Clinical Distinctions Between Selective Mutism and Social Phobia: An Investigation of Childhood Psychopathology

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ABSTRACT

Objective: To investigate the hypothesis that children with selective mutism are more socially anxious than children with social anxiety disorder but who are not selectively mute. **Method:** Twenty-three children with comorbid selective mutism and social phobia and 23 age-matched controls with social phobia alone and their parents participated in a comprehensive assessment of social anxiety and related aspects of psychopathology. **Results:** The results do not uniformly support previous suggestions that children with selective mutism refuse speech because they are "frozen with fear." Although clinician and observer ratings for children with selective mutism revealed higher ratings of social distress than for children with social phobia alone, self-report data do not support this conclusion. Furthermore, although there were no group differences on measures of trait anxiety, general fears, or scores on the Child Behavior Checklist broadband Internalizing or Externalizing scales, children with selective mutism scored higher than children with social phobia alone on the Child Behavior Checklist Delinquency subscale, suggesting the presence of a broader clinical syndrome. **Conclusion:** It remains unclear whether children with selective mutism have extreme levels of social anxiety. Potential areas that might shed further light on this interesting disorder are discussed. *J. Am. Acad. Child Adolesc. Psychiatry*, 2003, 42(9):1069–1075.

Key Words: selective mutism, social phobia, social anxiety disorder.

Selective mutism is defined as the refusal or withholding of speech in some situations while displaying normal speech in other settings (American Psychiatric Association, 1994). A disorder of low prevalence (0.3–0.71%) (Bergman et al., 2002), children with selective mutism display many clinical symptoms considered characteristic of social anxiety disorder, including social avoidance, distress in social situations, and fear of speaking to strangers (Beidel and Turner, 1998). Indeed, diagnostic studies of children with selective mutism (Black and Uhde, 1995; Dummit et al., 1997) indicate that almost all meet diagnostic criteria for social phobia, as defined by the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)* (American Psychiatric Association, 1994). In addition, the ages of onset for these conditions are virtually identical in children comorbid for both disorders (Dummit et al., 1997). Thus, the very similar clinical presentations, 90% to 100% comorbidity rate for social phobia among children with selective mutism, and the identical ages of onset found when the disorders co-occur have led some researchers and clinicians to suggest that selective mutism should be conceptualized not as a separate disorder but simply as a variant of social phobia (Black and Uhde, 1995; Kristensen, 2000), where children with selective mutism represent the "extremely anxious" end of the distribution.

From a symptomatic standpoint, children with selective mutism have been described as being "frozen with fear" (Anstendig, 1999), and extreme social anxiety has been proposed as an etiological factor. One difficulty with studies to date, however, is that most only compare children with selective mutism to a group without a disorder. For example, Bergman et al. (2002) examined the psychopathology of 12 children with selective mutism

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and 12 comparison controls (selected by the teacher for not having any language disorder or refusal to speak). Teachers rated children with selective mutism as having significantly higher social anxiety as well as difficulty with academic and social functioning. Despite the significant differences, when children with selective mutism were compared with normal controls, there are children with social phobia, often displaying multiple avoidance behaviors, who nevertheless will speak to strangers when necessary or when required to do so. Thus, it is unclear why some children with social anxiety exhibit selective mutism whereas others do not. One proposed hypothesis is that children with selective mutism suffer such extreme anxiety that they are physically unable to speak.

However, to date, few data exist to support the hypothesis that children with selective mutism score in the extreme range on measures of social anxiety. Dummit et al. (1997) found that clinician ratings of social anxiety on the Liebowitz Social Anxiety Scale were only in the moderate range (mean 36.5; SD 14.5) for children with selective mutism. Furthermore, teacher ratings from the Bergman et al. (2002) study indicated that although scores of children with selective mutism were higher than the comparison group, the scores (with one exception) were not in the range usually considered as clinically significant (T score above 70). Logically, these findings are inconsistent with the conclusion that selectively mute children are "frozen with fear." Rather, they suggest that additional behavioral factors may be involved in selective mutism.

Clinically, children with selective mutism are sometimes described as oppositional, perhaps as a result of social anxiety (Beidel and Turner, 1998). Although some adolescent externalizing behaviors such as alcohol and drug abuse have been retrospectively reported by adults with social phobia (e.g., DeWit et al., 1999), oppositional, delinquent, or aggressive disorders do not commonly appear among children with social phobia (Beidel and Turner, 1998) or among children with selective mutism (e.g., Black and Uhde, 1995; Dummit et al., 1997). However, as noted by Beidel and Turner (1998), children with social phobia may display oppositional behaviors, if not necessarily an oppositional disorder (i.e., refusal to participate in various activities may stem from fear of social engagement and refusal to speak may be a behavior to attenuate social distress). Therefore, using only presence/absence of a *DSM-IV* disorder may be an insensitive measure of oppositionality because these behaviors may be present, but at a degree insufficient for meeting diagnostic criteria.

