



Original article

“Homelessness and Trauma Go Hand-in-Hand”: Pathways to Homelessness among Women Veterans

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A B S T R A C T

Background: Veterans comprise a disproportionate fraction of the nation's homeless population, with women veterans up to four times more likely to be homeless than non-veteran women. This paper provides a grounded description of women veterans' pathways into homelessness.

Methods: Three focus groups were held in Los Angeles, California, with a total of 29 homeless women veterans.

Results: Five predominant “roots” (precipitating experiences) initiated pathways toward homelessness: 1) childhood adversity, 2) trauma and/or substance abuse during military service, 3) post-military abuse, adversity, and/or relationship termination, 4) post-military mental health, substance abuse, and/or medical problems, and 5) unemployment. Contextual factors, which promoted development of homelessness in the setting of primary roots, included women veterans' “survivor instinct,” lack of social support and resources, sense of isolation, pronounced sense of independence, and barriers to care. These contextual factors also reinforced persistence of the roots of post-military adversity and mental health and substance abuse problems, serving to maintain cycles of chronic homelessness.

Conclusion: Collectively, these multiple, interacting roots and contextual factors form a “web of vulnerability” that is a target for action. Multiple points along the pathways to homelessness represent critical junctures for VA and community-based organizations to engage in prevention or intervention efforts on behalf of women veterans. Considering the multiple, interconnected challenges that these women veterans described, solutions to homelessness should address multiple risk factors, include trauma-informed care that acknowledges women veterans' traumatic experiences, and incorporate holistic responses that can contribute to healing and recovery.

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Introduction

In November 2009, the Secretary of Veterans Affairs (VA) pledged to end homelessness among veterans within the next 5 years, and in June 2010, President Obama introduced a federal strategic plan to end severe homelessness among veterans. Veterans comprise a disproportionate fraction of the nation's homeless population, with an estimated one of every four

homeless people having served in the military (Perl, 2009). Prior research found that women veterans are up to four times more likely to be homeless than non-veteran women (Gamache, Rosenheck, & Tessler, 2003). This increased likelihood of homelessness among women veterans could be, in part, due to the additional trauma that they may have experienced during military service, and to difficulty in adjusting to life after military service (Washington et al., 2010).

Current limited evidence now indicates that homelessness among women veterans is on the rise, especially because there are more women veterans than ever and they are continually returning from recent conflicts (e.g., Operations Iraqi and Enduring Freedom). Given that most women veterans utilize services outside VA (Washington, Yano, Simon, & Sun, 2006), community-based organizations that serve homeless women need to be equipped to address the potentially unique needs and histories of women veterans.

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Multiple studies have focused on the mental health of homeless women (e.g., Austin, Anderson, & Gelberg, 2008; Wenzel et al., 2009) and formerly homeless women (Padgett, Hawkins, Abrams, & Davis, 2006). However, few have addressed how women came to be homeless (with notable exceptions, e.g., Belcher, Greene, McAlpine, & Ball, 2001) and even fewer have addressed how women veterans come to be homeless (Washington et al., 2010). Most literature on risk factors for homelessness points to childhood adversity, drug and alcohol abuse, and other mental health problems as major antecedents of homelessness (e.g., Belcher et al., 2001; Martijn & Sharpe, 2006; Wenzel et al., 2009). This literature tends to focus on isolating independent risk factors (e.g., Lehmann, Kass, Drake, & Nichols, 2007; Van den Bree et al., 2009), with less attention to how risk factors interplay and accumulate over the life course to result in homelessness. The purpose of this study was to examine pathways to homelessness, as described by homeless women veterans. With a grounded understanding of the interconnected roots of homelessness, we contend that it will be possible to identify critical junctures where intervention—and possibly prevention—are warranted.

Methods

Design and Sample

We conducted three focus groups among homeless women veterans in Los Angeles, California. Enrollment criteria were being a woman veteran and spending at least one night of the prior 30 in a shelter or transitional residential facility, a hotel paid for with a voucher, a car, an abandoned building, a nonresidential building, or another non-dwelling, or on the street. Exclusion criteria included military dishonorable or other than honorable discharge, current service on active duty in the armed services, and inability to complete the screening questions. All procedures were approved by the University of California Los Angeles and the VA Greater Los Angeles Healthcare System Institutional Review Boards.

