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# The Influence of Military Culture and Veteran Worldviews on Mental Health Treatment: Practice Implications for Combat Veteran Help-seeking and Wellness

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*Abstract: The influence of military cultural values consisting of unit cohesion (or the subordination of individual needs over the needs of the collective) the devotion to duty and to the mission, stoicism (emotional restraint) and the importance of adhering to the chain of command become guiding belief systems for military personnel. In fact, military culture has been recognized as a distinct sub-culture of American civilian society. Thus, in order to effectively reach veterans, practitioners need to explore the culturally based constructs of the warrior mentality or worldview. Mental health workers need to consider how military cultural values held by veterans interact with perceptions of trauma and affect their help seeking behaviors in general. Data shows that service personnel tend to under-report their mental health symptoms; are reluctant to seek out mental health services and if they do engage in treatment; they prematurely drop out of services. The reasons for this are complex, from the stigma associated with mental health issues, to the potential for negative work-related repercussions especially for the active duty service personnel (i.e., loss of promotion, medical discharge, or losing security clearance). However, the authors believe that the reluctance for seeking services has more to do with the veteran's worldview, than with the other reasons noted. Even though the U.S. military is making a concerted effort to de-stigmatize mental health and is attempting to ensure confidentiality and minimize negative career consequences, the reluctance continues to affect early intervention. The phenomenon described here with regards to treatment participation and compliance parallels the findings from the literature on cultural diversity and seeking therapy. It has been well established, that when working with culturally diverse clients, more than half do not return to therapy for a second session (Sue & Sue, 1999). The authors have borrowed from Brown and Landum-Brown's (1995) worldview dimensions to help us understand how worldviews and values (as adapted to military culture and "warrior ethos") can impact a veteran's attitude about seeking mental health services. Practical examples will be provided of how this model can be applied to combat veterans as a method of understanding their help seeking behaviors in order to more promote wellness in the veteran client population.*

Keywords: Combat-veteran Help-seeking Attitudes, Influence of Military Culture on Mental Health Services

**U**NDERSTANDING MULTIDIMENSIONAL AND multicultural worldviews in veteran clients is an important undertaking in promoting cultural competence in mental health practitioners treating veterans. The influence of military cultural values consisting of unit cohesion (or the subordination of individual needs over the needs of the collective) the devotion to duty and to the mission, and stoicism (i.e., emotional restraint) as well as the importance of adhering to the chain of command become guiding belief systems for military personnel. In fact, military culture has been recognized as a distinct sub-culture of American civilian society (Exum, Coll, & Weiss, 2011). Thus,

in order to effectively reach veterans, practitioners need to explore the culturally-based constructs of the warrior mentality. Considering that multiple forms of culture govern human behavior (Cohen, 2009); clinicians need to consider how military cultural values held by veterans interact with trauma treatment and influence help-seeking behaviors. In fact, data shows that service personnel tend to under-report their mental health symptoms; are reluctant to seek out mental health services and if they do engage in treatment; they prematurely drop out of services (Hoge, Auchterloine, & Milliken, 2007). The reasons for this are complex, from the stigma associated with mental health issues which is part of the veteran worldview to the potential of negative employment repercussions especially for the active duty service member (i.e., loss of promotion, medical discharge, or losing security clearance). Even though the U.S. military is making a concerted effort to de-stigmatize mental health and promises minimal negative career consequences, the reluctance in veterans continues to affect attitudes towards treatment seeking.

