

The Survivors Trust

Beyond Surviving to Thriving

National Network: of 70+ specialist organisations providing support for Victims of Rape, Sexual Violence & Sexual Abuse

Date: 9th July 2004

The inter-relatedness of sexual victimisation and priority social and health policy issues

A briefing from The Survivors Trust

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1. Introduction

The Survivors Trust is the first UK & Ireland national network to represent specialist voluntary sector agencies which provide emotional support and practical advice to victims of rape, sexual violence and childhood sexual abuse. Importantly, The Survivors Trust is not gender specific. Among it's 80 plus member organisations are projects working: only with women, only with men and with both women and men – plus some provide additional support for adolescents.

The Survivors Trust is a national voice for more than half of the 153 voluntary sector specialist agencies listed in the Spring 2004 edition of the DABS national resource directory [DABS, 2004] of services working with rape, sexual assault, childhood sexual abuse and related issues.

The long term effects of such abuse include post traumatic stress symptoms; depression; anxiety; dissociation; sleep problems; flashbacks; nightmares; irritability and outbursts of anger; low self-esteem; lack of confidence; self-harming behaviours; suicide; alcohol and drug abuse and dependence; work-holism; prostitution; criminal behaviour (including - for a small minority – sexual offending); homelessness; revictimisation; relationship problems; lack of trust in others; sexual

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problems; confusion about sexuality; chronic physical pain and other physical health problems; eating disorders; transient psychotic episodes; borderline personality disorder; dissociative identity disorder; somatisation. This is not an exhaustive list. In fact the experience of sexual assault or abuse at any age and whether female or male can have devastating effects on every aspect of oneself, one's mind, one's body; one's behaviour, thoughts and feelings. Not all victims will have all effects; the mix, severity and complexity is a unique experience for each individual. Help and support is not always available because specialist agencies for victims of sexual abuse, rape and sexual assault are overstretched; staff time has to be diverted to bidding for scarce funds which are usually short-term and insecure. Funding for core services is particularly hard to come by so agencies are frequently under threat of closure, with news of actual closures not infrequent.

This briefing focuses on how areas of health and social policy which have received some political priority are inter-related with the needs of victims of rape, sexual assault and childhood sexual abuse. It aims to show that enabling the survival and development of specialist agencies that work with such victims will support the achievement of objectives and targets within these priority health and social policy areas. It is also hoped that the briefing will raise general awareness of the complexities of the effects of sexual victimization and encourage involvement in the All Party Parliamentary Group on Survivors of Sexual Abuse and Rape.

2. Domestic Violence

Adults who were sexually abused in childhood are more likely to be victims of domestic violence. One study found that almost half (48.9%) of childhood sexual abuse victims became victims of a violent partner as an adult. This compared to 17.6% of non-victims of childhood sexual abuse. [Briere and Runtz, 1988]

The risk of rape, sexual harassment and domestic violence in adulthood is approximately doubled for victims of childhood sexual abuse. In one study of women who had been incestuously abused in childhood, two thirds were subsequently raped. [Russell, D.H., 1986]

This increased risk of victimisation in adulthood has been theorised to arise from recognised traumatic effects of childhood sexual abuse. [Herman, 1981; McCann et al., 1988; Russell, 1986; Steele & Alexander, 1981]

With help from specialist agencies to overcome such traumatic effects child, adolescent and adult victims of childhood sexual abuse can reduce their risk of becoming victims of domestic violence. Conversely, if adult victims of domestic violence who are also victims of sexual abuse in childhood are able to access

services to address both these needs the risk of future victimisation may be reduced.

Households in which domestic violence occurs are also at increased risk for rape within marriage/partner relationship and for the sexual abuse of children in the household. This is another reason why joint working between domestic violence agencies and specialist agencies working with victims of rape and sexual abuse needs to be funded and supported.

