



Suicide Risk Reduction: Suicide Specific Treatment

JOHN SIEGLER PSYD

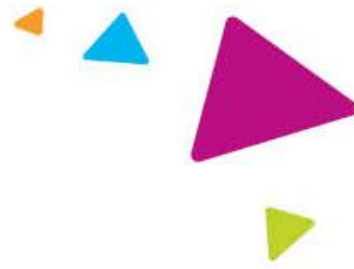
MAGELLAN BEHAVIORAL HEALTH OF PA

Course Outline



1. Review of Components of Suicide Risk Reduction
2. Conceptualizing Suicidality
3. The Concept of Suicide Specific Treatment
4. Evidence-based Suicide Specific Treatments
5. Safety Planning – An Ongoing Process
6. Resources for Further Training

Learning Objectives



01

Describe
Components of
Suicide Risk
Reduction

02

Identify how to
Conceptualize
Suicidality

03

Apply the
Rationale for
Suicide Specific
Treatment (SST)

04

Explain the Role
of Empathy and
Collaboration

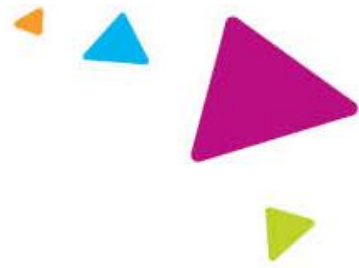
05

Relate Elements
Of Evidence-
based SST

06

Recognize
Available
Evidence Based
SST & Available
Training

Components of Suicide Risk Reduction



Risk
Assessment

Safety
Planning*

Suicide
Specific
Treatment

*including Means Restriction Planning

Means Restriction

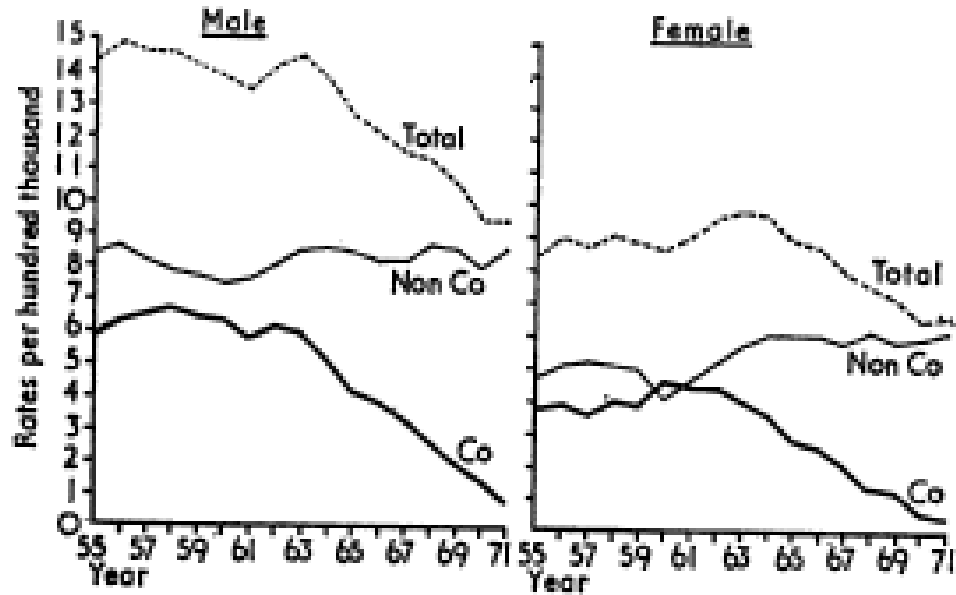
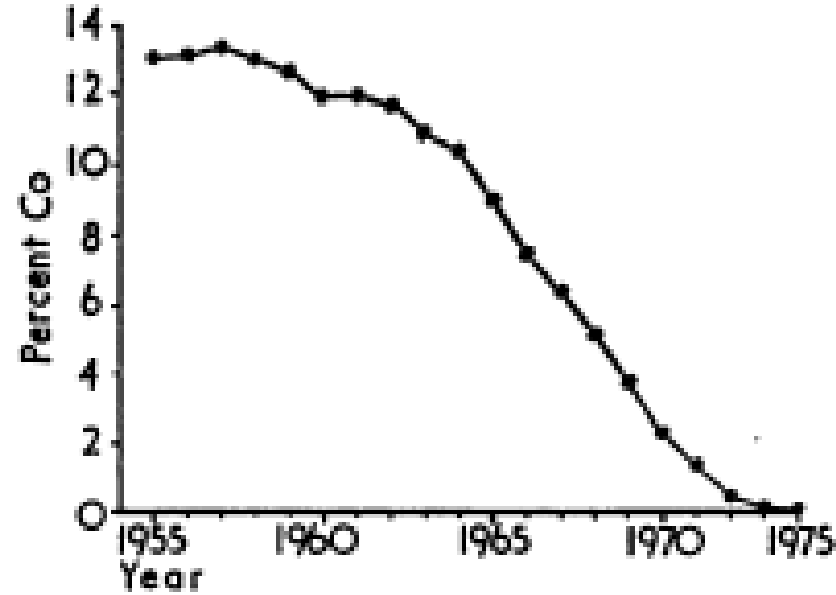


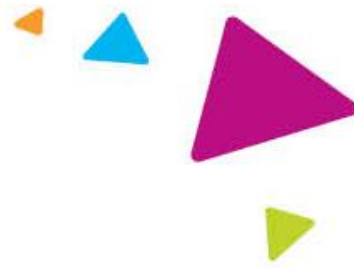
FIG. 4. England and Wales: sex-specific suicide rates by mode of death.



