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## Long-Term Sobriety Strategies for Men With Co-occurring Disorders

Alison Luciano, MPH, PhD, Elisabeth L. Bryan, MS, Elizabeth A. Carpenter-Song, PhD, Mary Woods, RN, LADAC, Katherine Armstrong, BA, and Robert E. Drake, MD, PhD

**Objective:** Roughly half of people with severe mental disorders also experience a co-occurring substance use disorder, and recovery from both is a critical objective for health care services. While understanding of abstinence initiation has grown, the strategies people with co-occurring disorders use to maintain sobriety are largely unknown. This article reports strategies for relapse prevention as described by men with co-occurring disorders who achieved one or more years of sobriety. **Methods:** We analyzed semi-structured interviews conducted with a sample of 12 men with co-occurring psychosis and substance use disorder who achieved and maintained sobriety for at least one year, supplemented with demographic and diagnostic clinical record data. These men were participating in residential or outpatient treatment at a private, nonprofit integrated treatment clinic. **Results:** The 12 men were primarily Caucasian (91.7%) and unmarried (100%), and their ages ranged from 23 to 42 years. The two most common psychiatric disorders were schizoaffective disorder ( $n = 4$ , 33.3%) and bipolar disorder ( $n = 4$ , 33.3%), while the two most commonly misused substances were alcohol and cannabis. Qualitative analyses showed that participants maintained sobriety for at least one year by building a supportive community, engaging in productive activities, and carefully monitoring their own attitudes toward substances, mental health, and responsibility. Alcoholics Anonymous might act as a catalyst for building skills. **Conclusions:** People with co-occurring disorders who achieve sobriety use a variety of self-management strategies to prevent relapse—seeking support, activities, and a healthy mindset. The findings suggest a relapse prevention model that focuses on social networks, role functioning, and self-monitoring and conceptualizes self-care as critical to extending periods of wellness. (*Journal of Dual Diagnosis*, 10:212–219, 2014)

**Keywords** *co-occurring disorders, severe mental disorders, addiction, relapse prevention, qualitative*

Approximately half of people with severe mental disorders such as schizophrenia, bipolar disorder, and severe depression also experience substance use disorder (Drake et al., 1990; Duke, Pantelis, & Barnes, 1994; Kendler, Gallagher, Abelson, & Kessler, 1997; Regier et al., 1990; Ziedonis & Trudeau, 1997). Achieving and maintaining substance use disorder remission is a key objective for mental health services. People with persistent substance use disorders often experience worse functional outcomes (Killackey, Jackson, Gleeson, Hickie, & McGorry, 2006; Roy, Rousseau, Fortier, & Mottard, 2009) and high risk of relapse (Hides, Dawe, & Kavanagh, 2006). Unfortunately, understanding of abstinence initiation has far outpaced advancement of knowledge in relapse prevention.

Controlled research studies show that group counseling, contingency management, and residential treatment improve rates of achieving substance use disorder remission among people with co-occurring disorders (Drake, O'Neal, & Wallach, 2008), but four literature summaries found no studies examining relapse prevention strategies (Brunette, Mueser,

& Drake, 2004; Drake, Mueser, Brunette, & McHugo, 2004; Drake et al., 2008; Mueser, Drake, Sigmon, & Brunette, 2005). One ethnography of 19 community mental health center clients with co-occurring disorders identified factors that supported sobriety. Regularly enjoyable activity, stable housing, and relationships with a sober community member and a thoughtful clinician appeared to support sobriety, while childhood homes with abusive relationships, substance use, poverty, or otherwise poorly functioning household members acted as obstacles to substance use disorder remission (Alverson, Alverson, & Drake, 2000). A second qualitative study of 38 formerly homeless people with co-occurring disorders distinguished between factors associated with achieving versus maintaining sobriety: Achieving sobriety involved key events and people, personal maturity, and institutionalization while maintaining recovery involved safe housing, self-help meetings (e.g., Alcoholics Anonymous) and significant others (Henwood, Padgett, Smith, & Tiderington, 2012). Together, these two qualitative reports indicate that achieving sobriety and maintaining sobriety are distinct tasks.