The phenomenon described here with regards to treatment participation and compliance parallels the findings from the literature on cultural diversity and seeking therapy. It has been well established, that when working with culturally diverse clients, more than half do not return to therapy for a second session (Sue & Sue, 1999). Additionally, it has been noted that the clients' explanations and expression of illness are often culturally based as well as their help-seeking behaviors (i.e., certain client groups are uncomfortable seeking help outside of the family or community). Thus, in order to conceptualize a veteran's approach to help seeking, the authors have borrowed from several theoretical models that propose different dimensions of the worldview construct (Brown & Landum-Brown, 1995; Janoff-Bulman, 1992; Kluckhohn & Strodtbeck, 1973; Sue & Sue, 2003). By adapting these models to veterans, specifically combat veterans, the authors propose to identify key differences in veteran worldviews that are based on the "warrior ethos" that are critical for the practitioner to understand in relation to veteran help-seeking and post trauma adaptation. Additionally, this paper will also provide a discussion on how a civilian clinician's own worldviews may differ from the clients' worldviews, thus, potentially impacting the quality of the therapeutic relationship. In fact, drawing from the literature on college student advising, Coll and Zalaquett (2008), discovered that advisors who possessed similar worldviews to their students (or advisees) developed stronger relationships with their advisees. Consequently advisees sought their advisors more often and followed their recommendations more frequently than those that did not share worldviews. Worldview also correlates with client preference towards counselors (Lyddon & Adamson, 1992). For Carl Jung, "the therapist as well as the patient had to come to grips with the issues raised by conflicting worldviews" (1942; cited in Koltko-Rivera, 2004, p. 9). Thus, these findings can be applied as comparisons to understanding how differences in practitioners' worldviews to that of their veteran clients' can tip the scales of therapeutic rapport building and possibly therapeutic outcomes.

## **Worldviews**

As in any other form of social congruity and culture, specific worldviews are developed and shared, which strengthen its society and social values. Sue (1978) defined worldview and its importance to the formation and maintenance of a person's identity by stating that it relates to the individual's perception of and relationship with the world. Ibrahim (1991; 1999) referred to a worldview as a philosophy of life or the individual's experiences within

social, cultural, environmental, and psychological dimensions. Worldviews contain the answers to existential questions such as the meaning of life and death (Dilthey, 1970); in other words, these act as a ‘filter’ through which one reads reality (Miller & West, 1993) and are culturally transmitted (Berger & Luckmann, 1967) to guide human cognition, affect, perception and behavior (Kotler & Hazler, 2001). The importance of an individual’s worldview to his or her life is emphasized by Koltko-Rivera (2004), who states that individuals are actively engaged with their surroundings through the process of specifically constructed worldviews in order to gain a self-defined purpose. Additionally, Sue and Sue (2003) posit that worldviews held by individuals are imperative to the development of relationships with others.

In utilizing Kluckhohn and Strodtbeck’s (1973) worldview construction, the authors provide a model that contains a relational orientation that guides the modality of interpersonal relationships. For example the authors posit that there are two types, there are ‘hierarchical’ (i.e., lineal) vs. ‘collateral’ (i.e., collegial) forms of interpersonal relating. In applying this model to veterans, social relationships for military personnel are defined in a linear manner (when relating to authority). For instance, Sue and Sue (2003) explain that lineal relationships are vertical in nature where there are leaders and followers. Koltko-Rivera (2004) argues that there is a further distinction within this model that needs to be highlighted in that it’s really a matter two types of relational orientations, one of an individualistic vs. collectivistic orientation and one of a person’s relation to authority, a linear organization (i.e., vertical or hierarchical) or a lateral structure (i.e., horizontal or democratic). Thus, if we are examining authority, a vertical worldview orientation coincides with the military’s strict chain of command, a lineal rank structure, where there is little room for autonomy in the mindset of a veteran. The veteran learns to trust his or her leaders absolutely and becomes dependent upon them for major decisions and when the veteran returns safely home from war, this event only reinforces their belief in this structure. And if we are examining an individualistic vs. a collectivistic perspective in human relationships, then military culture is highly collectivistic in terms of the value of unit cohesion. Therefore, participating in individual psychotherapy, in order to gain insight and self-actualize (Maslow, 1970), may represent a contradiction to the veteran who holds a collectivistic perspective in a world where individual growth is a remote concept. Triandis states that “individualism-collectivism is the single most important dimension of cultural difference in social behavior” (1996 as cited in Koltko-Rivera, 2004, p. 12). These relational dimensions can also present as challenges for the veterans who have separated or retired from the military as they transition into U.S. civilian society, a place where autonomy and individualism are highly valued.