There are some data to support the presence of oppositionality at least among a subsample of children with selective mutism. Opposition-defiance/aggression behaviors were found among 26% of a sample of 100 German and Swiss selectively mute children (Steinhauzen and Juzi, 1996). Additionally, among a sample of 153 individuals with past or current selective mutism (Ford et al., 1998), the top ranked concerns were avoidant behaviors, shy/withdrawn behavior, toileting problems, and strong willed behaviors (e.g., stubborn, controlling). Additionally, "oppositionality" items (refusal to talk; stubborn, sullen, or irritable; argues a lot; disobedient in school; whining; and temper tantrums or hot temper) were among the top ranked items on the Child Behavior Checklist (CBCL) (Achenbach, 1991). Thus, a dimensional, rather than a categorical, approach may provide a more sensitive assessment of the potential presence of oppositional behaviors in children with selective mutism.

In summary, a number of studies have documented a relationship between social phobia and selective mutism. However, emerging clinical observations and research data suggest that selective mutism may need to be conceptualized differently than merely "extreme social anxiety." Furthermore, to date, the data suggesting that children with selective mutism are "frozen with fear" are based on comparisons with children without a psychiatric disorder. This does not address the crucial question, however, which is as follows: why are some children with social phobia able to speak in distressful situations whereas others cannot? Do children with selective mutism represent the severe end of the distribution of children with social phobia, such that they are so overcome by social anxiety that they are incapable of speech? The current study is an initial attempt to address this issue and perhaps help clarify the clinical conceptualization of selective mutism.

METHOD

Participants

The sample consisted of 23 children diagnosed with social phobia matched by age with 23 children diagnosed with social phobia and a comorbid diagnosis of selective mutism (hereafter called the selective mutism group). Data were collected during pretreatment assessments from participants involved in research studies conducted at two separate anxiety centers. Some of the ads used to advertise availability of the treatment programs described symptoms of anxiety disorders and others specifically described symptoms of selective mutism.

Among the 46 total participants, 29 were participants in one of two randomized of the effectiveness of a behavioral controlled trials treatment for children with social phobia (University of Maryland)

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and 17 were participants in a randomized controlled trial of cognitive-behavior therapy for children with anxiety disorders (Florida International University). Each child was interviewed by a trained graduate student or clinical psychologist using the Anxiety Disorders Interview Schedule for Children (ADIS-C) (Silverman and Albano, 1996) in the presence of the child's parent. Data from both parents and children were used to determine the diagnosis. Socioeconomic status data were not collected for the entire sample, and children lived in either urban or suburban areas.

Demographic characteristics are presented in Table 1, and there were no differences on any demographic variables based on diagnostic group. There were no significant differences in demographic data by site except for race/ethnicity where there were more Hispanic children in the Florida International University sample ($p < .05$).

With regard to gender, the sample consisted of 20 males and 26 females. Among the entire sample, 22 (48%) were white, 4 (9%) were African-American, 15 (33%) were Hispanic/Latino, 2 (4%) were Asian, 2 (4%) considered themselves Pacific Islanders, and 1 (2%) was of Middle Eastern decent. The mean age was 9.5 years (range 5.4–13.1 years) for the social phobia group, whereas the average age of children in the selective mutism group was 9.4 years (range 5.3–14.6 years). In addition to the primary diagnoses, 13 (57%) members of the social phobia group met criteria for at least one additional diagnosis, as did 8 (35%) of children in the selective mutism group.

TABLE 1
Demographic Characteristics of Study Participants

	SP	SM	Total
Total *N*	23	23	46
Boys	10	10	20
Girls	13	13	26
Age, mean (SD)	9.5 (1.72)	9.4 (1.95)	
Ethnicity, *n* (%)			
White	12 (52)	10 (44)	22 (48)
African American	3 (13)	1 (4)	4 (9)
Hispanic	7 (30)	8 (35)	15 (33)
Middle Eastern	0	1 (4)	1 (2)
Asian	1 (4)	1 (4)	2 (4)
Pacific Islander	0	2 (9)	2 (4)

Note: SP = social phobia; SM = selective mutism.

