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Asian American Mental Health: What We Know and What We Don't Know

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Abstract

This chapter reviews and critically examines issues regarding the mental health of Asians in the United States. As a distinct ethnic group in the United States, Asian Americans have experienced value conflicts between their own ethnic culture and that of mainstream Americans, as well as instances of racial prejudice and discrimination. Given these experiences, it is important to examine the mental health status of Asian Americans. Several consistent research findings have emerged. First, few Asian Americans utilize the mental health system. Second, those who do use services are highly disturbed in terms of psychiatric disorders. Third, cultural factors appear to influence this pattern of low utilization but greater severity of disturbance. Fourth, epidemiological surveys show that the rates of mental disorders among Asian Americans are not extraordinarily low. Fifth, the relatively small population of Asian Americans, their heterogeneity, and the constantly changing demographic characteristics of the population have made it difficult to ascertain rates of mental disorders. More research is needed in order to gain insights into the within-group differences among Asian Americans, the role of acculturation in psychopathology and help-seeking behaviors, and cultural expressions of psychopathology.

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The Population of Asian Americans

Asians in the United States are comprised of many subgroups including Cambodians, Chinese, Japanese, Filipinos, Koreans, Laotians, Asian Indians, Vietnamese, etc. who speak over 30 languages. Asian Americans comprise 5% of the US population but 60% of the world's population. Despite the fact that Asian American groups are heterogeneous, researchers have often studied the subpopulations as an aggregate group because Asians often show similar cultural values that are in contrast to Westerners, e.g., Asian Americans are more likely to exhibit interdependence and family orientation than do White Americans.

In evaluating the mental health of Asian Americans, some inconsistencies are apparent. As an aggregate, Asian Americans appear to be relatively successful in terms of low rates of divorce, crime, and juvenile delinquency and high rates of educational attainments, family income, and socio-economic mobility. On the other hand, they have experienced racial prejudice and discrimination, stereotypic portrayals in the media, and English language and cultural adjustment difficulties. Given the inconsistent data on well-being, how adjusted are Asian Americans?

Mental Health Service Utilization

Research has consistently shown that Asian Americans are less likely to seek help for mental health problems than other racial demographic groups, and less than their representation in the US population (Abe- Kim et al., 2007; Kearney, Draper, & Baron, 2005; Matsuoka, Breux, & Ryujin, 1997; U.S. DHHS, 2001; Zhang, Snowden, & Sue, 1998). This lower use of mental health services applies to Asian Americans regardless of geographic location, age, gender, education, or Asian subgroup. Abe- Kim et al. (2007), for example, showed that only 8.6% of Asian Americans in the National Latino and Asian American Study (NLAAS) compared with 17.9% of the general population sought assistance from a mental health or health care professional. Among Asian Americans with a probable mental disorder, only 28% utilized specialty mental health services, in contrast to 54% of the general population as noted by Wang et al. (2005) (see also Meyer, Zane, Cho, & Takeuchi, 2009). Other data suggests that Asian Americans adults and youth are between two and five times less likely to seek mental health services than the Caucasian population (Eisenberg, Golberstein, & Gollust, 2007; Garland et al., 2005; Masuda et al., 2009; Matsuoka et al., 1997).

This underutilization is apparent even after controlling for prevalence of disorders. In the 2008 National Survey on Drug Use and Health, prevalence of disorders and mental health service utilization rates were calculated from different ethnic and racial groups. Asian Americans were least likely to use services, even after controlling for prevalence (Sue, 2011, April).

Instead of seeking help from mental health professionals, Asian Americans prefer informal solutions for their mental health problems, seeking the support of friends or family or working out problems on their own and delaying the decision to seek professional

assistance until problems have gotten severe (Durvasula & Sue, 1996; Kearney et al., 2005; Narikiyo & Kameoka, 1992, Zhang et al., 1998). When Asian Americans make the difficult decision to obtain help, they prefer contacting nonprofessional sources (e.g., online supports, self-help), healers such as traditional Chinese medicine providers, or medical professionals (Chu, Hsieh, & Tokars, 2011; Yang, Corsini-Munt, Link, & Phelan; 2009). Additionally, after initial contact with mental health professionals, about one-third of Asian Americans drop out of treatment before their intake session, and premature treatment termination is also common (Akutsu, Tsuru, & Chu, 2004).