Kluckhohn & Strodtbeck also make reference to the construct of time as a worldview. In other words, what is the temporal dimension of human life? (e.g., past, present or future oriented). For example, in the veteran worldview there is an emphasis on the importance of learning from the past and living in the present with little concern for the future. History is very much inculcated in young recruits, as stories are passed on about famous battles and the military leaders that led them. According to Vagts (cited in Grossman, 2009) military history has been partially responsible for “militarizing minds,” inasmuch as military history being an institution that has been self-serving and glorifying. Whereas a present time orientation for the combatant is a survival mechanism in order to remain focused on mission and security. The service member in combat learns that tomorrow is not guaranteed and determines that the only logical choice is to live for the moment. The focus on the present is reinforced when the warrior suffers the death of a comrade in combat. The combatant is psychologically

forced to isolate the grief experience of losing a friend in order to make room for tactical and rational decisions on the mission at hand. A future oriented time focus comes into play when preparing a will and testament prior to mobilization or during post-deployment when many may consider not re-enlisting and developing a new life and career outside the military.

Brown and Landrum-Brown (1995) discuss the worldview of emotional restraint vs. emotional expressiveness in making decisions about behavior. Early on military personnel are taught to be stoic and are indoctrinated to internalize feelings in order to bear any burden and weather any difficulties. Wertsch (2006) describes the military as a “warrior society” encompassing an authoritarian structure and stoicism, and one that exists in a constant state of “combat readiness” even in times of peace. This rigid posture becomes even more pronounced post combat, where emotional expression is desired by the family members and the veteran is still in the “zone” (i.e., combat zone) in his mind and often returns home even more defended against experiencing and expressing his or her feelings. In fact, it has been postulated that those individuals who have undergone traumatic experiences become either “numb” to feelings (often referred as “psychic numbing”) (Lifton, 1973) or are terrified of affect due to the fear of being overwhelmed by their emotions (Krystal, 1978). Wertsch describes stoicism as the warriors’ ability to control both physical and emotional pain. The author offers the following illustrative statement: “Many a warrior who spends his [her] life training to meet the enemy head-on – and even longing for the confrontation- will run the other way, wall himself off, drink himself into oblivion, do anything in his power to avoid facing the ‘enemy’ within” (p. 41).

The stoic demeanor is also difficult to negotiate in therapy, as processing thoughts and the accompanying feelings are typically what are expected as part of many therapeutic approaches. The mental health clinician must be aware that this is a culturally derived norm and that it has an adaptive quality in the battlefield that can become a hindrance in intimate relationships. The clinician could educate the veteran on the repertoire of emotions (beyond anger, sadness and happiness) and encourage as well as model expression of emotions in appropriate ways. One interesting incident that the first author (Weiss) unexpectedly faced (that was the impetus for writing this paper) in counseling an active-duty Marine who had returned from combat (two tours in Iraq and one tour in Afghanistan) and was anticipating another combat deployment in 6 months was that the Marine told this clinician that he needed to have his “anger in tact” because it benefitted him in the battlefield, although it was causing significant strain in his family life. Thus, he could not separate the two realities, combat vs. home, and his mindset was already gearing up for war.

Brown and Landum-Brown (1995) also address the cultural worldview of seeking help vs. saving face, which influences behavior and attitudes towards help-seeking. The notion of maintaining the appropriate “image” (i.e., saving face) in the military is important. Wertsch (2006) describes the concept of image as a “mask” that portrays organization, efficiency, strength and perfection, a mask that often hides the real people behind it, who like everyone else, have limitations and shortcomings. Many service personnel believe that those who seek help are “weak” and are often branded as a security risk to the rest of the unit in terms of being able to successfully accomplish their mission. As a result, those who seek mental health services can be ostracized by their peers in the workplace (i.e., viewed as a liability) or are ineligible for promotion as deemed by their superiors or lose their security clearance or worse yet, can be medically separated from military service. Thus, this inherent culturally based stigma presents as a potential barrier for service members to voluntarily seek profes-

sional assistance for mental health issues. It is the first author's experience that many individuals who are in active status whether they are Active Duty or are part of the National Guard or Reserve may not voluntarily seek out counseling unless they are given ultimatums by their spouses or family members or are ordered to do so by their command.