Measures

Self-Report and Clinician Ratings. Self-report measures included the Social Phobia and Anxiety Inventory for Children (SPAI-C) (Beidel et al., 1995), State-Trait Anxiety Inventory for Children Trait subscale (STAI-C) (Spielberger et al., 1973), and the Fear Survey Schedule for Children-Revised (FSSC-R) (Ollendick, 1983). As part of the ADIS-C interview, clinicians complete a 9-point rating scale estimating the severity of social phobia and selective mutism. The scale is anchored such that 0 = no dysfunction, 2 = slightly disturbing/disabling, 4 = definitely disturbing/disabling, 6 = markedly disturbing/disabling, 8 = very severely disturbing/disabling. The interviewing clinician assigned the severity rating based on data collected during the diagnostic interview.

Parent-Report. The CBCL (Achenbach, 1991) was completed by mothers of the participants. The Internalizing and Externalizing scales, as well as the Anxious/Depressed, Withdrawn, Aggressiveness and Delinquency subscales, were used for this analysis.

Behavioral Assessment Task (BAT). Only at the University of Maryland site, the assessment protocol was designed such that children who were diagnosed with social phobia (with or without selective mutism) were invited to complete the second phase of the pretreatment assessment. This consisted of a behavioral assessment of social performance and social skill. Nine children with social phobia and seven with selective mutism completed the behavioral task. This subsample was not preselected in any way but consisted of all children who returned to complete the second phase of the assessment. The parents of the remaining 13 children chose not to participate in the clinical research trial and therefore did not return for the behavioral assessment.

Children took part in five role-plays with a same-age, friendly peer who was instructed to respond to the subject in a neutral fashion. Scene content included starting a conversation with an unfamiliar child, offering to help a child, giving and receiving a compliment, and responding to the inappropriate behavior of another child. Independent observers unaware of group status made ratings of effectiveness using a 5-point Likert scale where 1 = completely ineffective and 5 = very effective. In addition, anxiety ratings were made using a 4-point scale where 1 = very relaxed and 4 = very anxious or distressed. The children also made a self-rating of anxiety using a 5-point scale where 5 = completely relaxed and 1 = very anxious.

RESULTS

Group differences were analyzed with analyses of variance. Because of variable *N* values, only subjects who completed each particular instrument or assessment were included in the analysis of that variable. No averaging or substitution of group means was used to correct for missing data. Thus, the number of subjects for each variable is slightly different. The number of subjects included in each of the analyses is presented in the tables below. It should be noted that the ratio of statistical tests conducted to number of subjects in the sample somewhat increases the likelihood of inflating the experiment-wise error rate. However, given the fact that this was the first study to compare these two groups of children, it was decided that the potential heuristic value of the results exceeded the need to control for the potential experiment-wise error rate.

Presence of Comorbid Diagnoses

Specific comorbid diagnoses by group membership are presented in Table 2. Chi-square analyses revealed a significant group difference in the percentage of children who had a comorbid diagnosis of generalized anxiety disorder (χ^2_1, $n = 46 = 4.21$, $p < .05$). There were no other differences in rates of comorbidity between the two groups.

Social Phobia Severity

The SPAI-C score and the ADIS-C clinician-rated severity of social phobia score were used to examine severity of social distress. The groups were not significantly

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TABLE 2
Additional Comorbid Diagnoses in Both Groups

	SP	SM	Total
Specific phobia	6 (26)	3 (13)	9 (20)
SAD	4 (17)	4 (17)	8 (17)
GAD	6 (26)	1 (4)	7 (15)
ADHD	1 (4)	0	1 (2)
ODD	1 (4)	1 (4)	1 (2)
Adjustment disorder	1 (4)	0	1 (2)

Note: Values represent *n* (%). SP = social phobia; SM = selective mutism; SAD = social anxiety disorder; GAD = generalized anxiety disorder; ADHD = attention-deficit/hyperactivity disorder; ODD = oppositional defiant disorder.

different with respect to SPAI-C scores (Table 3). However, there was a significant group difference on the ADIS-C severity rating ($F_{1,44}$ = 4.90, p = .032). Clinicians rated children comorbid for selective mutism and social phobia as having more severe social fears than children with social phobia alone.

Observer Assessment of Social Skill and Performance on the BAT

It should be noted that none of the children in the selective mutism group responded verbally during the role-play task. Significant group differences were found on observer ratings of anxiety ($F_{1,14}$ = 14.74, p = .002) and social skill ($F_{1,9}$ = 8.33, p = .010). Children with selective mutism were rated by observers as being more anxious and less skilled on behavioral tasks that involved conversational interaction with a same age peer. However, no between-group differences were found with regard to the children's self-ratings of anxiety when they were engaged in this task (Table 3), and ratings for all children were in the mild to moderate anxiety range.