A detailed analysis of suicide rates between 1960 and 1971 for England and Wales confirms that all age-sex subgroups have shown a marked decline in suicide due to domestic gas, corresponding in time to the fall in the CO content in domestic gas.

Kreitman, N. (1976). The coal gas story. United Kingdom suicide rates, 1960-71. *Journal of Epidemiology & Community Health*, 30(2), 86-93.

How do people most commonly complete suicide?

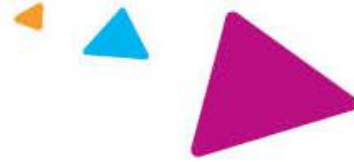


- More use a firearm (52%) than every other method combined.
- Suffocation (mostly hanging) accounts for 23%
- Poisoning/overdose for 18%
- Jumps 2%,
- Cuts 2%
- Other 4%.
- Most nonfatal self-harm treated in the emergency department results from poisoning/overdose (64%), followed by cutting (19%).
- Less than 1% of nonfatal attempts are with a gun.

CDC: Web-based Injury Statistics Query and Reporting System <https://www.cdc.gov/injury/wisqars/index.html>

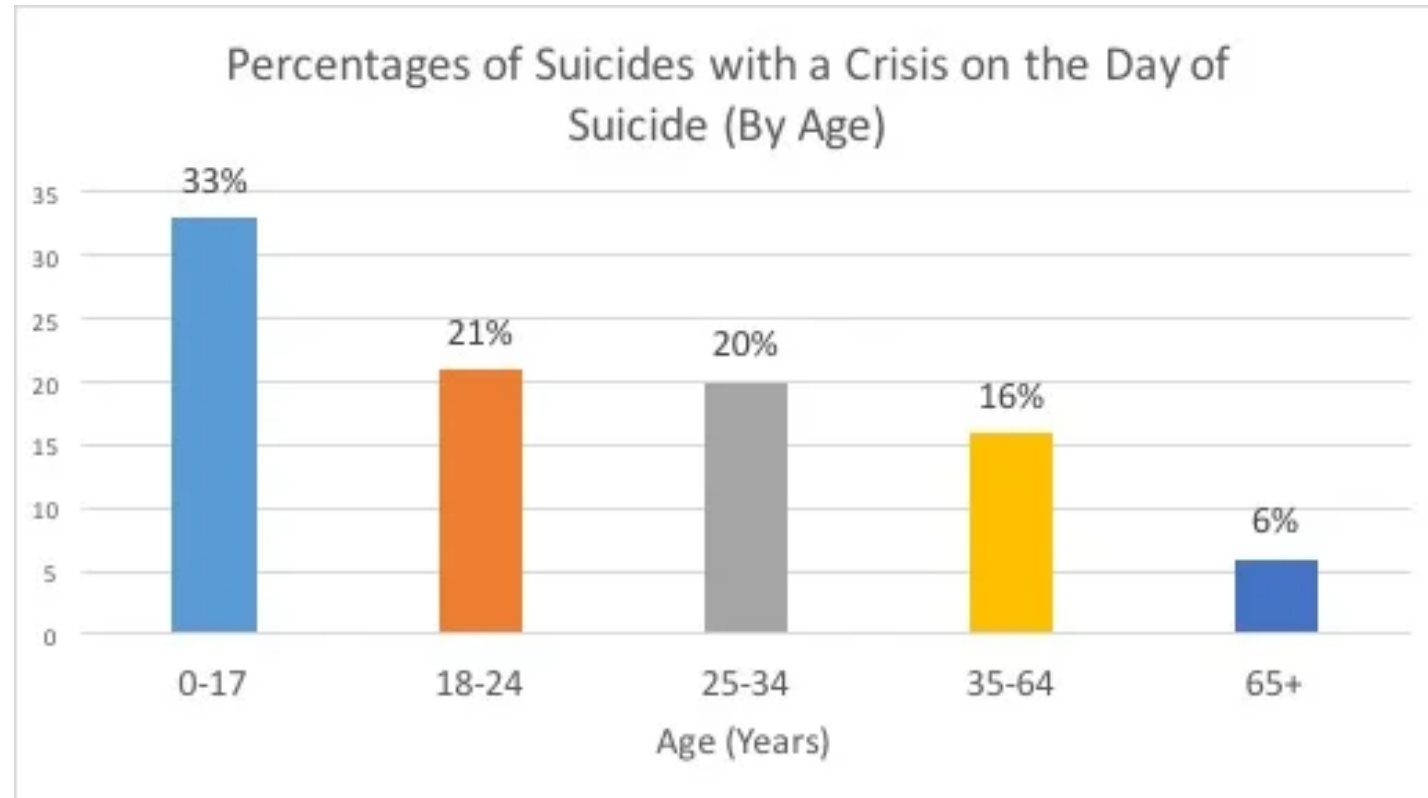
Johnson, R. M., Barber, C., Azrael, D., Clark, D. E., & Hemenway, D. (2010). Who are the owners of firearms used in adolescent suicides?. *Suicide and Life-Threatening Behavior*, 40(6), 609-611.