Several cultural, system, and care process factors must be considered in understanding mental health service utilization among Asian Americans. First, Asian Americans may have certain cultural ideas about illness and mental health services that affect their perception of the need for help. Some research suggests that greater acculturation and familiarity with Western conceptions of mental health facilitates help-seeking. In the NLAAS study, Abe-Kim et al. (2007) found that U.S. born Asian Americans were more likely than first generation immigrant Asian Americans to utilize mental health-related services, and that third or later generation Asian Americans with a diagnosable illness sought services at an even higher rate (62.6%) within the past year. Another study showed that Asian Americans with higher enculturation (stronger beliefs in Asian values) had less positive attitudes about seeking help for mental health problems (Kim & Omizo, 2003). Indeed, the use of Traditional Chinese Medicine healers for psychiatric disorders decreases as Asian Americans become more westernized and acculturated (Yang et al., 2009).

The concepts of stigma and shame play an important role in Asian Americans' low service use. "Haji" among Japanese, "Hiya" among Filipinos, "Mianzi" among Chinese, and "Chaemyun" among Koreans are terms that reveal concerns over the process of shame or the loss of face (Sue, 1994). Many Asian Americans tend to avoid the juvenile justice or legal system, mental health agencies, health services, and welfare agencies, because the utilization of services for certain problems is a tacit admission of the existence of these problems and may result in public knowledge of these familial difficulties. Older adult Korean Americans, for example, report greater misconceptions and stigmatizations about mental health as a weakness that would bring shame to a family if one were to reveal their mental illness by seeking treatment (Jang, Chiriboga, & Okazaki, 2009). Other recent studies have also confirmed that greater personal stigma and lower stigma tolerance predicts a lower likelihood to seek help among Asian American students, and that stigma about mental illness is higher among Asian Americans (Eisenberg, Downs, Goldberstein, & Zivin, 2009; Ting & Hwang, 2009).

System-level and care process factors also contribute to the considerable problem of mental health care disparities in Asian Americans. Higher rates of poverty and rates of being uninsured or underinsured, particularly among Southeast Asian Americans like the Cambodians, Hmong, or Laotians, can prevent access to needed mental health services (Reeves & Bennett, 2004). Compounding this problem of financial resources is the dearth of available language- and culturally-appropriate services for many Asian American individuals. Nearly half of Asian American and Pacific Islanders experience restricted

access to available mental health services because of limited English proficiency and a lack of providers with appropriate language-matched abilities (US DHHS, 2001).

Beyond the need to increase the availability of Asian-language clinicians, research has pointed to the need for culturally-competent providers who are able to understand and deliver mental health treatments with similar worldviews and cognitive styles, e.g., problem perception, coping orientation, and therapy goals, to that of Asian American clients (Zane et al., 2005). Asian Americans who make the difficult decision to initiate contact with mental health providers may be more likely to stay in treatment if they encounter these culturally-congruent aspects of the care process (Ivey, Ivey, & Simek-Morgan, 1997; Sue & Sue, 1999).

One pertinent question that arises from service utilization research is whether lower service use is reflective of lower need. Epidemiological research on the prevalence of mental disorders among Asian Americans sheds light on this important issue.

Mental Health Prevalence

An examination of epidemiological studies indicates that lower service utilization in Asian Americans is not necessarily commensurate with a lower need for services. Though some studies show lower rates of some mental disorders for Asian Americans compared to Caucasians (e.g., Meyer, Dhindsa, Gabriel, & Sue, 2009; Nicdao, Hong, & Takeuchi, 2007; Takeuchi et al., 2007), others show similar or even higher rates of some mental disorders in certain Asian subpopulations.