Other Measures of Psychopathology

Separate analyses of variance were used to analyze other measures of psychopathology. No significant group differences were found on the FSSC-R, STAI-C Trait subscale, CBCL Internalizing or Externalizing scales, or the CBCL subscales of Anxiety/Depressed or Withdrawn subscales. There was a trend for children with selective mutism to have a higher score on the CBCL Aggression subscale ($F_{1,39}$ = 3.6, p = .065), although the difference did not meet the traditional .05 significance level. Children with selective mutism did have significantly higher scores than children with social phobia alone on the CBCL Delinquency subscale ($F_{1,38}$ = 5.99, p = .02), although their T scores were still below the cutoff usually considered indicative of clinical significance. A comparison of scores on the individual items comprising the delinquency subscales did not reveal significant group differences for any one particular item.

TABLE 3
Performance of Social Phobic and Selectively Mute Groups on Measures of Psychopathology

	Social Phobia		Selective Mutism		
Variable	Mean	(SD)	Mean	(SD)	*p*
SPAI-C	21.7	(8.4)	23.9	(13.6)	NS[a]
ADIS-C Severity of SP	5.4	(1.5)	6.4	(1.6)	.032[b]
FSSC-R	140	(35.6)	148	(33.2)	NS[c]
BAT Anxiety Self-Rating	3.44	(1.2)	2.9	(2)	NS[d]
BAT Anxiety Rating	2.7	(.93)	4.0	(0)	.002[d]
BAT Social Skill Rating	2.2	(.86)	1.0	(0)	.010[d]
STAI-C (Trait)	33.8	(6.9)	36.7	(8.0)	NS[e]
CBCL (Internalizing)	65.5	(7.83)	62.3	(11.8)	NS
CBCL (Externalizing)	48	(7.9)	49.7	(10.4)	NS
CBCL (Aggression)	53.3	(3.4)	55.9	(5.2)	.065[f]
CBCL (Delinquency)	53.7	(3.5)	56.7	(4.2)	.019[g]
CBCL (Anxious/Depressed)	66.4	(11.6)	67	(9)	NS
CBCL (Withdrawn)	65.5	(7.2)	65.1	(12)	NS

Note: Some subjects had missing data; therefore, group *n*'s are variable. SP = social phobia; SM = selective mutism; SPAI-C = Social Phobia and Anxiety Inventory for Children; ADIS-C = Anxiety Disorders Interview Schedule for Children; FSSC-R = Fear Survey Schedule for Children-Revised; BAT = Behavioral Assessment Task; STAI-C = State-Trait Anxiety Inventory for Children; CBCL = Child Behavior Checklist; NS = not significant.

[a] SP = 15, SM = 15; [b] SP = 23, SM = 23; [c] SP = 17, SM = 13; [d] SP = 9, SM = 7; [e] SP = 10, SM = 14; [f] SP = 22, SM = 18; [g] SP = 22, SM = 19.

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DISCUSSION

Currently, the most common explanation for selective mutism is that these children exhibit such an extreme degree of social anxiety that they are incapable of speech. However, previous studies have only examined the clinical profiles of these children in comparison with a normal control group (Black and Uhde, 1995; Dummit et al., 1997). Thus, to date, conclusions about the relationship between selective mutism and social phobia have been drawn without the benefit of a direct comparison. To our knowledge, this is the first study to directly compare the psychopathology of children with selective mutism to children with social phobia alone. The results indicate that although there are some similarities between these two disorders, there may be some differences as well.

All children in this study met criteria for a diagnosis of social phobia, thus indicating that all of the children experienced social anxiety. However, there were conflictual findings with respect to the question of whether children with selective mutism had more severe social anxiety than children with social phobia alone. Using different measurement strategies, clinicians (using a semi-structured diagnostic interview) and blind observers (using behavioral samples during the BAT) rated children with selective mutism as significantly more socially anxious than children with social phobia alone. In contrast, there were no differences based on child self-report either in level of general social anxiety (as assessed by the SPAI-C) or specific anxiety during a role-play task (the BAT self-rating). These conflictual findings are difficult to interpret. One explanation might be that mutism attenuates social anxiety. That is, because the children have discovered a successful avoidance strategy (i.e., refraining from speech), their social anxiety is reduced in the same manner that refusing to leave home decreases distress for those with agoraphobia. Under such a scenario, children with selective mutism may not endorse "extreme" fear because they no longer engage in the feared situation (i.e., they no longer attempt to speak). Thus, because of their successful avoidance, children now report only moderate levels of distress, whereas adults view the avoidance behavior (mutism) as evidence of the severity of the child's social fear.