When do people take their lives?



A study of people who nearly died in a suicide attempt asked:

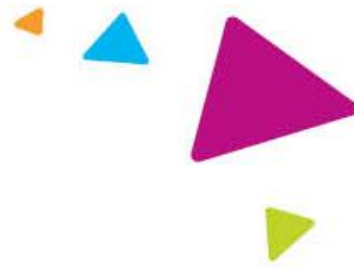
- *How much time passed between the time you decided to complete suicide and when you actually attempted suicide?*
- 24% said less than five minutes
- Another 47% said an hour or less



Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M. J., & O'Carroll, P. W. (2001). Characteristics of impulsive suicide attempts and attempters. *Suicide and Life-Threatening Behavior*, 32(Supplement to Issue 1), 49-59.

Assessment Tools and Training

- The Columba Suicide Severity Rating Scale (C-SSRS):
<https://cssrs.columbia.edu/documents/lifetimerecent/>
- The Columba Suicide Severity Rating Scale - Pediatric Version (C-SSRS-PV):
https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
- Training on administering the Columba Suicide Severity Rating Scale:
https://youtu.be/Xfddz_Yfnc4
- The Suicide Specific Form, 4th revision (SSF-4):
- <https://cams-care.com/>
- Training on use of the SSF-4 is available on the CAMS Care website
- Prevent Suicide PA Learning: Collecting Valid Data:
<https://youtu.be/WyxSuzWs7sw> (challenges associated with assessing adolescents)



Safety Plan Tools and Training



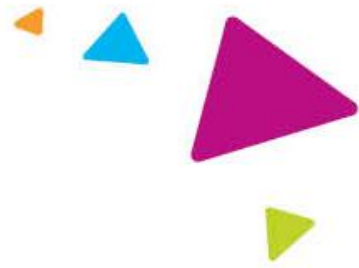
- The Stanley Brown Safety Planning Intervention can be found here:

<https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf>

- You Tube - Safety Planning with the Stanley-Brown Safety Plan: Dr. Barbara Stanley

<https://youtu.be/2g6PCKJ4m9o>

“Why do people attempt suicide?”



Suicide is a highly complex and multifaceted phenomenon

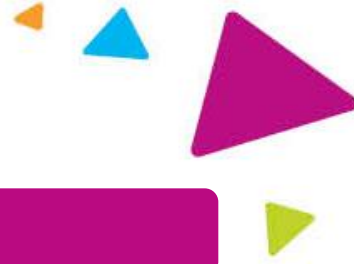
Intrapersonal Perception
(maladaptive cognitions, hopelessness, low self-esteem, meaninglessness, negative self attributions)

External Environment
(social status, lack of income, abuse, discrimination, poverty, unemployment)

Orsolini, L., Latini, R., Pompili, M., Serafini, G., Volpe, U., Vellante, F., Fornaro, M., Valchera, A., Tomasetti, C., Fraticelli, S., Alessandrini, M., La Rovere, R., Trotta, S., Martinotti, G., Di Giannantonio, M., & De Berardis, D. (2020). Understanding the Complex of Suicide in Depression: from Research to Clinics. *Psychiatry investigation*, 17(3), 207–221.

¹⁰<https://doi.org/10.30773/pi.2019.0171>

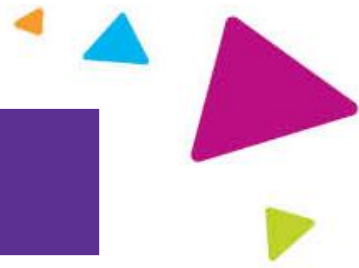
Ten Commonalties of Suicide



1. The common stimulus in suicide is unendurable psychological pain.
2. The common stressor in suicide is frustrated psychological needs.
3. The common purpose of suicide is to seek a solution.
4. The common goal of suicide is the cessation of consciousness.
5. The common emotion in suicide is hopelessness-helplessness.
6. The common internal attitude toward suicide is ambivalence.
7. The common cognitive state in suicide is **constriction**.
8. The common interpersonal act in suicide is communication of intention.
9. The common action in suicide is egression.
10. The common consistency in suicide is with life-long coping patterns.

Shneidman, E. (1977). Definition of suicide. Jason Aronson, Incorporated.

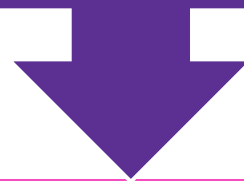
Cognitive Stress–Diathesis Model of Suicidal Behavior



Psychiatric illness + individual circumstances (SDOH)



Diathesis (tendency to experience more suicidal ideation/be more likely to act on suicidal feeling)



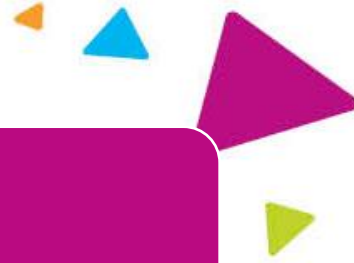
Sensitivity to signals of defeat - Perceived “no escape” Perceived “no rescue”

Handley, T., Rich, J., Davies, K., Lewin, T., & Kelly, B. (2018). The challenges of predicting suicidal thoughts and behaviours in a sample of rural Australians with depression. *International journal of environmental research and public health*, 15(5), 928.