Significant advances in the availability of epidemiological data about Asian Americans have been made in the past 10+ years. The Chinese American Psychiatric Epidemiological Study (CAPES) was a five-year community epidemiological study investigating the mental health problems of 1,700 native-born and immigrant Chinese Americans residing in Los Angeles County (Takeuchi et al., 1998). Chinese Americans in the CAPES project did not have higher rates of mental disorders than Whites. While it was argued that the rates of mood disorders among Chinese Americans were within the bounds of other Americans, the rates for anxiety were somewhat low. The 2008 National Survey on Drug Use and Health (NSDUH) administered audio computer-assisted self-interviews and found that Asian Americans had low rates of illicit drug use, alcohol use, tobacco use, substance dependence/abuse and serious mental health problems compared to other ethnic groups (including African Americans, Hispanics, and Caucasians) (US DHHS, 2009).

Finally, the National Latino and Asian American Study (NLAAS) constituted the first national epidemiology study of Asian Americans, and therefore represented an advance over previous sampling of single-Asian subgroups within a single geographic location such as that used in the CAPES study (Alegria, et al., 2004; Heeringa, et al., 2004). Utilizing a diagnostic interview methodology based on the World Health Organization Composite International Diagnostic Interview (WMH-CIDI; Kessler & Üstün, 2004), the NLAAS revealed a lifetime prevalence of 17.3% and 12-month prevalence of 9.19% for any mental disorder (Takeuchi et al., 2007). These rates were higher than Caucasians, African

Americans, and Latinos in the National Comorbidity Study (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005) but lower than Latinos and African Americans in studies with comparable methodologies (Alegria et al., 2007; Williams, Haile, Gonzalez, Neighbors, & Baser, 2007).

Given continuing problems in determining the cross-cultural validity of measures, possible occurrence of culture bound syndromes, heterogeneity of the Asian American group, and conflicting results concerning prevalence, it is difficult to draw definitive conclusion on whether Asian Americans are better adjusted than other groups. Furthermore, large variance is seen in mental health prevalence based on the clinical problem and Asian American subgroup. Certain groups such as Southeast Asian refugees have consistently high levels of depression and Post-Traumatic Stress Disorder, largely attributable to repeated exposure to catastrophic environmental stressors such as torture, combat, witnessing the death of family and relatives, and forcible detainment in harsh refugee camp conditions (Kinzie et al., 1990; Westermeyer, 1988). One study found 12-month prevalence of PTSD and major depression in as high as 62% and 51% of a sample of Cambodian refugees, respectively (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Examination of suicide in Asian American elderly woman also yields higher risk and higher rates compared to the general population – 11.91 completed suicides per 100,000 Asian American women ages 80 to 84 compared to 4.43 per 100,000 among White women in the same age cohort (CDC, 2006; Yang & Wonpat-Boria, 2007). Other studies have found higher suicidal ideation and behaviors in Asian American (56.8%) compared to African American (27.0%) elderly primary care patients (Bartels et al., 2002).

Interestingly, larger epidemiological studies frequently contradict previous evidence showing elevated psychological distress in Asian Americans compared to Caucasians, mainly in studies utilizing self-report symptom inventories such as the Center for Epidemiology Studies of Depression (CES-D), Beck Depression Inventory (BDI), or the Symptom Checklist-90-Revised (SCL-90-R) (Chang, 1996; Gratch, Bassett, & Attra, 1995; Greenberger & Chen, 1996; Hurh & Kim, 1990; Kuo, 1984; Yang & WonPat-Borja, 2007; Ying, 1988). Okazaki (1997), for example, found that Asian American college students reported higher levels of depression and social anxiety than White American college students. Lam, Pepper, and Ryabchenko (2004) performed a direct comparison of self-report inventories and interviews within the same sample and found a discrepancy in depression estimates between the two assessment methodologies. Though Asian American students scored higher than their Caucasian counterparts on the BDI, there were no differences in mood disorder diagnoses on diagnostic interviews. Similar overestimations of depression prevalence by self-report inventory compared to physician observation and diagnosis were also found in a sample of Asian American primary care patients (Chung et al., 2003).

Clearly, the study of Asian American psychopathology is subject to different results depending on the assessment methodology administered. Reporting style biases may account for the differing results between self-report questionnaire versus largely in-person interview methodologies of epidemiology studies, and present unique challenges for the cultural validity of research efforts. As a result, researchers have had a difficult time

ascertaining the true prevalence of mental disorders among Asian Americans and why findings may be inconsistent. These research challenges are examined in more detail in this article.