The authors capitalized on an unusual opportunity to further explore a critical gap in co-occurring disorders research—maintaining sobriety—using secondary qualitative data of participants with psychosis and co-occurring substance use disorder who achieved at least one year of sobriety. Participants were recruited from a health center offering integrated treatment for co-occurring mental health

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and substance use disorder, which is rare in the United States (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014).

Our central research questions were (a) what is the subjective experience of maintaining sobriety for people with co-occurring psychosis and substance use disorder? and (b) what behavioral strategies supported continued lifestyle change from these participants' points of view?

## METHODS

### Study Design

This paper reports an analysis of in-depth qualitative interview data, supplemented with clinical record data. The data were previously collected in an integrated co-occurring disorder treatment clinic via semi-structured interviews to provide personal narratives as descriptions of integrated treatment (Woods, Armstrong, & Drake, 2012).

### Study Setting and Participants

All participants were recruited from a private, nonprofit integrated co-occurring disorder treatment clinic that serves mostly younger individuals between 18 and 25 who have limited experience living independently and have experienced multiple failed treatment attempts in nonintegrated settings. Although the clinic provided treatment scholarships to some participants, availability is limited; therefore, the population often comes from resource-rich family backgrounds.

Clinic participants are typically admitted to residential treatment for adult men. The clinic provides single-sex housing for residential patients in keeping with evidence-based practices for substance use care. No complementary women's residential housing currently exists. Participants receive a full medical and psychosocial assessment, attend recovery groups, develop a Wellness Recovery Action Plan, participate in cognitive behavioral therapy, join family psychoeducation, receive motivational interviewing to encourage substance abuse treatment engagement, engage in daily wellness activities with other participants, and attend events in the community on the weekends. Participants often volunteer in the community toward the end of residential treatment. At the time of the study, participants in residential treatment were encouraged, but not required, to attend self-help groups in the community. The clinic functions as a medical home for participants by providing referrals to medical physicians for physical comorbidities. The treatment team and participants collaboratively determine when to begin the transition out of residential treatment.

Participants often choose to participate in long-term outpatient treatment by permanently relocating to the clinic's community. Outpatient treatment involves 24/7 assertive community treatment support, therapeutic activities, evening

mentor visits, individual counseling, and sleep coaches. Mentors and sleep coaches regularly visit participants in their homes to support them directly (e.g., providing transportation) or indirectly (e.g., providing companionship) in activities of daily living. Examples include medication management, food shopping, self-help meeting attendance, and establishing routines. All of the aforementioned activities are encouraged, but not required. Substance use testing is conducted regularly. Cases of relapse can result in readmission to residential treatment, but never in expulsion from clinical services. It is common for participants to gradually decrease the intensity of services as involvement in higher education or employment increases. Note that a similar summary of services offered by the clinic is published elsewhere (Woods & Drake, 2011).

Study eligibility criteria included (a) diagnosed co-occurring severe mental disorder and substance use disorder, (b) received inpatient or outpatient services, and (c) achieved sobriety for one year or more.

### Procedure

A non-clinical staff member approached participants in 2012. The interview topic guide explored participants' lives before, during, and after achieving recovery. Questions asked participants to reflect on their experiences leading up to illness, during illness, during treatment, and during recovery (See Table 1). A licensed nurse who is also a licensed drug and alcohol abuse counselor conducted all of the 60- to 90-minute interviews, which a research assistant simultaneously fully transcribed. Ten of the interviews were conducted in person; one was conducted via telephone and one via videoconference. To preserve participants' anonymity, program administrators collected minimal record data using a piloted data extraction form. Following a full discussion of the study, participants provided informed consent for researchers to receive the linked, deidentified verbatim qualitative transcripts and quantitative record data to analyze. The Dartmouth College Committee for the Protection of Human Subjects reviewed and approved the study procedures.