So, What about Trauma?



Trauma Informed Conceptualization



Seek to understand all the circumstances that contribute to the patient's perspective on the problems that drive suicidal ideation and behavior:

- The patient's experience of past adversity
- The patient's current exposure to adverse circumstances
- The patient's current capacity of emotional management
- The extent of the patient's suffering related to difficulty regulating emotions.

Factors to consider in identifying what kind of Suicide Specific Treatment might be appropriate

- The chronicity of the patient's experience of suicidal ideation
- The patient's ability to identify discrete drivers for suicidal ideation or behavior may be related to

Tunno, A. M., Inscoe, A. B., Goldston, D. B., & Asarnow, J. R. (2021). A trauma-informed approach to youth suicide prevention and intervention. *Evidence-Based Practice in Child and Adolescent Mental Health*, 6(3), 316-327.

Monteith, L. L., Holliday, R., Dichter, M. E., & Hoffmire, C. A. (2022). Preventing suicide among women veterans: gender-sensitive, trauma-informed conceptualization. *Current treatment options in psychiatry*, 9(3), 186-201.

Graves, K. N., Kaslow, N. J., & Frabutt, J. M. (2010). A culturally-informed approach to trauma, suicidal behavior, and overt aggression in African American adolescents. *Aggression and violent behavior*, 15(1), 36-41.

Trauma and Suicidality



Trauma has a potent impact on the risk of suicidality among individuals with PTSD

Childhood maltreatment appeared to have a remarkably strong relationship to suicidal behavior

Traumas relating to assaultive violence and peacekeeping also had similarly high rates of suicide attempt and suicidal ideation

Multiple traumas increased suicidality,

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: Findings from a US nationally representative sample. *Journal of traumatic stress*, 28(3), 183-190.

Trauma and Suicidality



- Seriously neglected < 18 years by parent/caretaker
- Saw serious fights at home < 18
- Attacked/beaten/injured < 18 years by parent/caretaker
- Attacked/beaten/injured by spouse/romantic partner
- Attacked/beaten/injured by anyone else
- Sexually assaulted/molested/raped
- Stalked
- Mugged/held up/threatened with weapon
- Kidnapped/held hostage or prisoner of war
- Serious/life-threatening accident
- Serious/life-threatening illness
- Serious fire/tornado/flood/hurricane
- Active military combat
- Peacekeeping/relief work in a war zone
- Unarmed civilian in war/revolution/military coup
- Refugee
- Directly experienced terrorist attack
- Injured in terrorist attack
- Indirectly experienced terrorist attack
- Saw someone badly injured/ killed or encountered corpse
- Someone close died unexpectedly
- Someone close died in terrorist attack
- Someone close directly experienced terrorist attack
- Someone close had other serious/life-threatening event
- Someone close had other stressful/traumatic event
- Other traumatic event

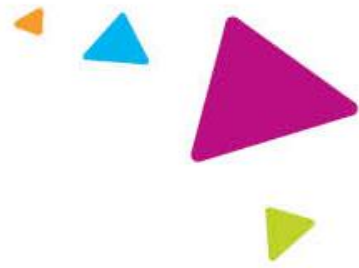
Rates of Suicidal Ideation and Suicide Attempt as a Function of the Number of Separate Traumas Reported

Separate traumas	Suicidal ideation			Suicide attempt		
	<i>n</i>	%	95% CI	<i>n</i>	%	95% CI
0	159	5.50	[4.5, 6.7]	24	0.9	[0.5, 1.5]
1–2	53	15.60	[11.4, 21]	13	3.3	[1.7, 6.3]
3	87	25.70	[20.5, 31.7]	18	5.8	[3.2, 10]
4	75	22.00	[17.2, 27.7]	24	7.1	[4.4, 11.2]
5	93	26.80	[21.8, 32.5]	33	8.3	[5.6, 12]
6	85	33.10	[26.8, 40.2]	27	8.7	[5.6, 13.3]
7	74	36.70	[29, 45.3]	29	14.9	[9.4, 22.7]
8	82	42.30	[34.5, 50.5]	44	21.6	[15.6, 29.2]
9	59	40.70	[31.3, 50.8]	30	19.3	[13.2, 27.3]
≥ 10	172	51.40	[44.7, 58.1]	122	36.9	[30.8, 43.6]

Note. Sample sizes are unweighted. Percentages and 95% confidence intervals (CIs) are weighted.

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: Findings from a US nationally representative sample. *Journal of traumatic stress, 28*(3), 183-190.

Why Suicide Specific Treatment



Treating the
Psychiatric
Disorder is not
sufficient

Identify and
target elements of
the diathesis

Diathesis is
unique to each
person.

