etiology of the problem, and diagnose the client and distinctly isolate clinical and cultural aspects of self (Hwang & Wood, 2007).

Use of complicated theoretical concepts of CBT can lead to misunderstandings if not spoken in the client's language. Many studies emphasize the use of bilingual employee for the therapeutic process in treating ethnic minorities (Casas, 1988; Hays, 1995; Conrad & Pacquiaio, 2005, Tewary, 2005). However, culture, religion, and spoken languages may differ in the vast diverse AIIW minority population. Therefore, finding a bilingual employee specific to the client's culture and background can be difficult. An engaged open discussion between the social worker and the client about the individual's interpretation of depression and cultural orientation can help generate a consensual agreement of an integrated treatment plan for the client.

Viewing CBT therapy as an ongoing process of mutual learning and exchange can help the therapist avoid unfounded stereotyping and learn how culture may be influencing the client. A cooperative process helps facilitate accurate therapist understanding of a case. Although accurate cultural knowledge by therapists is essential, it is unlikely that any individual therapist will be able to develop insider-level expertise with any more than a few cultural groups (Hays, 2001; Sue, 1998). Thus, developing a general approach for incorporating cultural factors into one's CBT practice is a key to enabling a therapist to accommodate a range of diverse cultural differences. To accomplish this, the therapist could view therapy as an ongoing *cultural exchange* where mutual learning occurs and cultural hypotheses can be tested (Lopez et al., 1989; Sue, 1990). Maintaining an open exchange and a hypothesis-testing approach (Sue, 1998) would allow the therapist to assess the degree to which cultural factors are important to the client and in what ways behavior is culturally influenced.

IMPLICATIONS FOR RESEARCH

A paucity of research with AIIW may result in poor diagnosis and treatment outcomes. Currently, there is no comprehensive epidemiological study examining mental health of Asian Indians. The prevalent institutionalized data provide a narrow view of prevalence rates, as there are numerous selection factors that may be important in the case of AIIW (Tewary, 2005). Asian Indians, a diverse group who differ in religion and languages spoken, are usually grouped in one single category. Measuring outcome by grouping them as one demographic variable can potentially confound the study results.

Existing measurement scales for depression (e.g., Beck's Depression Inventory, and Zung's Self-Rating Depression scale) are devised on the basis of Western clients. These scales might not apply to AIIW, because they might not have the same manifestation of the illness (Furnham & Malik, 1994; Voss Horrell, 2008). There are several terms used in the scales such as anxiety and nervousness that are vaguely interpreted and may draw different meanings (Fujita, 1990). Translation and back-translation of scales

is helpful, but it can change the perspective of the question asked (Fujita, 1990). Culturally appropriate standardized scales, increased sample size, and outcome studies are required to facilitate the understanding of CBT treatment outcomes among AIW.

CONCLUSION

Depression among AIW is often unreported due to the stigma associated with mental health issues. Depressive symptoms may not be a priority for treatments as they may be considered a typical reaction to harsh personal and social circumstances (Patel, Periera, & Mann, 1998). Cultural attitudes toward mental illness and its social implications are also pessimistic (Furnham & Malik, 1994; Conrad & Pacquiao, 2005). Lack of social support, appropriate coping mechanisms, unemployment, and limited insurance benefits further mitigate the treatment prospects. This review argues for a treatment plan that incorporates a multidimensional perspective treating migration-specific depression. Practice interventions can be designed and modified based on research findings and help practitioners improve the treatment outcomes. Cultural competency and integrating immigration history and personal beliefs about gender, race, and class in the therapy can further help in maximizing treatment goals.

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