### Analysis

Two researchers jointly analyzed all transcripts using Charmaz's constructivist grounded-theory approach (Charmaz, 2006). Charmaz's constructivist grounded theory was chosen as the analytic strategy because of its emphasis on foregrounding the voice and experience of participants throughout analysis and writing as well as its acknowledgment of the active construction of findings through an interpretivist approach, rather than "discovery" of findings as external reality per some interpretations of the traditional grounded theory of Glaser and Strauss (1967). The researchers involved in this study came from diverse backgrounds: a psychiatrist,

TABLE 1  
Semi-Structured Interview Questions

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1. Tell me about what life was like before you were diagnosed with [ . . . ]? Before you began abusing [ . . . ]?
  2. When did you first begin to experience symptoms of mental illness and substance abuse?
  3. What effect did these symptoms have on your experience in school, your hobbies, your relationships (with family and peers), and your goals (for yourself, for your future)?
  4. How many times have you been in treatment for mental illness? For substance abuse?
  5. Please tell us a bit about your experiences with treatment before [redacted]?
  6. What has been your experience with [redacted]'s model of treatment (residential and/or outpatient)?
  7. What have been the strengths of your experience with [redacted] What about [redacted]'s modality of treatment has been most effective for you?
  8. Have any individual staff members played a particularly significant role in your process of recovery at [redacted]?
  9. What has your family's experience been with [redacted]'s model of treatment?
  10. How do you define recovery for yourself?
  11. What is your life like now?
  12. How long have you been sober?
  13. What accomplishments have you achieved since you have been sober? What makes you most proud about where you are now?
  14. What has been your experience with self-help? How active are you?
  15. What role does spirituality play in your life?
  16. What suggestions do you have for people reading this book who might have a co-occurring disorder?
  17. What has been most helpful to you in your recovery process? About [redacted] in particular?
  18. What life lessons have you learned?
- 

a psychiatric nurse, a mental health services researcher, an anthropologist, and two relatively novice research assistants. They represent a variety of ages, nationalities, socioeconomic backgrounds, and sociocultural perspectives. Throughout the writing process, members of the research team challenged each others' interpretations of the data, serving as a check and balance to confirm that findings were not rooted in a particular observer's lens. After studying each utterance, researchers developed initial coding themes and applied these to text segments. The researchers continually focused and refined the categories through iterations of coding, actively seeking disconfirming evidence. Researchers chose quotations from the interviews included in this study on the grounds of representativeness. Descriptive statistics characterized the background information collected via record review.

## RESULTS

The participant sample was aged 23 to 42 years, largely Caucasian ( $n = 11$ , 91.7%) and unmarried ( $N = 12$ , 100%). Mental health diagnoses included schizoaffective disorder ( $n = 4$ , 33.3%), schizophrenia ( $n = 2$ , 16.7%), bipolar disorder ( $n = 4$ , 33.3%), and generalized anxiety disorder ( $n = 2$ , 16.7%). Substance use disorders included alcohol and cannabis abuse ( $n = 2$ , 16.7%), cannabis abuse only ( $n = 3$ , 25%), alcohol abuse only ( $n = 3$ , 25%), polysubstance dependence ( $n = 2$ , 16.7%), and opioid dependence ( $n = 2$ , 16.7%). Three successful relapse prevention strategies emerged from the data: building a supportive community, participating in active versus passive activities, and maintaining a healthy attitude. Participating in Alcoholics Anonymous supported all of these relapse prevention strategies.

### 1. Building a Supportive Community

Participants spoke about the nature and type of relationships in their lives as key elements of their relapse prevention strategy. "For me it comes down to relationships, how I get along with other people is very important." Peers in treatment accelerated their progress, for example:

"I think it really helped my recovery by having others recover with me. It propelled me in a positive direction."

"I think what's been the most helpful is the support of the people around me. Telling me and showing me that I can do it. Showing me that I'm a part of something, that maybe this way of life is different, and maybe this way of life is better."

"I think a big part, if you're going to deal with this, is to have people in the same boat with you. That helped—I didn't know anyone else that would have been a dual diagnosis. It wasn't something that was talked about at all in [state redacted], or a lot of the places I would go to AA meetings. Having that made it easier."

For men without strong community bonds, service providers were critical sources of support, for example "I live for my connection with care management and the mentors—I love to be out and doing things. I am very thankful."

### 2. Meaningful Activities

Many men expressed the value of a deliberately active routine:

"I knew that at least at first I needed to get the routine, do the 40 hours per week, get a pay check, get a car, do things like that."

"I guess being organized has been the most helpful for me, and [the program] has been a part of that. And having goals—

simple goals. The organization and the willingness to find time for me when I need it.”

