

Survivor Preferences for Response to IPV Disclosure

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Intimate partner violence (IPV) is a major cause of health conditions among women presenting for health care. Many physicians and nurses miss potential opportunities to increase battered women's safety. The purpose of this study is to increase health care providers' understanding of abused women's preferences concerning provider response when they do disclose IPV in order to increase effectiveness of interventions. A total of 26 abused women from a larger study participated in five focus groups at three agencies on "how a hospital or doctor's office can be most helpful to a woman who is experiencing domestic violence." Women identified seven preferences for responses: (a) treat me with respect and concern, (b) protect me, (c) documentation, (d) give me control, (e) immediate response, (f) give me options, and (g) be there for me later. These findings indicate that women prefer an active role by health care providers when responding to disclosure.

Keywords: *domestic violence; qualitative methods; survivor preferences*

Intimate partner violence (IPV) is now recognized as a significant public and women's health issue with negative health outcomes for women, their families, and society (Department of Health and Human Services, 2000; Tjaden & Thoennes, 2000).

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The high rates of lifetime, past-year, and current IPV among women who seek health care services and the negative health outcomes of IPV are well documented (Campbell, 2002; Campbell et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Dearwater et al., 1998; McCauley et al., 1995; Sutherland, Bybee, & Sullivan, 1998). These injuries and health problems result in battered women being seen more often in the health care system than others, creating many opportunities for health care providers to identify abuse and to intervene to support ending the violence (Cascardi, Langhinrichsen, & Vivian, 1992; Plichta, 1992; Sharps et al., 2001). A recent study found that a positive reply to questions about IPV is a strong predictor of future violence and therefore identifies those at risk for increased morbidity (Houry et al., 2004). Evidence still demonstrates low rates of screening, discomfort of some providers in screening, and unwillingness by some women to disclose, even when asked (McCauley, Yurk, Jenkes, & Ford, 1998). The purpose of this study is to increase health care providers' understanding of abused women's preferences concerning provider response when they do disclose IPV in order to increase effectiveness of interventions.

ECOLOGY OF DISCLOSURE

A woman's decision to disclose IPV to a nurse or physician depends on both contextual factors that do or do not create a safe, inviting environment and personal characteristics of the woman. Her past experiences and expectations shape her willingness to disclose IPV.

In a telephone survey of 375 ethnically diverse women, Rodriguez, Bauer, McLoughlin, and Grumbach (1999) found that women were less willing to disclose when questions by providers did not directly ask about specific IPV acts. Other characteristics of the person asking about IPV that are a barrier to disclosure are appearing insensitive, impersonal, indifferent,

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and unlikely to maintain confidentiality (Campbell, Pliska, Taylor, & Sheridan, 1994; Hoff, 1990; McCauley et al., 1998; Rodriguez et al., 1999; Yam, 2000). Even when these are not present, other factors about the institution, such as feeling rushed or otherwise lacking a welcoming atmosphere, may influence her willingness to disclose (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Martins, Holzapfel & Baker, 1992; McCauley et al., 1998; McNutt, Carlson, Gagen, & Winterbauer, 1999; Yam, 2000). One abused woman said, "It wasn't part of their job. It's not part of the system. They are there to fix the injury and that's it" (Gerbert et al., 1996, p. 11).

Personal characteristics or experiences of the abused woman may also make her reluctant to disclose. She may be in denial that she is abused (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999; Hathaway, Willis, & Zimmer, 2002). The embarrassment, shame, and humiliation of admitting to a nurse or physician that you are in an abusive relationship and being hurt makes it very difficult to disclose (Lutenbacher, Cohen, & Mitzel, 2003). Associated with this is the escalating emotional distress associated with disclosing based on the uncertainty this will engender from responses by providers, perpetrators, family, and friends (Gerbert et al., 1999). Minority and poor women have furthermore reduced trust based on life experiences of discrimination along racial and class lines, thereby reducing their willingness to disclose IPV, fearing stereotyping about being violent and irresponsible (Hampton, Oliver, & Magarian, 2003). Lowered trust may also be related to women's beliefs about the health care system such as the following: she would be reported to the police, she would be blamed for not leaving, her thinking the nurse or physician will not be able to help, physicians thinking abuse is not a medical problem, and fear of losing her children (Gerbert et al., 1999; Lutenbacher et al., 2003; Mayer, 2000; Yam, 2000). Immigrant women have additional barriers to disclosure including language and fear of deportation, and some share cultural taboos with other minorities against seeking help from strangers or revealing personal family information (McCaw et al. 2002; Pinn & Chunko, 1997). A last barrier is that she may have disclosed previously and had health providers ignore the statement or do nothing beyond acknowledge it (Lutenbacher et al., 2003).