Engagement



Looking back over the last week, including today,
rate how you have been feeling about the following areas of your life



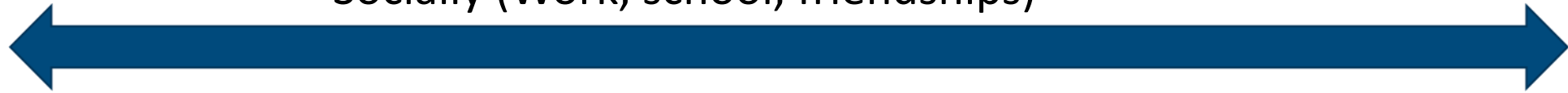
Individually (Personal well-being)



Interpersonally (Family, close relationships)



Socially (Work, school, friendships)

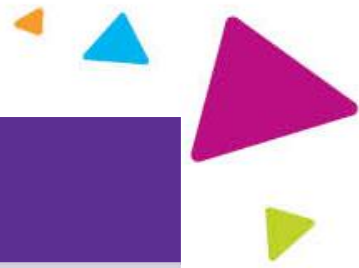


Overall (General sense of well-being)



Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2(2), 91-100.

3 Theories of Suicidality



Cube Model

- External Psychological Stressors
- Agitation – impulsive desire to “do something”
- Psychological pain

Hopelessness

- Negative view of the self in relation to the future

Self-Regard

- Awareness of one’s inadequacies
- Negative Attribution of Failures
- Self-awareness is painful.
- Escape from aversive self-awareness
- Self Loathing

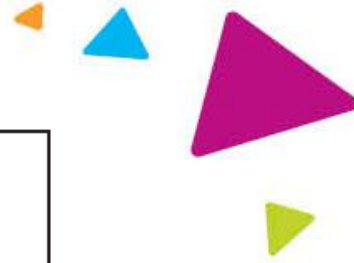
Shneidman, E. S. (1999). The psychological pain assessment scale. *Suicide and Life-Threatening Behavior*, 29, (4), 287-294.

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., Steer, R. A. (2006). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *Focus*, 4 (2), 291-296.

Beck, A. T., Brown, G., & Steer, R. A. (1989). Prediction of eventual suicide in psychiatric inpatients by clinical ratings of hopelessness. *Journal of Consulting and Clinical Psychology*, 57(2), 309–310.

Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review*, 97(1), 90–113.

Assessing the Dimensions of Suicidality



_____	<p>1) RATE PSYCHOLOGICAL PAIN (<i>hurt, anguish, or misery in your mind, not stress, not physical pain</i>):</p> <p style="text-align: center;">Low pain: 1 2 3 4 5 :High pain</p> <p>What I find most painful is: _____</p>
_____	<p>2) RATE STRESS (<i>your general feeling of being pressured or overwhelmed</i>):</p> <p style="text-align: center;">Low stress: 1 2 3 4 5 :High stress</p> <p>What I find most stressful is: _____</p>
_____	<p>3) RATE AGITATION (<i>emotional urgency; feeling that you need to take action; not irritation; not annoyance</i>):</p> <p style="text-align: center;">Low agitation: 1 2 3 4 5 :High agitation</p> <p>I most need to take action when: _____</p>
_____	<p>4) RATE HOPELESSNESS (<i>your expectation that things will not get better no matter what you do</i>):</p> <p style="text-align: center;">Low hopelessness: 1 2 3 4 5 :High hopelessness</p> <p>I am most hopeless about: _____</p>
_____	<p>5) RATE SELF-HATE (<i>your general feeling of disliking yourself; having no self-esteem; having no self-respect</i>):</p> <p style="text-align: center;">Low self-hate: 1 2 3 4 5 :High self-hate</p> <p>What I hate most about myself is: _____</p>

Assessing the Dimensions of Suicidality



1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all:** 1 2 3 4 5 : **completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all:** 1 2 3 4 5 : **completely**

I wish to live to the following extent: **Not at all:** 0 1 2 3 4 5 6 7 8 : **Very much**

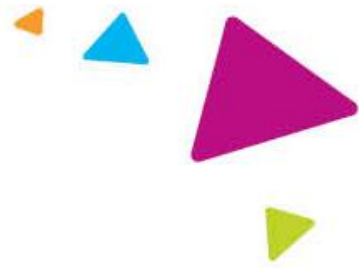
I wish to die to the following extent: **Not at all:** 0 1 2 3 4 5 6 7 8 : **Very much**

The one thing that would help me no longer feel suicidal would be: _____

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

What is Suicide Specific Treatment



Assessment of
suicide related
self-report

Review of the
Safety Plan

Treatment of
patient defined
problems

Evidence Based Brief Interventions to Reduce Suicide Risk



Safety Planning Intervention

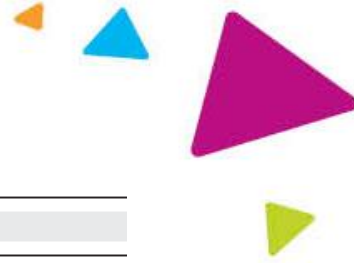
Crisis Response Planning

Teachable Moment Brief Intervention (TMBI)

Motivational Interviewing For Suicidal Ideation (MI-SI)

Attempted Suicide Short Intervention Program (ASSIP)

Stanley Brown Safety Planning Intervention



A brief standalone intervention that may reduce further suicidal behavior

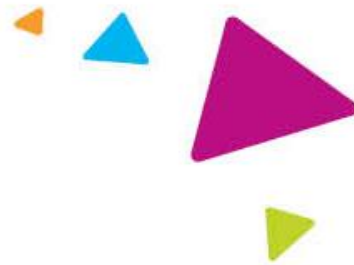
A systematic and comprehensive approach to maintaining safety in suicidal patients.

Patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time, reducing the risk for suicide.

Includes means restriction and emergency contacts, and utilizes internal coping skills and distracting strategies

SAFETY PLAN	
Step 1: Warning signs:	
1.	<u>Suicidal thoughts and feeling worthless and hopeless</u>
2.	<u>Urges to drink</u>
3.	<u>Intense arguing with girlfriend</u>
Step 2: Internal coping strategies - Things I can do to distract myself without	
1.	<u>Play the guitar</u>
2.	<u>Watch sports on television</u>
3.	<u>Work out</u>
Step 3: Social situations and people that can help to distract me:	
1.	<u>AA Meeting</u>
2.	<u>Joe Smith (cousin)</u>
3.	<u>Local Coffee Shop</u>
Step 4: People who I can ask for help:	
1.	Name <u>Mother</u> Phone <u>333-8666</u>
2.	Name <u>AA Sponsor (Frank)</u> Phone <u>333-7215</u>
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name <u>Dr John Jones</u> Phone <u>333-7000</u> Clinician Pager or Emergency Contact # <u>555 822-9999</u>
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Local Hospital ED <u>City Hospital Center</u> Local Hospital ED Address <u>222 Main St</u> Local Hospital ED Phone <u>333-9000</u>
4.	Suicide Prevention Lifeline Phone: <u>1-800-273-TALK</u>
Making the environment safe:	
1.	<u>Keep only a small amount of pills in home</u>
2.	<u>Don't keep alcohol in home</u>
3.	_____

Crisis Response Planning



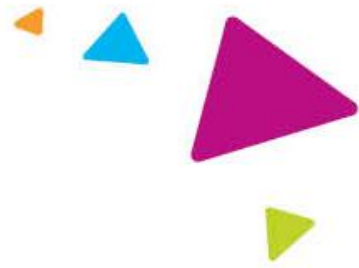
Component	Description
Narrative assessment	Chronological “story” of the suicidal crisis. Assessing for warning signs (e.g., thoughts feelings, physiology, behaviors), coping strategies, social support, and lethality. Typically done for first, worst/most lethal, and last suicidal crisis.
Warning signs	Indicators that a crisis may be starting and that the plan should be used. Warning signs can be behaviors, thoughts, emotions, or physical sensations and should be specific to a potential crisis.
Self-management	Helpful strategies that can be used to reduce stress. Should vary and be useful across situations.
Reasons for living	Reason for living; sense of purpose in life.
Social support	Someone who can be contacted to help reduce stress. May be family member, friend, coworker. Do not have to disclose to this person about the crisis.
Healthcare professionals	Contact information for psychologist/therapists, other medical providers, and other professional sources of help.
Crisis services	Crisis hotlines, emergency response, and/or presenting to an emergency department.

Bryan, C. J., Mintz, J., Clemans, T. A., Leeson, B., Burch, T. S., Williams, S. R., ... & Rudd, M. D. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in US Army soldiers: a randomized clinical trial. *Journal of affective disorders*, 212, 64-72.

Bryan, C. J., May, A. M., Rozek, D. C., Williams, S. R., Clemans, T. A., Mintz, J., ... & Burch, T. S. (2018). Use of crisis management interventions among suicidal patients: Results of a randomized controlled trial. *Depression and anxiety*, 35(7), 619-628.

Rozek, D. C., & Bryan, C. J. (2020). Integrating crisis response planning for suicide prevention into trauma-focused treatments: A military case example. *Journal of clinical psychology*, 76(5), 852-864.

Evidence Based Treatments for Suicidal Risk

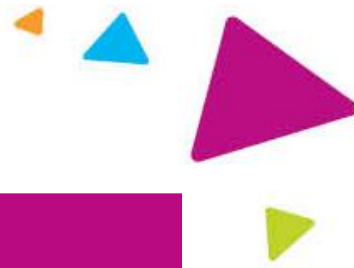


Cognitive
Behavioral Therapy
for Suicide
Prevention (CBT-SP)

Cognitive Therapy
for Suicide
Prevention (CT-SP)

Collaborative
Assessment and
Management of
Suicidality (CAMS)

Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)



A manualized cognitive behavioral treatment for adolescents and adults who recently attempted suicide (≤ 90 days).

Proven effective treating episodes of acute suicide ideation in which precipitants can be identified.

Based on a stress-diathesis model of suicidal behavior

Primary goals of this intervention

- reduce suicidal risk factors
- enhance coping
- prevent suicidal behavior.

Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., Kennard, B., Wagner, A., Cwik, M., Klomek, A. B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S. & Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(10), 1005-1013.