Cultural Treatment Options

Asian Americans may have needs for certain resources that are not reflected in lower service utilization patterns. Experts have criticized the mental health services currently available within the US mental health system as disjointed, culturally mismatched with the treatment preferences of ethnic minority clients, and non-representative of cultural ideas about illness and health (e.g., U.S. DHHS, 2001; President's New Freedom Commission on Mental Health, 2003). In recent years, culturally-specific service options have emerged to improve fit with the mental health needs of Asian Americans.

Cultural treatment adaptations, for example, refer to the process by which evidence-based practices (EBPs) validated in mainstream populations are tested and modified for the specific cultural needs of ethnic minorities like Asian Americans. Culturally-adapted EBPs systematically consider language, culture, and contextual issues consistent with clients' cultural values, beliefs, and practices, and have demonstrated beneficial outcomes in diverse populations (Bernal, Jimenez-Chafey, & Rodriguez, 2009; Griner & Smith, 2006; Pan, Huey, & Hernandez, 2011; Sue, Zane, Hall, & Berger, 2009). Several of these culturally-adapted treatment options have emerged as viable options for Asian American individuals, including Problem Solving Therapy for depressed Chinese older adults (Chu, Huynh, & Arian, in press), a culturally-adapted one-session treatment for Asian Americans with phobia (Pan et al., 2011), a culturally-adapted cognitive behavioral intervention to accommodate the somatic symptoms that accompany PTSD in Cambodian refugees (Hinton, Pich, Chhean, Safren, & Pollack, 2006), and a Cantonese language CBT for depressed Hong Kong immigrants in Vancouver Canada (Shen, Alden, Söchting, & Tsang, 2006).

As a relatively new field of study, the science of cultural adaptation has shown recent advances with strides in guidelines for when, how, and to what extent treatments should be adapted for a cultural population without significantly compromising fidelity to essential treatment components (Castro, Barrera, & Holleran Steiker, 2010). In fact, several models for the cultural adaptation process have been offered. Examples include the ecological validity framework (Bernal, Bonilla, & Bellido, 1995), cultural accommodation model (CAM; Leong & Lee, 2006), and the formative method for adapting psychotherapy (FMAP; Hwang, 2009). Most of these models recommend variations around four basic adaptation phases: information gathering, development of initial adaptation design, pilot testing, and additional refinement (Barrera & Castro, 2006). These culturally-adapted treatments show considerable promise to provide treatment options that are congruent with the cultural preferences, coping and interpersonal styles, and psychopathology expressions of Asian American clients. Continued work is needed to further develop and refine culturally-adapted treatments, and translational implementation efforts are sorely needed to transport such treatments from research to applied community settings.

Collaborations between mental health providers with other care resources that are less stigma-inducing and are more commonly sought by Asian Americans are also being discussed as innovative approaches to increasing Asian Americans' service access, e.g., primary care providers, healers, community organizations, and religious leaders. Dubus (2009) describes a collaborative approach where a licensed professional is teamed with a Cambodian paraprofessional to provide culturally-sensitive group support treatment for Posttraumatic Stress Disorder in Cambodian refugee women. Pairing a mental health professional with a community member like a paraprofessional who shares the same language and ethnic background as a client may enhance treatment engagement in this underserved Cambodian community. Collaborative models uniting teams of community organizations, schools, and family members with professionals to provide mental health and substance prevention treatments have also proved promising in building successful partnerships to engage Southeast Asians in Minnesota (Hosley, Gensheimer, & Yang, 2003). Finally, a most promising interdisciplinary approach is the integration of behavioral health into primary care settings. Yeung et al. (2010) showed a nearly seven-fold increase in treatment engagement rates among Chinese Americans primary care patients with depression upon employment of culturally sensitive collaborative treatment (CSCT). CSCT consisted of a multidisciplinary team (physicians, psychiatrists, care managers) working together to provide depression screening, assessment, culturally sensitive interview, and care management in the primary care setting.