Some studies have asked women their preferences for responses. Most important to the respondents was that they desired a provider who would believe her, provide privacy, take time with her, be nonjudgmental, take the responsibility to diagnose abuse, probe for stressors on each visit, have an advocate available to see her, advise about resources and referrals including safe shelters and counseling, provide printed information, and follow up within a few days (Campbell et al., 1994; Gerbert et al. 1996, 1999; Hathaway et al., 2002; McCauley et al., 1998; Yam, 2000). A few women wanted the physician to offer medications for stress such as sedatives and tranquilizers, although most did not (Rath & Jarratt, 1990). These findings go beyond guidelines developed for providers, by describing a more active role for the provider (U.S. Prevention Services Task Force [USPSTF], 2004).

PURPOSE

The purpose of this study is to increase health care providers' understanding of abused women's preferences concerning provider response when they do disclose IPV in order to increase effectiveness of interventions.

DESIGN AND SAMPLE

The study is a qualitative analysis of focus groups from a larger study testing an instrument to assess survivors of domestic violence (Dienemann, Campbell, Curry, & Landenburger, 2002). Institutional review board approval was received from the university and each participating agency. A total of 117 women, who identified themselves as victims of domestic violence, were recruited from three hospitals and two community-based domestic violence agencies to participate in the larger study.

The three hospitals each had an ongoing domestic violence response program with a full-time dedicated employee to coordinate and respond when patients disclosed IPV. The two community agencies were comprehensive domestic violence programs with women's and children's counseling, victim court assistance, and shelter programs. For the larger study, all

women who disclosed IPV and agreed to see a counselor were recruited. Those that consented completed a survey that included asking whether they were willing to return for a discussion group about “how a hospital or doctor’s office can be most helpful to a woman like myself who is experiencing domestic violence.” Compensation of a \$20 gift certificate, babysitting, free parking, and dinner before the focus group were offered. Slow accrual of participants to the larger study impeded recruitment to the focus groups. Many women moved from the safe address provided to the investigator or changed their telephone numbers prior to the focus groups forming. Using the standard that a minimum of 3 are needed for a focus group and you must recruit twice as many as will come (Stewart & Shamdansani, 1990), we invited 10 or more to each group and only scheduled a group if we had 6 or more responding that they would come. This standard resulted in only scheduling seven focus groups. Two groups had only 1 participant and were cancelled. The five focus groups held had 2 to 9 participants each, resulting in a final sample of 26 women.

Demographic information on the women is provided in Table 1. All the participants had received individual or group domestic violence counseling at the site of the focus group, except the 2 at the rural hospital. The 26 participants were almost all living in an urban environment apart from their abuser (92.3%), 38.5% were younger than 35 years old, two thirds (69.2%) were African American, and more than half (57.7%) were single. Two thirds (69.2%) had health insurance and a primary care provider. Eleven had not been to the emergency department (ED) and 7 had not seen a physician in the past year. Nine had been to the ED one to four times, and 6 had seen a physician one to four times in the past year. Only 2 had been to the ED five or more times, but 8 had been to the physician five or more times in the past year (all did not complete this question). Sixteen of the 20 (80%) women responding to the question reported that the physician, nurse, or counselor was helpful when they disclosed domestic violence.