“Creating a schedule and sticking to it. Just showing up and getting up out of bed.”

“Some of the most helpful things, it’s a combo, the structure and the day-to-day routine that I developed there. It has helped me for when I’m on my own.”

The men proudly shared their tangible success achieved through activity and engagement. For example:

“I got an associate’s degree in comp sci. I have landed a couple part time jobs in a professional capacity, not dead end.”

“I’ve gone back to school for my associate’s degree, I live on my own, I’ve been working part time for three years.”

“I’ve achieved a healthy state of mind. Playing my guitar, participating in a music group—I’m becoming a successful musician”

“I’m so much more active now, I walk, I ride bikes, I play music, and I’m good at it. It makes me happy.”

“I’ve been doing yoga, tai chi, martial arts. Also still very involved in art. Taking lots of different classes.”

“I’m proud that I’m actually going out and running races now, I did a 5-mile race a few weeks ago, a 10-mile this weekend. [Redacted name] introduced me to this. Training for a tough mudder.”

“I’m going to school, I’m looking for work, I go home every other week to see my family. I run, I’ve really gotten into that. I have friends now, I go fishing twice a week—even though we don’t catch much . . .”

Men not involved in work, school, or a volunteer organization took on the status of future worker or future student, rather than “unemployed” or “mental health services consumer.” For example: “School starts right after Labor Day. My program is 10 months, and I will be building a house. It’s a general carpentry class, and we work on a site. I think there are maybe 12 other students, and I guess we’re going to be constructing a house on someone’s property. It’s pretty cool. I’m really, really excited.” In general, engaging in productive activities was a key component of recovery: “I had to get myself out of a coffin to join everybody.”

### 3. A Healthy Mindset

The men conceptualized maintaining a healthy state of mind as a relapse prevention strategy in and of itself, involving vigilance for substance use relapse risk, mental illness insight, and responsibility to self and others. One man, who did not provide an active strategy to maintaining recovery spontaneously stated, “If you don’t do a damned thing all day then you’re still infinitely better off than someone that’s high all day.”

Several men described the need for vigilance, or to remain alert for and address cravings. For example,

“I would say I think about alcohol and have a craving almost once per day, or once every other day. If you can get past that craving and say “not today” if you can just get through it—

even for 15 minutes or a half hour—if you can get through that it subsides. So just give it a little bit of time. Maybe call a sponsor, call a friend, go for a walk, and go to the gym. Because the cravings do pass, and they do pass more easily when you have longer-term sobriety under your belt. After a while it’s like: “What are you, crazy? Why would you jeopardize what I’ve got going on in class? Why would I risk possibly going to the hospital, and having to do three to four more months of hard mental and emotional work?” I guess that’s what I think about when I have a craving.”

Nearly all of the participants believed insight, or awareness of mental health symptoms, facilitated recovery ( $n = 11$ , 91.7%). The men saw the consequence of substance abuse on mental health symptoms after achieving sobriety, as in the following examples:

“Using D & A [drugs and alcohol] is only going to make the problem worse, it’s not going to help things—you may be making yourself feel better in the moment but you’re really just creating more problems.”

“On the drugs I couldn’t manage my bipolar, one went with the other. Stopping the drugs, managing my [bipolar], you just get it [life] back.”

“I think the most helpful thing has been noticing a correlation between sobriety and a gradual improvement in my mental illness.”

The men also spoke about a sense of “responsibility” as part of living life in recovery, referring to their dedication to a moral or principled way of living ( $n = 6$ , 50%). These men mentioned two dimensions of responsibility in recovery—responsibility to others in order to strengthen positive personal identity and responsibility to self in order to maximize personal potential. Quotes such as these elaborate the link between responsibility and health:

“I’m doing the things I should be doing, starting to live the way I should morally be living, which is good.”

“I consider myself a more moral person than I used to be—I feel more spiritually and morally sound person, but I don’t define my life by spirituality.”

“I gained a liking for responsibility, for work.”

“During my second time at the [residential program], my parents told me that this treatment was a gift—the sort of habits and things that I was getting into wasn’t something that my parents could tolerate forever. That sense of accountability to them has been very important to my continued sobriety.”