Investigators have also begun to discuss treatments for Asian Americans that fit with cultural conceptions of mental health. The concept of mindfulness, for example, has roots in Buddhism and Asian traditions, and has been gaining momentum in Western psychology as a viable treatment for depression, anxiety, trauma, and other mental health problems, e.g., Mindfulness Based Cognitive Therapy, Mindfulness Based Stress Reduction. Mindfulness and acceptance techniques have been included in the categorization of the "third-wave" of cognitive-behavioral therapies (Brown, Gaudiano, & Miller, 2011). There has been recent interest in exploring mindfulness as an intervention strategy of cultural fit for Asian Americans. One study found that lower levels of mindfulness were related to higher psychological distress in Asian American students (Masuda, Wendell, Chou, & Feinstein, 2010). Additionally, Villareal Armas (2010) discussed mindfulness interventions as an appropriate intervention for trauma in Thai survivors of modern-day slavery. However, few existing studies have empirically investigated the efficacy of mindfulness-based treatments with Asian American populations.

The approaches of modifying existing evidence-based treatments, bridging mental health services with other more culturally-sanctioned services, and providing interventions that match well with cultural factors have yielded promising advances in treatment options for Asian American individuals. There is much room for innovation and expansion within these areas to increase knowledge and availability of culturally-congruent services.

Unique Research Challenges

Unique challenges for the validity of mental disorder research arise from the heterogeneity of Asian American populations, cultural biases in reporting style, and cultural idioms of distress. First, the nature of the Asian American population is that it is small, diverse, and ever-changing. Asian Americans represent only about 5% of the U.S. population but are rapidly growing. Consequently, some researchers have had a difficult time finding adequate sample sizes and representative samples of Asian Americans, particularly in smaller Asian American groups like Cambodian, Hmong, Lu Mien, or Pacific Islanders. The Asian American population is also extremely diverse and heterogeneous. More than 50 distinct ethnic groups that speak more than 30 different languages are included in the Asian American category. Even within a particular group such as Chinese Americans, heterogeneity is wide and far more diverse than the Chinese population in overseas countries. Chinese in the U.S., for example, are comprised of both native and foreign born individuals speaking many dialects and languages and coming from mainland China, Taiwan, Hong Kong, Singapore, Vietnam, and elsewhere. The same is true of nearly all Asian American groups – greater heterogeneity exists for their group in the U.S. than in their homeland. One challenge arising from this heterogeneity is that measures and findings may not apply with adequate validity from Vietnamese in Vietnam to Vietnamese Americans, or across different Asian American subpopulations.

Second, cultural variations in response style, particularly on self-report rating scales, present important challenges for researchers and mental health professionals in the interpretation and cross-cultural validity of questionnaires. Several trends regarding response tendencies among Asian Americans emerge. Some research suggests that Caucasians exhibit a self-enhancement bias that Asian Americans do not; as a result, symptom questionnaires such as depression inventories may yield a more negative picture for Asian Americans than Caucasians based not on actual depression severity levels, but rather cultural differences in response style (Norasakkunkit & Kalick, 2002). Other studies suggest that Asian Americans respond with a central tendency bias – an inclination to choose neutral or moderate rather than more extreme response options – on Likert scales with multiple points (Chen, Lee, & Stevenson, 1995; Hamamura, Heine, & Paulhus, 2008).

Asian Americans also exhibit cultural variations in the way distress is expressed – a term coined “idioms of distress” in the DSM-IV (American Psychiatric Association, 2000). These idioms of distress affect the likelihood and type of service utilization, and the way mental health symptoms are reported in research. Ethnic minorities, including Asian Americans, are less likely than Caucasians to express suicidal ideation on pre-intake questionnaires unless directly queried in-person by an intake therapist (Morrison & Downey, 2000). This tendency towards “hidden (suicidal) ideation” represents a cultural preference to inhibit the type of disclosure typically associated with seeking help for mental health problems. A long line of research has also found that Asian Americans are more likely to experience mental health symptoms in somatic rather than psychological terms (Leong et al., 2006; Mak & Zane, 2004; Ryder et al., 2008; Tseng et al., 1990). For example, a culturally sensitive measure of depression, the Vietnamese Depression Scale,

includes the idioms of distress of somatic symptoms and feelings of desperation and shame as two of three main factors (Dinh, Yamada, & Yee, 2009). Southeast Asian refugees in particular experience Posttraumatic Stress Disorder with comorbid panic-like khyâl attacks that include culturally-specific symptoms such as fear of death from body dysfunction or somatic symptoms like tinnitus (buzzing in the ear) (Hinton, Chhean, Pich, Hofmann, & Barlow, 2006; Hinton, Pich, Marques, Nickerson, & Pollack, 2010).