METHOD

The focus groups were held at a hospital or community-based agency in a private room and were led by trained teams of

Table 1
Frequency and Percentage of Focus Group Participant Demographics

	Frequency	Percentage
Location		
Urban	24	92.3
Rural	2	7.7
Age		
21-35	10	38.5
35-64	13	50.0
65+	1	3.8
Missing	2	7.7
Ethnicity		
White	8	30.8
African American	18	69.2
Relationship to abuser		
Married	4	15.4
Separated	5	19.2
Single	15	57.7
Missing	2	7.7
Now lives with abuser		
Yes	2	7.7
No	24	92.3
Number of times seen a doctor in past year		
None	7	26.9
1-4	6	23.1
5+	8	30.8
Missing	5	19.2
Number of times to emergency department in past year		
None	11	42.3
1-4	9	34.6
5+	2	7.7
Missing	4	15.4
Health insurance		
Yes	18	69.2
No	8	30.8
Family doctor		
Yes	18	69.2
No	8	30.8
Doctor, nurse, or counselor helpful when told about abuse		
Yes	16	61.5
Somewhat	3	11.5
No	1	3.8
Missing	6	23.1

a researcher and domestic violence advocate. A moderator's guide, as recommended by Krueger (1997), was developed by the researchers with an introduction, questions, and probes. The training session reviewed the process of focus groups, the purpose for these focus groups, each person's role, and the moderator's guide. During each focus group, two tape recorders were used and placed prominently in the center of the table, as recommended by Cote-Arsenault and Morrison-Beedy (1999). Each discussion group lasted between 90 and 120 minutes. During the sessions, the moderator used comprehension probes (Krueger, 1997) to clarify and elicit responses from participants. For example, the moderator may have asked, "Would you give me an example of what you mean?" or "I'm not sure I understand, could you explain further?"

On entering, women were welcomed, offered some refreshments, and asked to make and put on nametags with only their name. They were asked to sign in and to include a safe if they wanted a summary of the study findings sent to them. The facilitator then introduced herself and the co-facilitator from the agency. The co-facilitator was a domestic violence counselor known to the women. The facilitator then reminded them of the purpose of the meeting, that they had signed a consent form and they could leave at any time they desired, and informed them of the rules for communication—to use first names, to not talk while another woman was sharing, and to keep what they heard confidential. The researcher then pointed out the two tape recorders and assured the women that the tapes were to help to accurately write down what they said and would be destroyed after the study ended. They were also told that the co-facilitator would be writing down their main ideas on the flip chart and that they would be asked to review it several times to be sure the researchers understood what they meant. They could change what was on the flip chart if it was not accurate.

The questions began with asking about memories of initial disclosure of domestic violence at a hospital or doctor's office and what was helpful or not helpful. They were then asked to recall other times when they disclosed and what was helpful or not helpful at that time. A third question asked their opinion as to what health care providers should do if a woman discloses

domestic violence. All these responses were put into a list on the flip chart; the women were then asked if the list was correct and then to choose what every provider should always do whenever a woman told them about domestic violence. For the next phase, the questions shifted to focus on what the women knew about documentation in medical records, then more specifically, to documentation of domestic violence, and finally their thoughts about whether disclosure should or should not be documented. The last question was whether they desired that the doctor communicate in referrals to other doctors about their disclosure of domestic violence. At several points during the session, the women were asked to verify that the notations on the flip chart portrayed what they meant.

DATA ANALYSIS

Transcripts (i.e., hard copies) of the discussions were prepared by one transcriptionist with participants' names removed. To verify accuracy and completeness, the transcripts were compared to the original audio recordings and corrected as necessary. The Non-Numerical Unstructured Data Indexing Searching and Theory-Building (NUD*IST; version 4) software program for text-based data was used to code and analyze the transcripts. NUD*IST allows for the hierarchical, or "tree-like," coding and analysis of large amounts of text across multiple themes, participant responses, and groups. To develop a codebook, one transcript (selected at random) was independently read by two of the researchers. When encountering an idea or theme, each analyst marked the text and assigned a semantic code. They then compared their ideas and codes to determine whether they arrived at similar interpretations of the data. Consensus was reached on the ideas to be captured by each code. One researcher then coded the remaining transcripts. Following this, the second researcher read the coded text and verified coding. All of the coded transcripts and corresponding text lines were entered into NUD*IST. Printouts of these "coded" data files were reviewed for accuracy. Codes were said to be themes if they were mentioned more than one time across the groups. Recurring themes are discussed in this article.

FINDINGS

The survivors' desired responses following disclosure of IPV to health care providers are discussed under the seven themes presented below. There is no order of priority; the women only stated what was important for all providers to do, and they did not prioritize them at all. Not all themes were expressed at all focus groups.