Janoff-Bullman (2005) offers the idea of benevolence as a worldview in which an individual gravitates towards the belief system that the world is a benign place, where goodness and altruism reside. Military values correspond with this worldview in the aspect that no matter what branch of the military a service member belongs to (there are 'within' differences between branches, however this is beyond the scope of this paper) they all uphold the value of a devotion to duty in the motto "we exist to serve." The virtues that shape military personnel regardless of the distinctions based on branch of service include the values of peacefulness and restraint (DeGeorge, 1987; Exum, Coll, & Weiss, 2011; Coll, Weiss, & Yarvis, in press). For instance much of the U.S. military involvement overseas has been rooted in peace keeping missions that have ironically resulted in conflicts. Rules of Engagement (i.e., laws of war) also include standards of conduct for service member restraint that are strictly upheld, for example the circumstances under which American forces can return enemy fire and the restraints imposed by the Geneva Convention such as the treatment of civilians in war zones (Exum, Coll, & Weiss, 2011). However, the military boot camp experience begins narrowing the concept of benevolence for the service member. The new recruit is instructed to primarily rely on his or her platoon developing a "unit first" mentality. Grossman (2009) stated that combatants are primarily motivated into battle by factors relating to group cohesion: "(1) regard for their comrades, (2) respect for their leaders, (3) concern for their own reputation with both and (4) an urge to contribute to the success of the group" (p. 88-89). The unit cohesion or bond with fellow warriors is so strong that it is thought to match the bond between a parent and child; a Vietnam veteran offered the following commentary on the strength of the bond "it's a hell of a lot stronger than man and wife- your life is in his hands, you trust the person with the most valuable thing you have." (Grossman, 2009, p. 89). This notion is further elaborated as "a special kind of love that has nothing to do with sex or idealism." (p. 150). The notion of benevolence is further diminished by the introduction of the division between those that have served in the military and those that have not (referred to as "civilians"). Unfortunately, this very culture that fosters strong camaraderie amongst soldiers that is necessary for survival in the battlefield may also engender anti-civilian sentiments (Davenport, 1987; Coll, Weiss, & Yarvis, in press). Interestingly, these sentiments are also shared by military spouses. A recent study found that Army wives' experience with civilians during wartime deployment is not always a positive one. The wives often felt that civilians unwittingly made offensive remarks towards them based on faulty assumptions about their experiences as military wives; consequently many of the wives would "silence" themselves in an effort to protect themselves from the pain associated with marginalization (Davis, Ward, & Storm, 2011). Civilian mental health providers must be aware of this mistrust and not interpret it necessarily as treatment resistance, but rather become educated on military cultural issues (Coll, Weiss, & Draves, 2010) and utilize this material in therapy by providing empathic understanding and by asking questions, rather than by making assumptions.

The shaping of the worldviews from the civilian mindset to the military become part of the "new normal" in the military subculture. The service member becomes almost exclusively surrounded by those who share a similar experience and this proximity reinforces the beliefs to a point that the service member loses the "civilian" part of themselves; and vice versa, it

can also present a challenge for the veteran to then transition from the military worldview back to the civilian worldview.

### ***Worldviews in Veterans Post Combat***

In exploring how military cultural values held by veterans interact with factors relating to trauma treatment and their help seeking behaviors, it is necessary to first explore a theory of trauma that captures the worldview perspective. Therefore, trauma will be examined from a constructivist self-development lens as proposed by McCann & Pearlman (1990).

The authors view trauma as:

The experience of trauma begins with exposure to a non-normative or highly distressing event or series of events that potentially disrupts the self. The individual's unique response to trauma is a complex process that includes the personal meanings and images of the event, extends to the deepest parts of the person's inner experience of self and world, & results in an individual adaptation. The major underlying premise of constructivist self-development theory is that individuals possess an inherent capacity to construct their own personal realities as they interact with the environment. This constructivist position asserts that human beings actively create their representational models of the world (Epstein & Erskine, 1983; Mahoney, 1981; Mahoney & Lyddon, 1988) (McCann & Pearlman, 1990, p. 6)