### 4. Alcoholics Anonymous: A Catalyst for Building Change

The men all mentioned self-help participation as part of their recovery process ( $N = 12$ ). Eleven of the 12 participants maintained active participation in self-help, which was provided in the community, with the clinic facilitating participation (e.g., by providing rides). One participant chose to participate less over time: “I’ve had a very good 12-step experience. I have a

home group at home. A sponsor that's really helped be a lot. I do AA [Alcoholics Anonymous] even though I don't have a drinking problem. I find it more structured and helpful. I don't go to meetings too much anymore, because I do feel like I have it a lot under control." The centrality of Alcoholics Anonymous meeting participation to the majority of participants' sober lifestyle is particularly striking because many of the men described a relationship between Alcoholics Anonymous and at least one of the three relapse prevention strategies (finding a supportive recovery community, productive activities, and a healthy mindset), illuminating how Alcoholics Anonymous might act as a catalyst for developing relapse prevention skills.

### *Alcoholics Anonymous and Supportive Community*

The supportive recovery community effects of Alcoholics Anonymous fostered opportunities to normalize personal narratives and socialization: "It has been a total backbone for me, to have a place where I can identify with people." The men often reiterated this view:

"I think what's been the most helpful is the support of the people around me. Telling me and showing me that I can do it. Showing me that I'm a part of something, that maybe this way of life is different, and maybe this way of life is better."  
 "I was fortunate to meet some great people. Just by happenstance I met this guy who I eventually asked to be my sponsor, and we've been close friends ever since—that always helps, to have someone leading the way."

### *Alcoholics Anonymous and Meaningful Activities*

Alcoholics Anonymous served another practical purpose for these men in their recovery: a place to be. Many of the men regularly participated in meetings, attending as many as four per week. One man described his engagement in Alcoholics Anonymous as follows: "I have a job at meetings, I make coffee, sell raffle tickets, etc. It's hard, it's a lot of work, but it's great." Active participation in Alcoholics Anonymous becomes part of everyday life "... it's kind of intertwined into how I function daily anyway." Its role appeared to decrease over time for some as they increased their involvement in other activities of daily life. "I don't go to many AA [Alcoholics Anonymous] meetings [currently]. The first year of my sobriety I went every morning, first light of day."

### *Alcoholics Anonymous and a Healthy Mindset*

Self-help reminded the men to maintain vigilance. "I definitely need that side of it to be my medicine—I'm taking

medicine for my MI [mental illness], I need something to medicate my SA [substance abuse], and I get that from my meetings. I still keep it in my mind at all times. Whatever situation I'm in I think, where did it take me when I was abusing. If I didn't have AA [Alcoholics Anonymous] I would not have that ingrained response."

Alcoholics Anonymous also emphasized responsibility to self and others. "The program works if you follow the steps and the things you do. You get what you put into it I guess." "I had to make that transition from having a whole lot of thoughts and expectations that were not valid to knowing how to handle myself and manage my own life, and AA [Alcoholics Anonymous] is definitely where that change happened. The way you behave really does matter, it matters down to a very minute level. If you do anything that has an impact on others or yourself, you will have to deal with it, it will never go away on its own."

## DISCUSSION

Participants identified several self-management strategies that promoted continued sobriety, including positive peer relationships, meaningful activities, and a healthy mindset. The findings suggest a relapse prevention model that focuses on social networks, role functioning, and self-monitoring rather than symptomology, adding to a growing corpus of literature that conceptualizes self-care as critical to extending periods of wellness (Alverson et al., 2000; Deegan 2005).

Participants' subjective experience of social networks as helpful to relapse prevention concurs with findings reported in naturalistic follow-up studies of people with co-occurring disorders (Drake et al., 2006; Drake, Xie, McHugo, & Shumway, 2004; Xie, Drake, McHugo, Xie, & Mohandas, 2010; Xie, McHugo, Halmstetter, & Drake, 2005). While a previous ethnographic study of people with co-occurring disorders separated healthy relationships into community-based and clinically based social supports (Alverson et al., 2000), participants in the current sample found one or the other sufficient. Future research needs to investigate how to assist isolated people in expanding their community-based social network as a strategy for relapse prevention. Family psychoeducation is one such evidence-based practice (Dixon et al., 2001; Lucksted, McFarlane, Downing, & Dixon, 2012), but interventionists have not yet developed a consensus regarding how to reduce isolation in more fluid social contexts where participation is voluntary (i.e., community friendships; Gayer-Anderson & Morgan, 2012; Harley, Boardman, & Craig, 2012).