TREAT ME WITH RESPECT AND CONCERN

Across all focus groups, the women asked for health care providers to listen without judgment or stereotyping. Several also mentioned how the health care system today acts as a barrier to listening due to pressure on providers to see high numbers of patients daily. They suggested that if the provider feels unable to respond, the health care institution should have a domestic violence specialist, social worker, or domestic violence advocate for immediate referral. The group noted that providers should also sincerely apologize if they do not feel prepared or cannot take the time to give the serious response this problem demands. One woman described her provider's positive response as "understanding and sympathetic but was not condescending and not maudlin. . . . It was an adult situation."

PROTECT ME

Participants gave several examples of when the abuser accompanied them to the ED and were allowed to speak for them. They stated that the ED personnel should have noticed the hovering as a sign of IPV and created an opportunity for them to be seen separately. Even when the woman denies abuse, they thought physicians should be alert for defensive injuries and actively initiate probes, then offer services. She should not have to openly acknowledge abuse to receive assistance. One woman went on to state that physicians should be aware that signs such as "weight loss, sleeping problems, fatigue, or calling all the time needing medication" indicate possible abuse.

They pointed out that sometimes denial is self-protective. For example, she may deny abuse out of concern for her children.

After a long waiting time in the ED, she may be concerned about her child care arrangements and deny IPV. In some cases, if the physician wants to admit her, she may refuse out of fear her children will be placed in the foster care system and they will have difficulty negotiating the complex social service system to regain custody after discharge.

Two women spoke of protective interventions by their physicians and hospitals when they were admitted to deliver their babies. They had confidential admissions with active limitation of access to their room and the baby, and the hospital set up a restriction on incoming telephone calls.

Another instance in which the women did not see hospital personnel as protective was at discharge when they could not safely return home. They spoke about how they were told of shelters in the community, but there were no arrangements made for them to go there. They pointed out that shelters are often full, requiring a waiting period for an opening and, in the meantime, there is no safe place to go. Even when they did arrange for shelter admission on their own, they needed to return home briefly to gather their children and belongings including important documents, clothing, and medication for themselves and their children before going to a shelter. The women in the focus groups felt that hospitals and police should collaborate to arrange for a safe place to go and also provide police accompaniment to the home and to the safe place if there is high danger. Several women said that they felt the health care system is better prepared to protect abused children than abused women. One woman said,

Because we are adults, we don't get the same treatment as a child. And you know what and I'm going to look at it this way, when you're in a situation like that, you're stressed, you're overwhelmed, you know, you don't have anywhere to go, you don't know which way to turn. You have the mentality level of a child because you feel vulnerable and that unprotected.

DOCUMENTATION

The women stated that they did want the health care provider to document and describe all their injuries, even if they did not disclose IPV. They also reported wanting documentation of any threats made by the abuser to the health care pro-

vider stating who received the threat, so that they could be contacted later to testify in a court case. The participants requested that health care providers document the name and badge number of police who brought them into the ED even if police told the woman this information because in a medical and emotional crisis, they may not remember this information later when it is needed. The women also spoke of the usefulness of photographs of their injuries. They believed that counselors and advocates in the community and hospital providers should take the photographs and give a copy to the women for safekeeping. Several commented that pictures had been taken but lost by hospitals. One woman summed it up as, "You want it for the court situation and also from my own personal standing that I know that if it's documented someplace that I didn't just stand by and do nothing."

GIVE ME CONTROL

The women emphasized that health care providers should not tell abused women what to do; they should listen and make suggestions. They pointed out that making suggestions reflects respect and acknowledges that patients do have control over their lives at a time when they feel they have little control. One woman gave the following example:

Just her talking to me, making me feel comfortable, trying to make me not feel ashamed with what happened, trying to lift my spirits. Not telling me what to do, but just the strength in her letting me know that okay, you've made the first step and just educating me enough to know what to do next.