The Los Angeles-based Homeless Women Veterans Coordinator assisted with recruitment, which primarily took place during an annual open house for women veterans who are homeless or who have accessed homeless services. This open house draws from a number of outreach sites, including four shelters, one drop-in center for homeless people, six transitional housing programs and residential substance abuse rehabilitation programs, the county jail, several soup lines, and direct outreach to people on the streets in an area in downtown Los Angeles with a high concentration of homeless individuals. The Homeless Women Veterans Coordinator was in contact with approximately 150 women at the time of this study. Participants were recruited between December 2005 and January 2006. Twelve women were recruited for each focus group, with the goal of seating at least nine. A total of 29 women veterans participated in the three focus groups.

Procedures

Focus groups were held at a large, urban VA site where a Homeless Women Veterans program is based. All focus groups were moderated and co-moderated by authors IP and DW, respectively. The study used a semistructured moderator guide, which allowed the facilitators to follow certain topics and open new lines of inquiry when appropriate. The moderator

guide elicited general information about participants' personal contexts (e.g., homelessness history, military experience, perceived needs, and priorities), use of VA and non-VA health care and homeless services, and perceptions of and experiences with VA use. Snacks were provided during the focus groups. Each focus group participant was reimbursed \$25 and given a gift bag of hygiene supplies valued at \$25.

Analysis

All focus groups were recorded and professionally transcribed. We analyzed the interview transcripts using the constant comparative approach (Glaser, 1965). This approach involves four iterative stages: 1) Comparing incidents (i.e., discrete narratives or dialogues) within categories (i.e., themes), 2) integrating categories, 3) delimiting a theory for how the categories relate to each other, and 4) writing the theory. In this study, the category, or theme, of "entry into homelessness" was derived a priori from the interview guide, and data coded to this category were reviewed by all authors independently, with a focus on identifying common factors that contributed to homelessness. Each author developed a list of primary factors, or what we refer to below as "roots" of homelessness; the authors were in 100% agreement on these primary factors. Reflection on the types and timing of factors contributed to the development of what Glaser termed "theoretical properties of the category." Theoretical properties, in this case, included subsidiary factors and contextual elements that influenced the primary factors; these properties were inductively derived from the data and became additional categories. Using axial coding (Boeije, 2002), the code "entry into homelessness" was then integrated with categories that overlapped with this code, for example, lack of social support. Through this integration of categories, a theory of roots and contextual and subsidiary factors was delimited, and then the "web of vulnerability" theory was schematized.

Results

Characteristics of the participants are presented in Table 1. Focus group participants represented a diversity of current age and age at post-military entry into homelessness. No women were currently married or employed, almost two thirds were disabled, and over half had completed an Associate's Degree or higher.

Figure 1 depicts the "web of vulnerability" illustrating interrelated pathways into homelessness for women veterans, as described by the participants. Participants associated their homelessness with one or more of five primary "roots," or initiators or precipitating factors for their path toward homelessness: 1) Pre-military adversity (including violence, abuse, unstable housing), 2) military trauma and/or substance use, 3) post-military interpersonal violence, abuse, and termination of intimate relationships, 4) post-military mental illness, substance abuse, and/or medical issues, and 5) unemployment. Criminal justice involvement (6) was a subsidiary factor that related to the roots. The links, or pathways, from roots toward homelessness are depicted in the figure with arrows. Pathways (arrows) may be unidirectional or bidirectional, with the latter linking together factors that both lead to and result from homelessness (i.e., factors implicated in a cycle of homelessness). Contextual factors, when present, promoted these pathways. These included "survivor instinct," lack of social support and resources, a sense of isolation, a pronounced sense of

Table 1
Characteristics of Focus Group Participants (n = 29)*

Age, Mean (range), Years (n = 25)	48 (32–68)
Age at discharge from military, mean (range), years (n = 25)	26 (17–45)
Age at first homelessness, mean (range), years (n = 17)	36 (17–62)
Race/ethnicity (%) (n = 24)	
African American	46
White	33
Mixed	13
Hispanic	4
American Indian/Alaskan Native	4
Marital status (%) (n = 17)	
Single	41
Divorced/separated	47
Married	0
Widowed	12
Education level (%) (n = 17)	
High school/GED	18
Vocational school	12
Associate's degree	59
Bachelor's degree	12
Work status (%) (n = 17)	
Employed	0
Unemployed	29
Disabled	65
Retired	6
Percent on probation or parole (n = 17)	47
Service connection (%) (n = 24)	
Non-service connected	58
Branch of military (%) (n = 29)	
Army	69
Navy	14
Air Force	10
Marines	3
Coast Guard	3
Period of military service (%) (n = 29)	
Vietnam Era	24
Post-Vietnam Era	45
Period around Persian Gulf War	21
Between Persian Gulf War and 9/11	10

* Data were incomplete for some demographic items, so the sample size for each item is provided.

independence, and barriers to care. Contextual factors variably contributed to unmet health care and psychosocial needs, prolonged vulnerability, and homelessness.