This study and others suggest that typical time use among people with psychiatric disorders, which often centers around sleep, food, hygiene, and solitary activities such as reading, may not be conducive to long-term recovery (Eklund, Leufstadius, & Bejerholm, 2009). The value the men placed on non-medical, non-passive participation resonates with social role theories. Furthermore, holding a higher valued role such as

employment reduces the likelihood of emotional injury from stigmatization (Hunt & Stein, 2012).

These men who successfully achieved and then maintained sobriety stated they found deliberate introspection useful. Their internal attitudes closely mirrored the relevant therapeutic tasks of the relapse prevention stage of readiness for change: monitoring for relapse, lifestyle changes, reducing exposure to triggers, and rallying social support. The men monitored their own substance use (“vigilance”), focused on lifestyle changes (“illness insight”), reduced exposure to triggers (“responsibility to self”), and rallied social support (“responsibility to others”). Much of the literature pertaining to the treatment of people with co-occurring disorders underscores the importance of matching treatment delivery with internal motivation as fundamental to stage-wise models of integrated treatment for co-occurring disorders (Mueser, Noordsy, Drake, & Fox, 2003). Future investigations of the relapse prevention stage might consider how to cultivate the internal self-management approaches that these men found useful.

The participants’ narratives identified Alcoholics Anonymous as a catalyst for life changes that support long-term sobriety. Trials of specialized self-help interventions for people with co-occurring disorders, known as Double Trouble in Recovery, show promising results (Laudet et al., 2004; Magura, 2008; Rosenblum et al., 2014). The narratives presented in this article imply that more widely available traditional 12-step models, including Alcoholics Anonymous, are also acceptable and useful to people with co-occurring disorders.

The relapse prevention strategies reported in this paper largely parallel the strategies used in active psychotherapeutic interventions developed for people with substance use disorders not co-occurring with severe mental illness, including 12-step model rehabilitation programs (McGovern, Fox, Xie, & Drake, 2004). These components generally include preventing exposure to substances, decision and motivation support, self-monitoring, monitoring and coping with cravings, identifying unhealthy thoughts, and developing a crisis plan (Carroll, 1996; Carroll & Schottenfeld, 1997; Irvin, Bowers, Dunn, & Wang, 1999; McGovern, Wrisley, & Drake, 2005). Evidence-based practices are often developed by adapting interventions that are effective for one population to another population (Mueser & Drake, 2011). This small qualitative investigation provides cautious optimism that many of the strategies developed in addictions treatment for relapse prevention might translate to integrated service settings for people with co-occurring disorders with minimal adaptation.

### Limitations

Several caveats of this study deserve mention. Secondary analyses of qualitative data are vulnerable to bias when the fit between data collection and secondary research questions is poor. The original study was designed to elicit personal perspectives on recovery among integrated co-occurring disorder

treatment program participants who self-identified as sober for a year or more. This primary qualitative study of maintenance strategies aimed to elicit similar interview data. Other concerns include the small sample size and lack of generalizability to the broader population of individuals with co-occurring disorders not in treatment. Generalizability is further limited in terms of social class (not impoverished), ethnicity (Caucasian), and gender (male) of the participants. Although the research team was relatively diverse, all maintained a philosophical perspective toward mental illness that was optimistic and sociocultural. In keeping with Charmaz’s constructivist grounded theory, we acknowledge that the act of representing qualitative data is inherently interpretivist and that our interpretation of participants’ narratives may at least partially reflect our own philosophical orientations. Given the sociological nature of co-occurring disorders, the salient supports for sobriety in other sociocultural and socioeconomic contexts might differ extensively from those identified in the current sample (Drake & Wallach, 2007).

### Conclusions

This study suggests people with co-occurring disorders who achieved lasting sobriety attributed their success to experiences and strategies beyond the bounds of traditional medical care—including community building, active time use, and healthy attitudes. The findings indicate self-help referral as an opportunity to build skills for maintaining long-term recovery.

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### DISCLOSURES

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