Janoff-Bulman (1992) posits the following assumptions or beliefs about the world that can be affected by trauma: (a) "Benevolence" of the world is the belief that the world is a "good place". (b) "Meaningfulness" of the world refers to the belief that there is order and justice in the universe in that positive or negative events happen to people who deserve positive or negative outcomes based on their actions (this is based on Lerner and Miller's, 1978, "just world" hypothesis) (c) "Self-worth" is the global evaluation of the self, derived from a person's willingness to engage in appropriate behaviors and serves as a judgment of self-competence. Where, according to Maslow (1970), self-worth is considered a fundamental need for humans. Following combat, the veteran's worldviews can be redefined as a result of the war experience. Janoff-Bulman (1992) refers to a "shattering of assumptive worlds" following traumatic events. In a 1989 study by the same author, she found that trauma victims in fact tend to view the world as being a less benevolent place and perceived themselves less positively and no longer believed in the construct of a "just world," but rather believed in a random world, compared to non-victims. Furnham and Procter (1989) add that there are really three options, "just," "random," and "unjust," (this last option, in our opinion can lead to feelings of rage and resentment towards the world or towards institutions or minority groups). Thus, traumatic events can cause a sense of helplessness (Seligman, 1975), a diminished sense of self-esteem or self-worth (Janoff-Bulman, 1992) and a reduction of self-efficacy (Bandura, 1977). Although not all veterans who go to war are "traumatized" from a formal diagnostic perspective (i.e., posttraumatic stress disorder), however many will admit to somehow being profoundly changed by the combat experience. According to McCann and Pearlman (1990, p. 7), "trauma by definition, requires an accommodation or a modification of schemas" (i.e., worldviews). For instance, a service member sacrifices himself in order to defend the constitution of the United States, and after combat for many there is a re-evaluation of the meaningfulness of life and a re-assessment of self-worth. The atrocities

of war, the killing (although socially sanctioned), the potential for guilt, shame and loss, all of these facets that often accompany the war experience, combine for the veteran who begins to question existing worldviews that were once held as truths. There is a potential for an unsettling of the foundation of character, values, judgment, trust in self and in others and sense of safety (Janoff-Bulman, 1992; McCann & Pearlman, 1990). Human relationships and connectedness to others is another area that can also be disturbed (Lifton, 1979).

There is yet another worldview that comes into question following combat. Brown and Landrum-Brown (1995) suggest an ontological perspective, is reality objective/material or is it subjective/ spiritual? Or is it both? Religious or spiritual beliefs are a relevant aspect of an individual's worldview. It has been posited that religion can provide comfort for those individuals who experience devastating life events that do not coincide with logical explanations (Dull & Skokan, 1995). For some people, loss events can challenge spiritual beliefs (Kushner, 1981) and for others it can facilitate the meaning making process (Davis & Nolen-Hoeksema, 2001). Thus, the authors comment that when existing worldviews no longer fit new perceptions of reality, an individual experiences cognitive dissonance, and must revise or rebuild old worldviews in order to accommodate the new experience and that this is an ongoing process. From a spiritual perspective, therapy for warriors should include providing a safe haven, through listening, grounding, accepting and encouraging forgiveness and community (Oliver, 2011). Walsh (1999) recommends asking clients how important faith, religious practice and congregational support are in the life of the client and if deemed appropriate to then help clients identify potential spiritual and/or religious resources that can be used to ease distress and support coping. From anecdotal interviews with clients during therapy, the first author has discovered that religious or spiritual beliefs are unique to every individual. For some, there is a sense fatalism or determinism (i.e., personal destiny) combined with a strong pride in military service, as expressed by a Marine who served in the initial invasion of Iraq, he makes the following statement about dying in combat, "when it's your time to go there is little you can do about it, but at least if I die in battle, I will die with honor." This reflects an external locus of control as posited by Rotter (1996) that is the role of luck, chance, and fate rather than an internal locus of control (outcome of an event being contingent upon a person's behavior) and that internal locus of control is often what is most affected by trauma (Janoff-Bulman, 1992). An additional element to locus of control is the fact that today we have an all-volunteer force, so those that are serving in Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom are there on a volunteer basis, which reflects an internal locus of control, (an 'agency of free will' as cited in Koltko-Rivera, 2004, p. 39) in that they chose to join the service. Whereas in prior conflicts, such as Vietnam, service was compulsory (i.e., draft), thus, the sense of internal locus of control was non-existent from the beginning, which only compounds the sense of helplessness. Furnham and Procter (1989) add that the sense of control is divided into three "spheres": the personal, the interpersonal and the political. Control or the "illusion of control," (Langer, 1975) is often associated with power and mastery, and this sense of power, according to Rollo May (1969) is a central theme for humans, which is often destroyed by trauma (McCann & Pearlman, 1990). McCann and Pearlman state that the danger-seeking behaviors that Vietnam veterans exhibited once returning home, maybe a method for an individual to re-assert a sense of power and mastery over his or her environment. We are currently witnessing similar behaviors, where OEF/OIF veterans with PTSD and traumatic brain injuries are engaging in risk-taking behaviors, aggressive acts and becoming involved with the legal system (Burke, Degenefte,