Each of the roots is described, with attention to contextual factors. Although each root is described separately, they are highly interconnected. Each woman experienced a subset of the roots and contextual factors.

Pre-Military Adversity (Root 1)

Fifteen of the 29 participants (52%) described pre-military adversity (including child abuse and domestic violence) that either resulted in homelessness pre-military, or sowed “seeds of homelessness” that occurred post-military. For example, some women described childhood experiences of being shuffled from the home of one extended family member to another, sent to live with a relative, or placed in foster care. These women were not sure that these experiences qualified as being homeless, but they had the sense that they were definitely without homes. Those who were not technically homeless reported feeling alienated, threatened, or unwelcome in their own home either because of sexual, physical, and/or verbal/emotional abuse, or a feeling of not belonging or not being loved. In the second focus group, four of the seven women endorsed this experience, which one woman described as the “seeds of homelessness.”

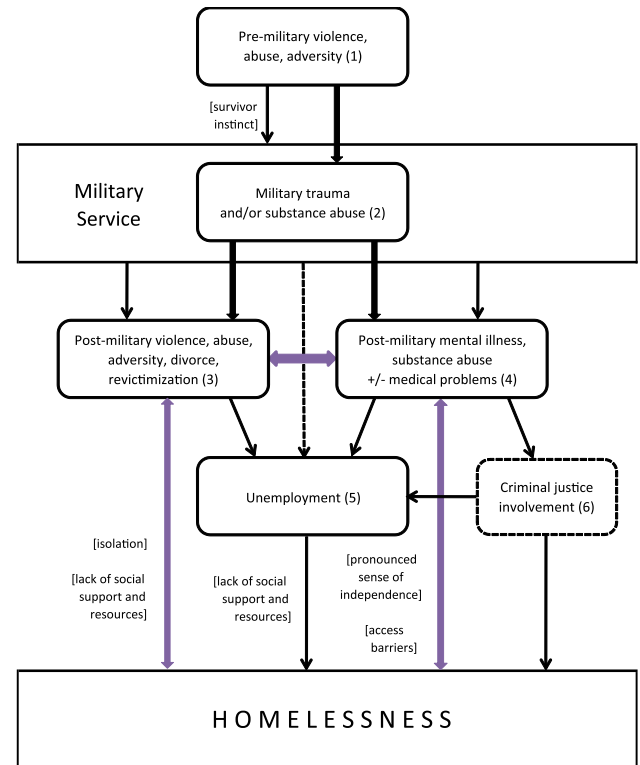


Figure 1. Web of vulnerability illustrating inter-related pathways into homelessness for women veterans. (1) – (5) Roots of homelessness, namely, initiators or precipitating factors for path toward homelessness; (6) Subsidiary factor; Links (arrows), that is, pathways from roots toward homelessness, where weight of arrow conveys strength of link; [Contextual factors] – individual characteristics or structural factors, that when present, promote the pathway. Pronounced sense of independence inhibits care-seeking; access barriers (mental health, social service) lead to unmet need. Note: Not all roots, links/pathways, or contextual factors are present in all individuals, for example, military trauma without an adverse pre-military history could initiate the pathway.

Adversity often contributed to women’s decision to enter the military. In the third focus group, 8 of the 12 women expressed that they entered the military in order to escape abuse and violence. Women referred to their “survivor instinct” and independence, which saved them from abuse; these characteristics were honed via military training and experience, but ultimately promoted the pathway to homelessness by inhibiting women from seeking help:

I was moved from relative to relative so basically I was homeless as a child. . . . And my independence developed then. And then even the short stint in the military made me even more independent. You don’t seek out that help that other women would seek out because they’re lost. We don’t feel like we’re lost. We can do it.