3. Drug and Alcohol Abuse and Dependence

Women who experience any type of sexual abuse in childhood are roughly three times more likely than non-abused women to report drug or alcohol dependence as adults. [Kendler, K.S., et al., 2000]

67-90% of women with alcohol and drug addiction problems are survivors of childhood sexual abuse. [Wilson, J., 1998a]

Adult male victims of childhood sexual abuse are significantly more likely than their non-abused counterparts to meet diagnostic criteria for a substance use disorder (55.4% versus 26.7%, respectively) or for drug abuse/dependence (44.9% versus 7.8%, respectively) [Stein et al. 1988]

Rape victims are 5.3 times more likely than non-victims to have used prescription drugs non-medically; 3.4 times more likely to have used marijuana; 6 times more likely to have used cocaine; and 10.1 times more likely to have used "hard drugs" other than cocaine [Kilpatrick, Edmunds, and Seymour, 1992].

Such evidence is often interpreted as either a causal or collateral factor to the offence(s) leading to a 'blame the victim' attitude. However, combined with the statistics for addictions in adult survivors of childhood sexual abuse and evidence from the specific studies immediately below it is supportive of specialist agencies' experience that victims of sexual abuse, sexual assault and rape are much more likely than non-victims to use alcohol and other drugs as a way of coping with the trauma of victimization. Such substance use is clearly a consequence of their victimization.

One study proposes that individuals will often choose and use drugs which manage specific effects and consequences of abuse (such as intrusive recollections, flashbacks, nightmares, avoidance, numbing or hyper-vigilance) [Stewart et al, 1998]

Addictive substances may also be employed by victims of childhood sexual abuse to counteract the effect of poor self-esteem [Paone, D. et al, 1992]

If there was securely funded access to the services of specialist agencies to overcome these effects for all victims of rape, sexual abuse and assault then the need to self-medicate with drugs and alcohol could be reduced.

However, because these are addictive substances it is also important to fund and otherwise facilitate partnership working between substance abuse services and specialist agencies working with victims of rape, sexual abuse and assault. The following two studies which look at the problem from the perspective of substance abuse agencies support this further. Responding only to the individual's needs as an addict is unlikely to have long-term success unless their needs as a victim of sexual violence are also addressed.

A survey of workers at 47 drug addiction agencies in Scotland estimated that 50% of their clients had been abused in childhood. [Wilson, J., 1998b]

A UK study in which the subjects were 40 male and 20 female patients in a regional in-patient drug detoxification unit found that 90% of the women and 37% of the men had been victims of childhood sexual abuse [Porter, 1994]

Finally, it should be noted that drugs and alcohol are frequently abused by perpetrators of sexual crimes. In this case the addictive substance lowers any natural inhibition the perpetrator may have against committing rape, sexual violence or the sexual abuse of a child. Also, the use of drugs and alcohol by perpetrators to lower or annihilate their victims' resistance (e.g. in so called date-rape and in ritual or organized abuse) should also not go unmentioned.

4. Crime and Anti-social Behaviour

Under this heading it is important to first of all dispose of the myth that people who have been sexually abused in childhood are more likely to commit sexual offences in adulthood. This is simply not true. If it were, the majority of perpetrators would be female as most victims (though certainly not all) of childhood sexual abuse are girls. The opposite is true. The majority of individuals convicted of sex offences of all kinds are male. So, is it true that the majority of male victims of childhood sexual abuse become abusers in adulthood? No, this also is a myth.

A UK study published in The Lancet showed that 88% of men who were abused in childhood did not become abusers in adulthood. Of the minority that were convicted of a sexual offence in adulthood there were specific factors additional to the fact that they were themselves abused which increased the risk of becoming an abuser. [Salter, D et al, 2003]

US surveys of prison inmate and probation populations show that many people convicted of any criminal offence report having been sexually abused at some time before their current conviction. The prevalence figures are between 2 to 6 per cent for male prisoners/probationers and 22 to 39 percent for females. When asked about rape before their current conviction these populations reported incidents of having been the victim of an attempted or completed rape at the rate of 1 to 4 percent for males and 21 to 38 percent for females. [Wolf Harlow, C, 1999]

Victims of child sexual abuse are 27.7 times more likely to be arrested for prostitution as adults than non-victims.[Widom, 1995]. This may be the result of being forced into prostitution by their abusers. In adolescents and young women who have left home to escape the abuse, prostitution may be the only way they know to support themselves. For others, it can be a consequence of the low self-esteem and relationship difficulties which are almost universal results of being sexually victimised and make victims particularly vulnerable to exploitation in adulthood.