Another woman said, "Make resources visible—if you leave it in a safe place. I may deny it, but when you are not looking, I'll take it." Several women also pointed out that they do lie sometimes as a form of maintaining control when feeling vulnerable. Other situations in which they desired more control were related to confidentiality and personal safety such as whether they are admitted to the hospital anonymously, whether they receive incoming telephone calls as an inpatient, if they should remain in the labor and delivery suite to increase security, where follow-up telephone calls or mail should be sent,

whether to disclose IPV in reports to primary care providers or specialists, and where her photographs are kept.

IMMEDIATE RESPONSE

The women gave examples of positive immediate responses: being active, nonjudgmental, and informative.

When I finally brought myself to the breaking point, my doctor was wonderful. . . . He was very—he never even blinked. As a matter of fact, he kept examining me while he was telling me what he wanted me to do and then he led me here to [hospital], and then I met [domestic violence counselor] . . . Um, I think with a lot of abuse the terrible part is that because when you're abused, you don't feel like it's abuse because it's part of your everyday life to basically live with it.

Women also described negative experiences in which health care providers were condescending, cold as ice, angry with her, hurried and insensitive, unbelieving, left the room to make a referral without telling her, physically pulled back from her, or were insincere as demonstrated by apparent listening followed by focusing on fees or other topics. In the words of one woman, "When you are physically or mentally abused and you tell someone, the feeling you get inside is that you want the help then, because the courage does not last long."

GIVE ME OPTIONS

The women described how abuse was not their only problem and resolving that was tied to resources for all their problems. They mentioned the importance of considering their ability to afford the referrals made and providing support when they were unsuccessful in making contact for assistance or the resource was not helpful. The lack of response from some "helping agencies" can be frustrating, as one woman said, "They never called me back. My doctor called and they did call him back." Another said, "cause one is not guaranteed to be there, or it will work the way you need it to work that day." They desired basic information of their human and legal rights given in the context of offering them a list of different resources. As one woman said, "Just to let you know your rights . . . and let you know there is a place you can go."

BE THERE FOR ME LATER

Women spoke of desiring an open door if they return for help after refusing services or continuing to live with their abuser. They acknowledged that change is slow with movement forward and backward over time. As one said, "In abuse, it has you so that you are imprisoned in yourself. It took years to get there and will take years to get out." They gave examples of how refusal at one time did not mean readiness would not be there another time. They also discussed the value of having a counselor or advocate they could work with over time. One explained, "Support has to go on . . . it gives you a chance to make mistakes." They acknowledged that they are making small steps and mistakes and want continued support.

The participants responded with surprise when they learned that not all health care providers receive training in IPV screening and interventions and that all hospitals do not have domestic violence programs on-site. Women participating in the focus groups supported universal screening using the health history form, followed by screening in a private location. Participants suggested that physicians in private offices have guidelines on their wall of what to do when someone discloses IPV and that EDs should have someone who is a specialist in domestic violence scheduled for every shift. Most of these women spoke about how positive domestic violence counseling had been for them.

DISCUSSION

Because all but 2 of the participants had received domestic violence counseling, and the focus groups were held at a later date than disclosure, the participants had had time to reflect on what happened when they did disclose, what went well, and what did not. Their answers may have been more insightful and contained more language to express their observations and desires than women immediately after disclosing in an emergency situation.

The women were positive about the need for the health care system to provide opportunities to disclose through universal screening and primarily reported positive assistance when they had disclosed domestic violence. This is consistent with other

studies of abused and nonabused women, although many do not report as high a rate of assistance when disclosing (Gielen et al., 2000; Glass, Dearwater, & Campbell, 2001; Lutenbacher et al., 2003; McNutt et al., 1999; Rath & Jarratt, 1990). This discrepancy may be explained by the sample including only women who had at least some positive experiences when they disclosed, as shown by accepting a counseling referral.

The themes of "treat me with respect and concern," "give me control," "immediate response," and "give me options" reflected themes reported in earlier studies, as cited above (Gerbert et al., 1996, 1999; McCauley et al., 1998; Yam, 2000). They desired the provider to reach out and actively help them while not violating their autonomy or self-respect. The importance of providing respectful support has also been found in other studies (Lutenbacher et al., 2003; McCaw et al., 2002). In the words of 1 participant, "Don't look at us like it (domestic violence) is something we did. Don't be scared of us, or [be scared] to treat us."