One participant with a history of child sexual abuse experienced early homelessness and went into the military for a “safe haven.” Instead of experiencing safety, she was revictimized both during (Root 2) and after her military service (Root 3), which contributed to substance abuse (Root 4):

Part of the reason that I went into the military was to be like a safe haven for me. And then after I encountered the same type of abuse in the military, it was no longer safe for me and I had thought that that could have [been] my home away from

home. Then that's when I started with the alcohol and stuff when I was in the military because I was just lost . . . I didn't report [the abuse]. . . . So that left me kind of numb. And when I got out of the military, the same things started to happen all over again.

Similarly, a participant in another group stated, "I went from childhood abuse to husband abuse, and then from husband abuse to military abuse."

Trauma and/or Substance Use During Military Service (Root 2)

Twenty-three of the 29 participants (79%) described being traumatized, victimized by a colleague or superior, or otherwise rejected and stigmatized during active duty, in many cases leading to a cycle of violence and despair, sometimes involving substance abuse. As one woman stated:

It's like for me, you start with the rape. Then you go into the drugs. And drugs leads to homelessness. You regroup. You go back to the rape. You go back to the drugs. Go back to the homelessness. . . . You go to stay with people and they rape you. It's a vicious cycle until something stops.

In the first focus group, in response to a comment about military sexual trauma, the moderator asked how many women believed that sexual trauma during military service and later homelessness go "hand-in-hand," and all of the women ($n = 10$) raised their hands. One woman said, "They go hand-in-hand, with low self-esteem and no relationships."

Traumatic experiences in the military contributed to women feeling "lost," although it was often difficult for women to come to terms with that feeling owing to an internalized pressure to be "independent." This emphasis on independence, along with a fear of reporting abuse, very likely magnified feelings of isolation. Without help or support—and often under conditions of heightened stigmatization and/or continual victimization—some turned to drugs or alcohol to cope with their emotional pain before, during, and/or after military service (Roots 2 and 4). Substance abuse was also a response for women who were not assaulted in the military; a few women discussed using alcohol and/or other drugs "just to cope day by day."

One participant described extensive harassment in the military that was ignored by the authorities. These experiences contributed mental illness and medical problems (Root 4), and to isolation, lack of social support, and eventual homelessness:

I wanted a career to make something of myself—to put the 20 years in and retire out. And it didn't turn out that way. I was harassed, sexually, non-sexually. I did not feel a part of the family. I felt very pushed out, pushed away. And the harassment that I had gone through was so severe that I have anxiety, even more depression, major [posttraumatic stress disorder]. I have a lot of physical and emotional and mental problems now. . . . After the military I felt so lost. I had no self-esteem. I didn't know what to do. I thought everyone hated me. I couldn't go back to my family. I felt I had to just take off somewhere and just isolate myself. I felt so detached from society.

Post-Military Violence, Abuse, and Relationship Termination (Root 3)

Several women experienced relationship problems, including violence and break-ups, after their return from military service.

For example, one participant said that she went back home when she got out of the Air Force to clear up her divorce, had nowhere to stay, and so she became homeless. Other women described abusive relationships that ultimately resulted in homelessness. For example, one woman explained:

After I got out of the Service I had gotten married and then had my two daughters. I was in a very abusive relationship. . . . I ended up leaving him and taking my kids. . . . I left one of my daughters with my grandparents and my other one with my mom and that's when I got into drugs and all that. . . . My bout of homelessness would be [when I was] about 25. And I stayed out there for a good 10 years.

As evident in this quote, in many cases, relationship problems and break-ups contributed to initiation, maintenance, or exacerbation of substance abuse (Root 4), and eventual homelessness. As one woman stated, homelessness was "a result of an abusive relationship and drugs as well—a combination." For many women, post-military violence related to violence they had experienced in the military. In the first focus group, 7 of the 10 women raised their hands when asked if sexual abuse in the military led to what one woman called a "string of abusive relationships" post-military service.

Post-Military Substance Abuse, Mental Illness, and/or Medical Conditions (Root 4)

Although substance abuse and mental illness permeated women's descriptions of other roots of homelessness, for some women, these conditions, along with medical conditions, were perceived to be the primary root of homelessness. In the first focus group, 7 of the 10 participants raised their hands when the moderator asked if drug use contributed to their homelessness. For example, one participant explained her pathway as follows:

After I came home from the Army I got a pretty good job. I guess [when] I was about 31, I couldn't handle a job and the kids, and I had no support. . . . So then we were homeless for a period of time . . . and [then] we stayed with family for a while. And then we were homeless again and then the kids' father . . . took [the kids]. So I was kind of out there by myself and I got a good job. My real bout with homelessness—I mean really being homeless—didn't start until I was about 35 years old, after I became a drug addict.