Naturally, such figures are not conclusive of a simple cause and effect between sexual victimisation and criminal behaviour. They also have to be weighed against evidence that suggests some sex and violent offenders falsely claim they were victimized as a way of explaining or excusing their own crimes. One study of sex offenders showed that after they were told they would be subject to a polygraph test, the percentage of those claiming sexual victimization dropped from 67% to 29%. [Hindman, J. 1988]

However, the available evidence and the experience of workers in specialist agencies suggest that helping prisoners to overcome the trauma of prior sexual abuse and rape is a largely unmet need, which if addressed could contribute to crime reduction. One UK specialist agency for male victims of sexual abuse and rape has this to say on the subject:-

"Estimates vary, but at least 80% of the male prison population in the United Kingdom have suffered some form of sexual abuse, either as children or adults, and many men have been subjected to rape and/or sexual abuse by other prisoners, and in some cases, have also been sexually abused by staff in the jails.

There are literally thousands of men who end up in prisons who have ended up there due to drug and alcohol misuse, anger issues etc., all of which have been caused by the fact that they were sexually abused as children, or as adults.

With the right support, these men can turn their criminal behaviours around and overcome the past, and in doing so, leave the prison life behind, and become 'normal' citizens" [Survivors Swindon]

5. Mental Health

50 – 60% of psychiatric inpatients and 40-60% of outpatients were physically and/or sexually abused as children. [Jacobson, A. & Richardson, B., 1987; Bryer, J. B. et al, 1987; Jacobson, A., 1989; Briere, J. & Runtz, M. 1987] Where such abuse involved penetration there are 16 times as many psychiatric admissions compared to the general population. [Read, J., 1998]

50-80% of women who are raped develop post-traumatic stress disorder. This compares to 5-8% of combat veterans. [Putnam, F., 1998]

Follow-up studies find that rape victims have high levels of persistent post-traumatic stress disorder, compared to victims of other crimes. [Breslau, N. et al, 1991] Women who have a pre-existing mental health problem before they were raped suffer particularly severe and complicated post-traumatic reactions. [Burgess, A & Holmstrom, L., 1979]

Men and boys who have been sexually assaulted are more likely to suffer from post traumatic stress disorder, other anxiety disorders, and depression than those who have never been abused sexually [Bauserman, R. B., & Rind, B., 1997; Black, C. A., & DeBlassie, R. R., 1993; Collings, S. J., 1995]

40 to 71% of people diagnosed with borderline personality disorder report having been sexually abused [Psychology Today]

An audit of inpatients of a UK psychiatric unit found that 5% were highly likely to meet diagnostic criteria for dissociative identity disorder (formerly known as multiple personality disorder) yet none of the patients in this study had this diagnosis. The results of this study closely correlate with results of similar international studies. [Aquarone, R. 2002]. 97% of patients diagnosed with dissociative identity disorder have histories of major childhood trauma, most commonly sexual abuse [Putnam, F.W. et al 1986]

Young girls who are sexually abused are more likely to develop eating disorders as adolescents [Wonderlich, S.A. et al, 2000]

It is clear that there is a significant correlation between severe mental health problems and experience of sexual abuse, sexual assault and rape. Yet, staff in statutory mental health services are generally inadequately informed, trained and supported to appropriately assess, diagnose and work effectively with victims to help them recover from the trauma of sexual violence. [Nelson, S. 2001]. Staff and volunteers in the voluntary sector's specialist agencies are generally more appropriately skilled in working with victims towards long term recovery but the

main problem in this sector is lack of secure and core funding to ensure the organizations' survival and development to meet the high demands.

Recent national policy and best practice guidance on women's mental health and personality disorders give some hope that more attention could be given to meeting the needs of victims of sexual abuse, assault and rape within mental health services. [NIMHE, 2003(a); 2002(a); 2003(b)]. However, there is still the risk that, buried within such wider issues, the specific needs of victims of sexual violence will not receive the necessary priority and development. Also, if the hopes raised by these initiatives are to be realized the national policies, strategies and best practice need to be implemented in all localities and given some priority in local commissioning and funding decisions. This local implementation and the funding available for it needs to be influenced by, accessible to and inclusive of the specialist agencies in the voluntary sector.

Work also needs to be done on developing a complimentary men's mental health strategy which, among other things, recognizes the needs of male victims of sexual violence within mental health services.