Cognitive Behavior Therapy-Suicide Prevention (CBT-SP)



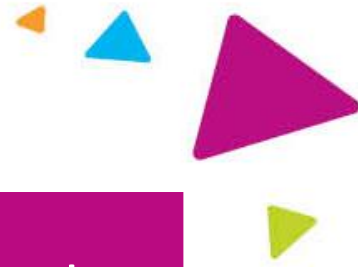
CBT-SP was developed using a risk reduction, relapse prevention approach

Theoretically grounded in principles of cognitive behavior therapy & dialectical behavioral therapy

CBT-SP consists of acute and continuation phases, each lasting about 12 sessions includes:

- a chain analysis of the suicidal event
- safety plan development
- skill building
- psychoeducation
- family intervention (adolescents)

Cognitive Therapy for Suicide Prevention (CT-SP)



Evidence-based, manualized treatment developed for individuals who recently attempted suicide,

Protocol can also be applied to individuals with acute suicidal ideation.

Assumes individuals who are suicidal or who attempt suicide lack specific coping skills

Cognitive and behavioral strategies were applied to address identified thoughts and beliefs

Patients develop adaptive ways of coping with stressors that provoked the suicidal crisis

CT-SP targets suicidal ideation and behavior directly

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. *Jama*, 294(5), 563-570.

Henriques, G., Beck, A. T., & Brown, G. K. (2003). Cognitive therapy for adolescent and young adult suicide attempters. *American behavioral scientist*, 46(9), 1258-1268.

Collaborative Assessment and Management of Suicidality (CAMS)



Well Supported intervention for suicidal ideation per Center of Disease Control and Prevention criteria.

A phenomenological approach to understanding a patient's suicidality

Suicide Status Form (SSF-4) used to document assessment, treatment planning, tracking, and outcome.

of sessions is determined by patient's progress in reducing SI

Suicide-specific treatment planning

CAMS Therapeutic Worksheet (CTW) explore drivers and conceptualize the suicidal crisis

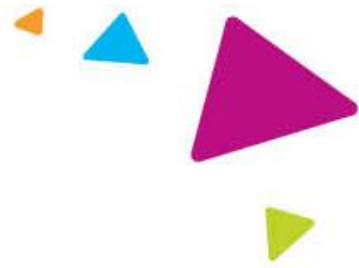
Jobes, D. A. (2023). *Managing suicidal risk: A collaborative approach*. Guilford Publications.

Santel, M., Beblo, T., Neuner, F., Berg, M., Hennig-Fast, K., Jobes, D. A., & Driessen, M. (2020). Collaborative Assessment and Management of Suicidality (CAMS) compared to enhanced treatment as usual (E-TAU) for suicidal patients in an inpatient setting: study protocol for a randomized controlled trial. *BMC psychiatry*, 20, 1-15.

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CAMS THERAPEUTIC WORKSHEET: UNDERSTANDING YOUR SUICIDALITY



Date of Session: _____

Session #: _____

I. PERSONAL STORY OF SUICIDALITY

Why are you suicidal? How do you understand your suicidality? How do you understand your relationship to suicide? What is your personal story?

II. DRIVERS OF SUICIDALITY

Problem #2: _____

Problem #3: _____

Now let us examine the factors underlying your suicidality or what we refer to as "drivers." Please only complete those sections that have relevance toward your own experience of suicidality. Your answers may overlap with the information you provided on the Suicide Status Form in the first therapy session. However, new information may also be added over the course of treatment in order to most accurately reflect your personal experience of suicidality.

What are the "direct drivers" that lead me to feeling suicidal?

Specific thoughts (e.g., "It would be easier on everyone if I were dead.")

Specific feelings (e.g., "I just feel so much shame.")

Specific behaviors (e.g., "When I waste time all day long.")