Although she cycled in and out of employment (Root 5) and lacked consistent social support and resources, she clearly related her homelessness to substance abuse.

One participant's physical disability as a result of substance abuse contributed to her relationship ending (Root 3) and unemployment (Root 5):

I'd done some heroin and I damaged my heart . . . with endocarditis. And I was in a coma for 2 months and when I woke up from that my boyfriend and I kind of broke up . . . and I had no way of working because I was so sick. . . . So since then I've been homeless.

Relevant to Root 4 (but beyond the scope of this paper), participants described access barriers to mental health and social service treatment programs (e.g., lack of geographic proximity to women-only programs) that prolonged their mental illness/substance abuse cycle.

Unemployment (Root 5)

Some women found employment or went back to school after they were discharged from the military, but their circumstances were unstable, often because of a lack of social support and underlying mental health issues (Root 4). In some cases, women moved away from their home town to find employment. However, often because of the economy, women were laid off, or cycled in and out of employment. Substance abuse (Root 4) was a typical means of coping. Some women realized that they had mental health issues (Root 4) well after they had left the military and pursued employment:

I had no problems [for 15½ years] until I got to this particular company . . . and it was all guys. And I started going through the same thing with them that I was going through in the military. So I lost my job. I couldn't deal with the male authority figure any more.

Criminal Justice Involvement (Subsidiary Factor 6)

As noted in Table 1, several participants were on probation or parole. The contribution of criminal justice involvement to homelessness was raised in the second group. Participants noted that they were homeless because they were not allowed to leave the county in which they were paroled or on probation, and therefore could not pursue housing with family that lived elsewhere: "I'm on probation and had I been allowed to leave the county to go stay with family, I may not have been homeless."

Discussion

Findings from this study suggest that homeless women veterans are caught in a web of vulnerability. The five predominant roots of homelessness for participants were 1) childhood adversity, 2) trauma and/or substance abuse during military service, 3) post-military abuse, adversity, and relationship termination, 4) post-military mental health, substance abuse, and or medical problems, and 5) unemployment. Notably, lack of education was not identified as a root of homelessness; more than half the participants had an Associate's Degree or higher. As expressed throughout the focus groups, multiple roots and contextual factors were replete in women's experiences, with an apparent compounding effect as women traversed the web of vulnerability. It is important to note that our representation of this web (Figure 1) depicts connections that the participants themselves made regarding their pathways into homelessness. It is likely that additional connections and bidirectional associations exist, for example, the contextual factor of isolation is likely related to more than post-military violence and relationship issues (Root 3).

With regard to what is known about risk factors for homelessness among women veterans, this study supports the work of prior studies by describing the pathways where risk factors exert an effect. Washington et al. (2010) found that military sexual trauma, unemployment, disability, poor health, and screening positive for PTSD were primary risk factors for homelessness among women veterans. These factors (Roots 2, 4, 5) were all described by the participants in this study, and we also identified pre- and post-military abuse and violence as roots of homelessness (Roots 1 and 3, respectively). This study is not able to tease out the extent to which women attributed their military service (and possible combat exposure) to their homelessness,

but it was evident that women attributed many of their post-military challenges to trauma that occurred during their service.

In a qualitative meta-analysis of homelessness among women, Finfgeld-Connett (2010) referred to the process of becoming homeless as a "downward spiral," which often begins in childhood with adverse life circumstances. Belcher et al. (2001) found that childhood abuse and neglect, substance abuse, economic instability, social isolation, separation from children, and domestic violence precipitated homelessness, and that these events typically occurred in combination, with no one factor more important than another. For at least half of the women in this study, the downward spiral did indeed begin in childhood, or at least pre-military service; and for all of the women, the downward spiral after military service lasted an average of 10 years before homelessness. During this period, these women veterans experienced a host of mutually reinforcing challenges that ultimately led to homelessness.

Furthermore, several studies indicate that cumulative trauma (including revictimization) and adversity, especially among individuals with substance use disorders, have significant negative effects on medical and psychosocial outcomes (Lehmann et al., 2007; Messina & Grella, 2006; Wu, Schainer, Dellor, & Grella, 2010). These interconnections between risk factors or precipitating events have been referred to as "complex subsidiary pathways" (Craig & Hodson, 1998), that is, linked factors that may play a cumulative role in risk for homelessness. These concepts are highly applicable to the findings in this study, and are magnified by the fact that added to these precipitants for women veterans are the experiences of military service and, for many women, trauma during military service.