Another positive recent development is the joint programme on Violence, Abuse & Mental Health which was announced at the Home Office National Victims Conference in April 2004. The programme involves joint working between the DoH, NIMHE and the Home Office. It's purpose is to identify and address the health and mental health implications of child sexual abuse, domestic violence and sexual violence for professionals and services responding to the needs of victims, survivors and abusers, including children, adolescents and adults. The Survivors Trust is a key participant in developing and delivering this programme.

Undoubtedly the statistics on mental health and sexual violence are convincing of the need for changes in the mental health system, including increased partnership working with the specialist agencies in the voluntary sector. However, it should not be forgotten, that the vast majority of victims of sexual violence never come to the attention of mental health services. This is not because they are unaffected by their trauma history.

Almost all victims will experience one or more of the long term effects listed in the introduction. Many turn to the voluntary sector specialist agencies for support, some referred from other related statutory and voluntary services such as domestic violence units and Victim Support Services. But classically, the funding to work with these clients does not follow them from the referring agencies.

6. Suicide Prevention

Adults who experienced childhood sexual abuse are 12 times more likely to attempt suicide than those who did not. [Fellitti, V & Anda, R. 1998]

One study showed that nearly 20% of rape victims had attempted suicide compared to just over 2% of non-victims [Kilpatrick, D.G. et al (1985)]

It is estimated that one in ten people who survive a suicide attempt will eventually make a fatal suicide attempt.

The suicide rate among sexually abused boys is between 1½ to 14 times higher than their non-abused counterparts. [Holmes, W.C. 1998]

Sexually abused young men are amongst the highest risks groups for youth suicide [O'Leary, T & Pratt, R. 2003]

Again, it is good to report that national policy does now reflect that working with sexual abuse victims is a factor in preventing suicide. The DoH's Suicide Prevention Strategy for England [NIMHE, 2002(b)] includes a specific objective of promoting the mental health of survivors and victims of abuse, including child sexual abuse. And some of its other objectives could have impact on suicide rates in this group e.g. reduce the number of suicides in the year following acts of deliberate self-harm; and reduce the number of suicides of young men.

Regrettably the actions specified in the implementation section of the strategy for the only objective specific to this group are relatively weak, referring only to supporting the implementation of the Women's Mental Health Strategy (which excludes male victims) and liaising with other organisations about ways to achieve the objective.

The Survivors Trust is a named liaison partner and is contributing towards achieving this objective through its work with the Violence, Abuse & Mental Health programme mentioned above. However, having been successful in getting NIMHE to recognise the risk of suicide in sexual abuse victims it was a disappointment that a suicide prevention toolkit issued to mental health services contains no mention of this at-risk group. [NIMHE, 2003(c)]

7. Deliberate Self-Harm

The most common method of self-harm involves repeatedly cutting the skin, but others include burning, scalding, hitting or scratching, hair pulling or swallowing small amounts of toxic substances to cause discomfort or damage.

The onset of self-harming behaviour has been linked to difficult things going on in a young person's life including (but not exclusively) abuse and rape.

Rates of self-harm in the UK have increased over the past decade, making them the highest in Europe [National Institute for Clinical Excellence, 2002]

Those who have self-harmed are 100 times more likely than the general population to die by suicide in the subsequent year. One-half of the 4000 people who die by suicide each year will have self-harmed at some time in the past. [National Institute for Clinical Excellence, 2002]

The connection between childhood abuse and self-harming behaviour is well-documented. Repetitive self-injury develops most commonly in those victims whose abuse began in early childhood. [Herman, J.L. 1992]

Dissociative processes, including amnesia, depersonalisation (feeling of being detached from one's body and mental processes) and derealisation (feeling that the outside environment is unreal or changing shape/size etc) are increasingly recognised as underpinning much self-injury. [Sutton, J. 2004]. Yet, very little training is available in dissociation for mental health and other health professionals who may be working with victims of childhood sexual abuse who self-injure.

Previous physical and sexual abuse is common amongst those who self-harm in prisons, especially young girls (15-17years) and women. [NIMHE, 2003(d)]

In the United Kingdom 10,000 episodes of self-cutting come to the attention of the accident and emergency departments of hospitals each year [Williams, M. 1997]. This is likely to be a gross under-estimate of the actual incidence of self-cutting as many people who self-harm will not seek treatment for their injuries.