A final concern related to the way Asian Americans choose to express their distress is that of language terms utilized on research instruments. Emotion terms in particular often lack equivalents between English and Asian languages, resulting in Asian American clients having problems discerning subtle yet important differences between words like “sadness”, “despair”, and “depression” (Westermeyer & Janca, 1997; Yang & WonPat-Boria, 2007). As a result, Asian American clients may have a difficult time understanding Western-based scales and provide responses that are not conceptually equivalent to the measures’ intended meanings.

These cultural variations in idioms of distress, language, and response style on self-report measures present distinct challenges for the interpretation of research data. Often, it is unknown whether a self-report response represents a true value corresponding to the descriptions provided on a scale, or a socialized behavior based on cultural factors. Similarly, emotion inhibition, hidden suicidal ideation, or somatization of distress may contribute to underestimation or underdetection of mental health symptoms in Asian Americans. Researchers and mental health professionals must incorporate awareness of these cultural influences in their choice of assessment instrument, interpretation of reported responses, and differential diagnosis decisions. Such response style issues have presented understandable barriers to accurate mental health data for Asian American groups.

Conclusions

Much is known about the mental health of Asian Americans. Help-seeking and service utilization is lower than their representation in the U.S. population, and lower than other racial and ethnic groups with cultural, system, and care process factors presenting barriers to access of mental health services. Lower service use is not indicative of lower need; epidemiological studies show elevated rates of certain clinical problems in some Asian American subgroups (e.g., PTSD in Southeast Asians and suicide in Asian elderly women), and similar or lower overall prevalence rates of mental disorders compared to the general population. Notably, methodological issues stemming from the heterogeneity of Asian American populations, cultural biases in reporting style, and cultural idioms of distress pose considerable challenges to the interpretation of these epidemiological studies. In an effort to address mental health care disparities, innovations in cultural treatments for Asian Americans have recently become available. Still, there is much more we don’t know about Asian American mental health. Future research is needed to gain insights into the within-group differences among Asian Americans, cultural expressions of

psychopathology, the quantification of cultural reporting biases, and innovative cultural treatments to increase service access.

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Questions for Discussion

1. What kinds of treatments, services, or mental health systems are needed to make mental health services more accessible and culturally-appropriate for Asian Americans?
2. Why do you think Asian Americans are less likely to utilize mental health services?
3. What is stigma and shame, and how might they influence the mental health and/or service use among Asian Americans?
4. Which Asian American subgroups are most at risk for which mental disorders?
5. How might culture affect the mental health symptoms experienced and reported by an Asian American individual?
6. What effect does Asian Americans' tendency to experience somatic symptoms have on their help-seeking preferences, and their responses to research studies?
7. What is a culturally-adapted evidence-based treatment? Discuss pros and cons of cultural adaptation.
8. If you were to form collaborations between mental health and other organizations to improve treatment for Asian Americans, what would that look like? Which organizations would you target?
9. Discuss mindfulness as a treatment for Asian Americans.

Resources and Links

1. The UC Davis Asian American Center on Disparities Research:
<http://psychology.ucdavis.edu/aacdr/>
2. Asian American Resource and Fact Sheets from the National Alliance on Mental Illness (NAMI):
<http://www.nami.org/Template.cfm?Section=Resources&Template=/ContentManagement/ContentDisplay.cfm&ContentID=21026>
3. Link to the 2001 report "Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General":
<http://www.surgeongeneral.gov/library/mentalhealth/cre/>

4. Link to the 2003 report “Achieving the Promise: Transforming Mental Health Care in America” by the President’s New Freedom Commission on Mental Health: <http://store.samhsa.gov/product/SMA03-3831>
5. The National Asian American Pacific Islander Mental Health Association (NAAPIMHA): <http://www.naapimha.org/>
6. Asian American Psychological Association: <https://aapaonline.org/>
7. The UCLA Asian American Studies Center: <http://www.aasc.ucla.edu/>

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