& Olney, 2009). From this perspective, it would be interesting to evaluate if there are differences in post combat adjustment, between the young newly enlisted, who have less power and control in the decision making in the battlefield, from the senior (officers) who have a greater influence over what happens in battle. This brings us to another question, the one of locus of responsibility, as an additional worldview posited by Sue (1978). “Whereas locus of control refers to the perceived control of contingencies, locus of responsibility as defined by Sue refers to perceived blame or responsibility” (Koltko-Rivera, 2004, p.19). Thus, according to this paradigm, the officer may feel an external locus of control (war being waged by the U.S.) but an internal sense of responsibility towards the welfare of his or her troops (he or she commands the combat operations).

### ***Treatment Implications***

In our opinion, it is essential, that mental health clinicians be sensitive to veteran worldviews and the worldviews that have been modified as a result of combat and whether or not these alterations have become problematic for the client. McCann and Pearlman (1990) suggest that possibly the client will need assistance in accommodating his or her worldviews to fit the new post-trauma reality and that if there are disturbed schemas (or worldviews) that produce feelings of fear, shame and rage in the client, these will only be expressed within a safe therapeutic environment. The authors add that “trauma can disrupt any or all parts of the self, including capacities, resources, needs and schemas” (p. 14). Thereby they recommend that treatment be based on the client’s needs and on a continuous assessment of their meaning making process or life narratives (rather than an emphasis on historical or factual truths). The authors go on to say that in treating those who have been traumatized, it is important to examine the social and historical context of the individual’s experience. For example, Grossman (1996) points to the lack of social support encountered by Vietnam veterans in their homecoming in comparison to the veterans of World War II (where society deemed it was a justified war); whereby the lack of social support could present as a “second injury” to the veteran (Symonds, 1980). Koltko-Rivera (2004) speaks about worldviews and the stimuli of experience in terms of the behaviors of others towards an individual (i.e., others who hold dissimilar worldviews than the individual) and the impact of these behaviors towards the person. An instance of this was the sense of social alienation that was felt by Vietnam veterans where their sense of belonging in society was threatened. According to Maslow, (1970) the sense of belonging and feeling loved is high in the human hierarchy of motivation and needs as exemplified by the following quote: “People need other people to feel a sense of belonging to some place, community or person” (Bellah et al., 1985 as cited by McCann & Pearlman, 1990, p. 77). It is our opinion that the current OEF/OIF and OND (Operation New Dawn) veterans are feeling some degree of apathy and ambivalence at best, in terms of society’s attitudes and behaviors towards them. Thus, this where mental health clinicians need to be aware of their own political views, agendas and feelings towards the current wars and not allow the differences in worldviews to come into play in the therapy sessions. Clinicians need to withhold negative judgment and/or not treat veterans if they are not able to be genuinely empathetic in their stance towards veterans.

An additional consideration is the influence of social class, race, gender, ethnicity and minority status and how these elements intersect with the client’s worldview; as well as the effects of these dimensions on trauma (Hays, 2008). Clinicians need to consider the effects

of cumulative trauma across generations and “that in some ethnic populations, PTSD is a derivative of racism and colonization” . . . therefore, certain client groups are more “vulnerable than others to the development of PTSD” (Brave Heart, 2005, Yehuda, 1999; as cited in Diller, 2011, p. 167). Thus, as the ethnic composition of the military continues to grow, in fact, the ethnic and racial composition of the veteran population is equivalent that of the general U.S. population (U.S. Census Bureau, 2003; cited in Exum, Coll, & Weiss, 2011); clinicians need to develop a multidimensional awareness of culture (i.e., military culture) in addition to the consideration of ethnicity, gender and social class. Ultimately, Peskin (2009; cited in Diller, 2011, p. 181) recommends that as therapists, we need to become a ‘therapeutic witness’ in the treatment of trauma in order to validate another’s experience in making sense of humanity – “one’s personal history, identity and aliveness.”

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