A welcome initiative in the area of self-harm is the recently announced national inquiry into self-harm amongst 11 to 25 year olds. [Mental Health Foundation & Camelot Foundation, 2004] Given the known links between self harm, sexual abuse and rape it will be important that The Survivors Trust and its member organisations are enabled to contribute evidence and actively participate in this inquiry.

The process of trying to influence the NICE clinical guidelines on self-harm, has been disappointing. Rigid adherence to a professionally dictated value hierarchy of evidence has meant that it has been difficult to get the experiences and results of service-user led qualitative research reflected in the guidelines.

It is important that the voice of voluntary sector services for rape and sexual abuse victims participates in such initiatives as these. The Survivors Trust and its member organisations do all that we can to ensure that voice is heard but doing so puts

unnneeded pressure on already overstretched services because of the lack of secure funding and funding for core activities of the specialist agencies.

8. Improving the health of the nation

Those who have experienced serious childhood trauma such as physical, sexual or emotional abuse, may have twice the rate of cancer, heart disease and chronic bronchitis than those who have not experienced such trauma. [Acierno, R. 1997]

Childhood sexual abuse can affect risk of infection with HIV. This is because sexual abuse in childhood distorts victims' physical, mental and sexual image of themselves. These distortions combined with coping mechanisms adopted to offset the trauma, can lead victims into high-risk sexual and drug-using behaviours that increase the likelihood of HIV infection. [Prillo, K.M. et al 2001]

Women who were sexually abused as children are nearly four-times more likely to be current smokers than women who didn't report sexual abuse. They are also two-times more likely to have started smoking before age 14. [Figuroa-Moseley et al, 2004]

Exposure to traumatic events such as sexual abuse and assault can be related to poor physical health. Posttraumatic Stress Disorder which is common mental health sequelae to rape, childhood sexual abuse and rape is also related to health problems.

There is not yet sufficient evidence to conclusively show a direct cause and effect between trauma / PTSD and poor physical health but a number of studies have noted the association. Particular physical health problems that have been reported in studies are cancer, ischemic heart disease, chronic lung disease, hypertension and other cardiovascular symptoms; abnormalities in thyroid and other hormone functions; increased susceptibility to infections, immunologic disorders; gastrointestinal and musculoskeletal disorders. [Jankowski, 2003]

The findings of these studies, which have mostly been done with combat veterans with PTSD rather than abuse or rape victims, are none-the-less supported by the observations and experience of workers in specialist agencies working with victims of sexual violence.

The implications for health services of the inter-relatedness of childhood sexual abuse, sexual assault and rape and poor physical health need to be further researched. One possibility, is that helping victims to recover from post-traumatic stress will have a positive impact on targets in the improving the health of the nation programmes. A positive outcome could be a change in medical

professionals' attitudes of dismissive-ness when victims of sexual abuse and rape complain repeatedly of physical health problems.

9. All Party Parliamentary Group – Rape or Sexual Abuse (APPG RoSA)

There is now an All Party Parliamentary Group on Survivors of Sexual Abuse & Rape (APPG), for which The Survivors Trust provides administrative support. This is a forum in which members of the Houses of Commons and Lords, together with experts and representatives from specialist agencies, can debate on the issues of childhood and/or adulthood sexual abuse and rape, its long term effects and links with mental health problems, alcohol and drug abuse, domestic violence, homelessness and other health and social care priority policy areas with the purpose of developing an agreed specific programme of targets and action. The group will ascertain the level of current service provision nationally, identify gaps in services and address funding issues. The group will consider the requirement for care pathways for survivors as well as the need for joined-up policies. The legal considerations surrounding such sexual abuse and those agencies over which Westminster has authority will be considered. The group will seek to create greater public awareness and understanding of the issues, and combat the many myths that surround sexual abuse and its impact on our society as a whole.

Vera Baird Q.C. M.P. is chair of the APPG;
Sandra Gidley M.P. is vice-chair;
Virginia Bottomley M.P. is secretary.