Study Implications

In describing their pathways to homelessness, women in this study noted multiple points along their pathways where they did not report or seek help for detrimental experiences they were having. Although we do not have detailed data about women's childhood experiences, it seemed likely that they did not receive care or counseling in response to abuse and neglect. In many cases, women entered the military in order to escape from abusive situations (see Gamache et al., 2003; Sadler, Booth, Cook, Torner, & Doebbeling, 2001). This pattern of non-reporting continued into adult experiences of trauma, particularly in the military where reporting typically resulted in further abuse and stigmatization, along with damage to self-esteem and a sense of safety (Campbell & Raja, 2005; Sadler, Booth, Cook, & Doebbeling, 2003). This pattern of revictimization is key to conceptualizing what, in this study, was a predominant root of homelessness (see Browne, 1993). There is considerable literature on the increased risk for revictimization for those who have been victimized, as well as on the importance of intervention and services after victimization in order to minimize the likelihood of additional victimization (Sadler, Booth, Mengeling, & Doebbeling, 2004; Zinzow, Grubaugh, Frueh, & Magruder, 2008).

Considering the multiple, interconnected challenges that these women veterans described, solutions to homelessness should address multiple risk factors and include trauma-informed care (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008; Hopper, Bassuk, & Olivet, 2010; Tam, Zlotnick, & Bradley, 2008). Trauma-informed care acknowledges traumatic experiences in the lives of service recipients, and incorporates holistic responses that can contribute to healing and recovery.

Our findings, although not generalizable to all homeless women, suggest several preventive actions and interventions that could potentially sever the pathways to homelessness. First, intake interviews for the military should assess histories of abuse and homelessness (Root 1), to identify soldiers at risk for re-victimization during and/or after military service or future homelessness, so that strategies to boost their resiliency can be employed (see Zinzow et al., 2008). Second, procedures for addressing military assault (Root 2) should be reviewed to ensure that women are not penalized for making their claim, and psychological services are offered as soon as possible (see Kimerling et al., 2010; Sadler et al., 2003; Street, Vogt, & Dutra, 2009; Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). The Sexual Assault Prevention and Response Office (available: www.sapr.mil) has an essential role in oversight of the Department of Defense's sexual assault policy. Third, social and psychological services available to women veterans should be reviewed to ensure that they are addressing women's relationship issues (Root 3), as well as their substance abuse and other mental health issues (Root 4). Although VA universal screening is already in place for military sexual trauma and selected mental health disorders, screening should also assess for domestic violence. Settings outside the VA that provide services for homeless women should screen for veteran status, and when they identify women veterans, they should screen for military sexual trauma (Root 2). Fourth, psychological services should possibly include dismantling counterproductive notions of "independence" that increase isolation and undermine self-esteem. Fifth, efforts should be made in primary care to screen women continually for histories of trauma (Roots 1 and 2), especially considering that some mental health sequelae may be latent. Given the strong association between trauma and physical health outcomes (Root 4) among homeless women and among women veterans (Sadler, Booth, Nielson, & Doebbeling, 2000), primary care may be a likely safety net where appropriate care or referrals can be provided. Sixth, current VA compensated work therapy and other job training programs should be reviewed to assure there are no gender-related barriers to women's participation (Root 5). Finally, outreach efforts to incarcerated women veterans (subsidiary factor 6; McGuire, 2007) and to homeless women veterans not currently receiving Veterans Health Administration (VHA) care should be enhanced (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003), with careful attention to women's potential preconceived notion that they will not receive gender-appropriate care in VHA (Washington et al., 2006; Washington, Kleimann, Michelini, Kleimann, & Canning, 2007).

Conclusion

Women veterans are at increased risk of homelessness compared with non-veteran women. We identified several interconnected pathways to homelessness for women veterans, with military trauma, and post-military sequelae as key factors differentiating veteran and non-veteran women. Prior research indicates that homelessness is typically chronic and cyclical, with homeless women veterans having an average of four entries into and exits out of homelessness (Washington et al., 2010). Women veterans in our study described the roots of homelessness along with subsidiary and contextual factors that drove this cycle. Our framework depicting this web of vulnerability could be incorporated into federal and community programs to identify at risk women veterans, so that they may be triaged for receipt of

targeted services and actions such as those suggested herein. Future research should evaluate systematic processes for accomplishing these actions to ensure that they reach women in need.

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All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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