In speaking of their preference for active protection, the women in this study spoke more strongly of its priority than reported in other studies. They saw lying when asked as a self-protective action when they did not sense that protection would be present. Other studies in discussing barriers to disclosure have not framed denial as self-protection, except when discussing possible retaliation from the perpetrator (Gerbert et al., 1996, Martins et al., 1992). Other studies have acknowledged that loss of confidentiality is a loss of protection that may not only lead to retaliation but also affect their work and other family members or lead to police interference (Gerbert et al., 1999; Lutenbacher et al., 2003; Pinn & Chunko, 1997; Rath & Jarratt, 1990).

The emphasis on active protection included the importance of documentation for future legal action related to the abuse. This may be related to the timing of the study in the women's lives; these women had already disclosed and participated in counseling. Only 2 still lived with their perpetrators. Although it was not asked, several disclosed that they were legally seeking restraining orders, custody, or divorce, making them more aware of the need for documentation of their injuries and the perpetrator's behavior.

In the theme “immediate response,” these women preferred that providers not only screen but also be sensitive to nonverbal clues and respond even if women denied abuse. Despite the increase in training programs associated with the Joint Commission on Accreditation of Healthcare Organizations (2001) mandate for identification of child, partner, and elder abuse, many providers remain uncomfortable to screen for IPV. This is consistent with a survey of ED staff, with 54% reporting that they “never” or “rarely” screened for IPV (McGrath et al., 1997). In addition, only 10% of primary care physicians reported screening for IPV on new patient visits (Rodriguez, Quiroga, & Bauer, 1996). One factor hindering providers from screening in many agencies is the lack of an on-site advocate for immediate referral or sufficient local resources to assist the survivor who does disclose.

The theme of “be there for me later” includes a preference for access to ongoing counseling. Shamai (2000) interviewed abused women who went to counseling and found that they most valued being given space and time to tell their stories with someone attuned to them who validated they were someone with legitimate feelings, thoughts, and desires. The most important outcome of counseling the women saw was beginning recognition of their “self” and an emerging sense of independence whether they left their partner or not. Perhaps the women in this study experienced the same positive outcomes leading to this preference.

These women lived in a metropolitan area that had a strong network of coordinated domestic violence screening, counseling, shelter, and legal advocacy programs. This may have been the basis of their surprise that provider training and hospital-based domestic violence programs were not universal. They responded enthusiastically to providing ideas of what supports providers may need to be more responsive to IPV victims’ needs.

IMPLICATIONS FOR NURSING PRACTICE

Based on the responses of these women, nurses should do universal screening for IPV while providing cues that they will respond positively if a woman discloses. Cues might include

appearing interested in more than the presenting complaint, wanting to hear their answer, providing privacy when screening without the perpetrator present, and making brochures or other information available in multiple places. If they do disclose, they want nurses to actively protect them such as not telling the perpetrator when they left or where they went.

The women emphasized that their answer to screening questions should not fully determine the nurse's response. Perhaps a woman needs to deny IPV for one or several self-protective reasons. If the nurse still suspects domestic violence, she or he should gently probe but not demand disclosure in exchange for help. In such cases, the nurse should provide help through information, documentation of injuries, and the woman's description of the incident (especially discrepancies with the injuries), offering to photograph the injuries, and leaving a brochure within reach. They also wanted nurses to make it clear that not disclosing now does not close the door on later assistance.

Nurse administrators should note that the women were aware of systematic barriers to assisting them and strongly supported having available an advocate/counselor to spend time with the woman after disclosing to listen and then offer suggestions to assist her to meet her needs. A coordinated response program will often increase screening when nurses and physicians know they have "backup" when a woman discloses. These results, overall, speak to the need for more intensive training for health care providers in detection of nonverbal signs and access to more resources for response. This was also noted by McCaw and associates (2002) in reporting the evaluation of a comprehensive domestic violence response program.

CONCLUSION

The information provided by these survivors is consistent with that of other published reports of qualitative studies asking similar questions, adding validity to the results. Its major addition was the high importance women placed on protection and documentation. Performance improvement efforts of training programs for health care providers and existing domestic violence response programs may use this information for program changes. More research is needed to define measures of

effectiveness for domestic violence response programs that reflect the preferences of customers served.

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