10. Conclusion

Domestic violence, drug and alcohol abuse and dependence, crime and anti-social behaviour, mental health, suicide prevention, deliberate self-harm, and improving the health of the nation are all areas of health and social care policy which have been prioritised for development by the current political environment. All have significant overlap, inter-dependence and cross-implications with services which help the recovery of victims of childhood sexual abuse, rape and sexual assault which have not been identified for priority development.

ORGANISATIONAL MEMBERS, or who are in the process of applying to join THE SURVIVORS TRUST (March04)

<p>ABSS Association Boarding School Survivors Abuse Not, Scotland Adult Survivors of Incest & SA, Norwich APHIST Abused People's Help in Sexual Trauma ASCA Adult Survivors of Childhood Abuse Newcastle on Tyne Avon SA Centre Axis Counselling, Shrewsbury Aylesbury Vale Rape Crisis Basingstoke Rape & Sexual Abuse Counselling Crisis Centre Breaking Free, Morden Surrey Breakthrough for Women, Glasgow Cambridge Rape Crisis Centre Chester Rape Crisis & Incest Line CHOICES, Cambridge CIS'ters (Childhood Incest Survivors) Colchester Rape Crisis Line Cornwall Rape & SA Centre CRASAC Coventry Rape & Sexual Abuse Centre Derby Rape Crisis Doncaster Rape & Sexual Abuse Counselling Centre Dublin Rape Crisis Centre East Dorset Rape Crisis Line East Kent Rape Line Emerge, Staffordshire Fire in Ice, Liverpool First Person Plural (FPP) First Step, Leicester Herts Area Rape Crisis & SA Centre ICAIR Independent Care After Incest & Rape ISAS, Nottinghamshire Jig-Saw, Isle of Wight Kilmarnock Rape Counselling & Resource Centre KASP Kingdom Abuse Survivors Project, Scotland KRASACC Kirklees Rape & Sexual Abuse Counselling Centre, Huddersfield Lancashire Survivors Metamorphosis, Milton Keynes MKRASASC Milton Keynes Rape & Sexual Abuse Support Centre MOSAC Mothers of Sexually Abused Children New Pathways, Wales North West Wales Rape Crisis & Sexual Abuse Line One in Four (UK) One in Four (Ireland) Peterborough Rape Crisis Open Secret, Scotland Oxford Sexual Abuse and Rape Crisis Centre</p>	<p>PARCS Portsmouth Area Rape Crisis Service Rape & Sexual Abuse Line, South Wales Rape & Sexual Abuse Support Centre Croydon Rape & Sexual Abuse Support Centre Guildford Rape & Sexual Abuse Support Centre Warrington RASAC Rape & Sexual Abuse Centre Winchester Respond, London (helping survivors who are LD) Revival, Trowbridge Rugby RoSA SAIFLINE, Warwick SAIL Sexual Abuse & Incest Line, Chesterfield SARAC, Staffordshire Scarborough Male Survivors Scunthorpe & Grimsby Rape Crisis SEARCH Sexual Abuse & Rape Counselling, Hartlepool SERICC South Essex Rape & Incest Crisis Centre SHE Survivors Helping Each other, Notts Sheffield Rape Crisis Counselling Service Southampton Rape Crisis & Sexual Abuse Counselling Service Spelthorne Open Space SURVIVE, North Yorkshire Survivors Network, Brighton Survivors Sheffield Survivors Swindon Survivors UK Survivors West Yorkshire The Lantern Project Watford Rape Crisis Women Emerging (WE), Nottingham Wiltshire Rape Support Helpline Worcestershire Rape & Sexual Abuse Support Centre WRSAC Womens Rape & Sexual Abuse Centre Bodmin Wycombe Rape Crisis York Rape Crisis Young Womens Housing Project, Sheffield</p> <p><u>Associate Organisations</u> Amazon Young Peoples Counselling Service Bristol Crisis Service for Women DABS NAPAC National Association People Abused As Children Safe, Strong & Free, Scotland West Hampstead Womens Centre</p>
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Research and statistics quoted in this briefing should be regarded as indicative not conclusive of a simple cause and effect inter-relationship between sexual abuse & rape and the various policy areas covered. The reality of this inter-relatedness is surely complex and attempts to demonstrate it are hindered by the variety of definitions of rape and sexual abuse, inconsistencies of terminology used in the policy areas mentioned and differences in the methodologies used across the available research sources.

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