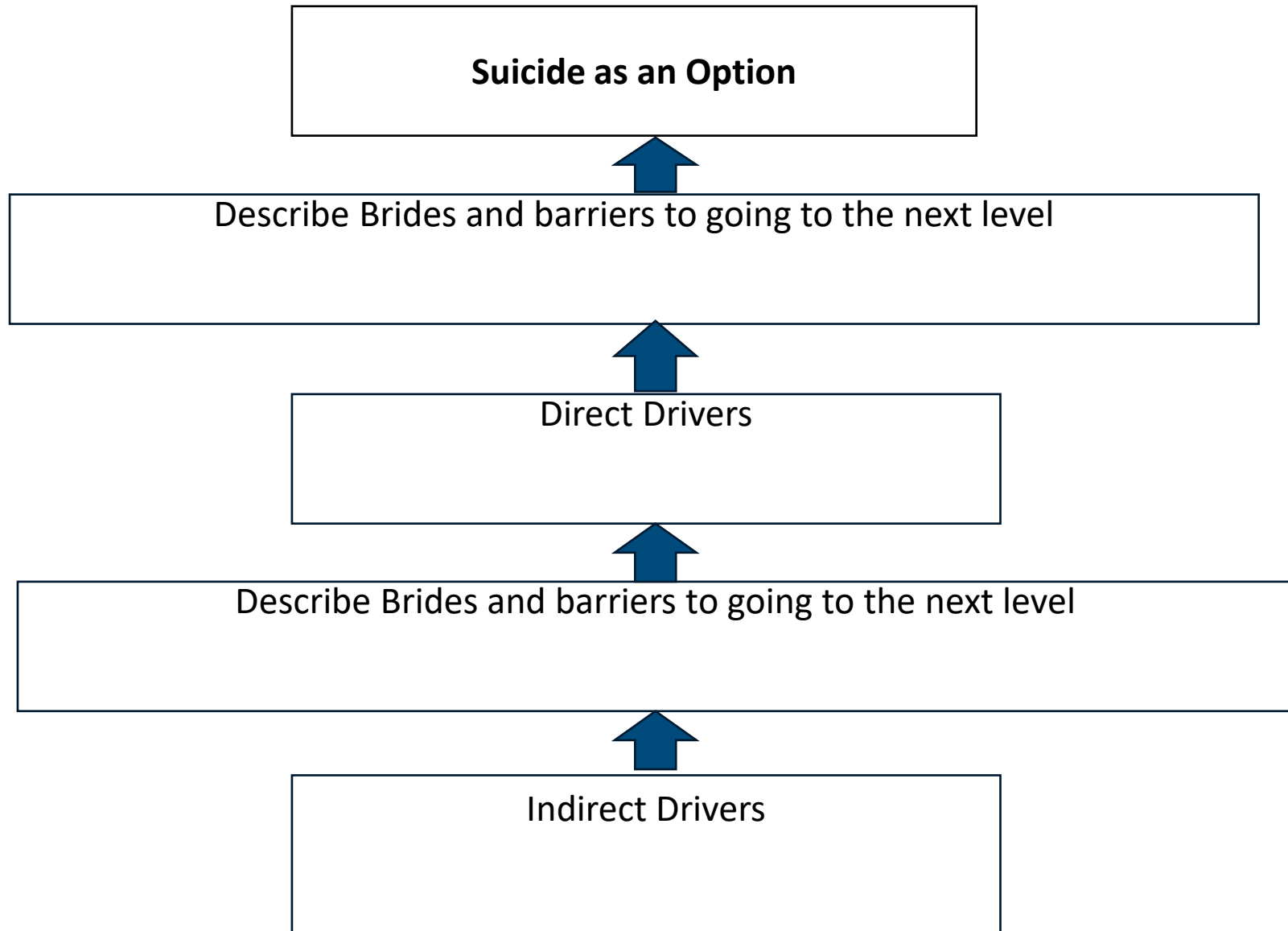
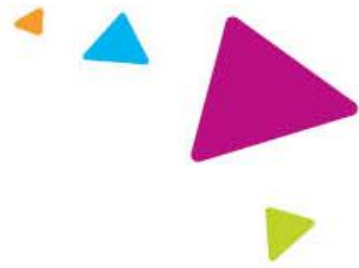
Specific themes (e.g., patterns in relationships or self-concept)

What are the "indirect drivers" that lead me to feel suicidal?

Indirect drivers: Underlying factors that contribute, but do not necessarily lead to, acute suicidal ideation, feelings, and behaviors (e.g., homelessness, depression, substance abuse, PTSD, isolation).

³¹ Jobs, D. A. (2016). Managing suicidal risk: A collaborative approach (Second edition). The Guilford Press.

Suicidal conceptualization



Suicide Specific Treatment



A Stepped Care Model for Suicide Care

Stabilization Planning + Lethal Means Safety + caring follow-up used throughout the model

Suicide-specific Care at Each Step
From Least to Most Restrictive Intervention

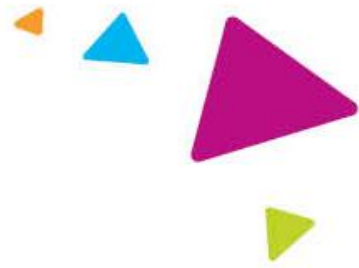
Suicide-specific care that is evidence-based, least-restrictive, and cost-effective...



- Increase Member access to high quality suicide risk assessment and risk reduction interventions at ALL levels of care.
- Increase clinician access to high quality tools and training resources
- Increase utilization of high-quality suicide risk assessment and suicide risk reduction intervention at all levels of care

Jobes, D. A., Gregorian, M. J., & Colborn, V. A. (2018). A stepped care approach to clinical suicide prevention. *Psychological services, 15*(3), 243.

Dialectical Behavioral Therapy (DBT)



DBT proven effective with suicidal “multiproblem adolescents”

DBT conceptualizes suicidal behavior as a learned method of coping

Suicidality with chronic, aversive emotional dysregulation

Rathus, J. H., Miller A. L. Dialectical behavior therapy adapted for suicidal adolescents. *Suicide Life Threatening Behavior*. 2002;32(2):146–57.

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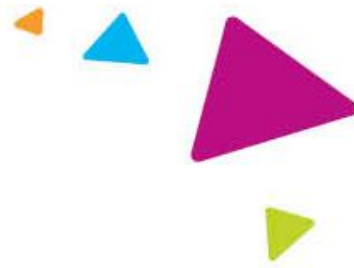


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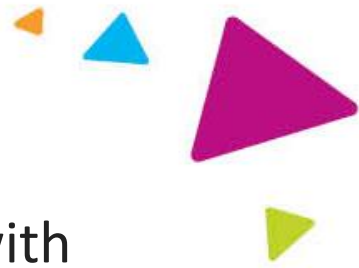


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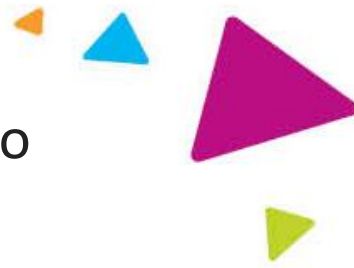
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