An alternative explanation, however, is that adults might be overinterpreting the child's behavior. That is, adults may simply infer that a child who does not respond verbally to the overtures of a caring, nonthreatening adult (teacher, grandparent, psychologist) must be "frozen with fear." Such an interpretation might have influenced the raters in this investigation inasmuch as the same raters rated both the children with selective mutism and those with social phobia alone. Thus, the lack of speech may have led the raters to infer a greater level of social distress. However, just as there are many reasons for school refusal, there may be more than one simple explanation for speech refusal (i.e., selective mutism). Clinicians who work with selectively mute children observe that a number of children will willingly interact nonverbally with adults and peers, making appropriate social responses such as smiling or engaging in games at recess. Thus, if they are socially fearful, their anxiety does not appear to inhibit the nonverbal parameters of social behavior. Again, this conflicts with the behavior of many children with social phobia who will avoid all types of interactions with children or hide when strangers come to their home. At this time, the most parsimonious conclusion appears to be that children with selective mutism do indeed suffer from social anxiety (as indicated by their elevated SPAI-C scores), but other factors also may play a role in the inhibition of speech. Some of these directions for future research are discussed below.

With respect to other aspects of psychopathology, there were no significant differences on the CBCL Internalizing or Externalizing scales, or the CBCL Anxious/Depressed or Withdrawn subscales. Consistent with Ford et al. (1998), CBCL Delinquency subscale scores for children with selective mutism were higher than scores of children with social phobia alone. However, these scores were not in the clinically significant range. Also, the actual between-group differences for both the Delinquency and Aggression subscales were quite small, suggesting only minimal between-group differences. Thus, it is important not to overinterpret this statistically significant difference until it can be replicated with other groups and other types of measures.

Clinical Implications

With respect to treatment implications, this study further confirms previous findings that many children with selective mutism meet criteria for social phobia. Thus, addressing the social anxiety in selective mutism should be considered a crucial component in the treatment of this disorder. However, assuming that the primary clinical distinction between children with selective mutism and those with social phobia alone is simply a difference in the severity of social anxiety does not fully characterize the differences between these two groups. Thus, inter-

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ventions that focus solely on decreasing social anxiety in children with selective mutism may not be sufficient. For at least some children with selective mutism, a broader intervention addressing oppositional behaviors through treatments such as parent training, behavior modification, and interventions to decrease social distress may be needed for optimal treatment outcome. Similarly, if some children with selective mutism do have severe levels of social distress, a combination of pharmacological and psychological interventions may be the most effective approach. Finally, if operant features are present and speech refusal is a function of reinforcement contingencies, it is possible that significant improvement will not occur without addressing these issues directly.

Limitations and Directions for Future Research

This study has several limitations. Selective mutism is a low prevalence condition; thus, ability of any one study to collect a large sample of children is difficult. Thus, replication with a larger sample would be important to confirm the significant findings in this investigation. Second, all of the subjects were referred for participation in clinical research trials; thus, the findings may not generalize to community children with social phobia and/or selective mutism. Additionally, the mean age of the sample was just over 9 years, making this sample somewhat older than that reported in other studies of children with selective mutism. This somewhat older sample may explain why there were significant differences on the CBCL Externalizing subscales such as oppositional/avoidant behaviors may become more entrenched with increasing age. Third, there was no correction for the ratio of statistical tests to the number of subjects in the sample. However, this study represents the first attempt to directly compare children with selective mutism to children with social phobia alone. Thus, given the descriptive and exploratory nature of the study, no attempt was made to constrain the analyses and thereby falsely eliminate initially positive findings which could be followed up in future, more tightly controlled investigations.

With respect to future research, there is a need to further investigate the conflictual findings regarding group differences in social anxiety. In this study, social anxiety was assessed by self-report, clinical interview, and a behavioral task. One of the shortcomings of these latter two tasks is that the child's refusal to speak may have affected the ratings of social anxiety severity. Thus, knowing that the child would not speak may have affected the clinician or observer's ratings of anxiety. Two alternative strategies may avoid this confound. First, the addition of psychophysiological assessment to the current behavioral task would allow the assessment of parameters of heart rate and skin conductance, variables that, unlike speech, are not usually under the direct control of the subject. Second, behavioral observation strategies that allow for visual observation of nonverbal aspect of social interaction, but do not allow an assessment of verbal behavior, would avoid the potential confound of equating lack of speech with high degrees of social distress. Children without social anxiety could also be included in the observational group, further decreasing the likelihood of rater bias.

Another area for further investigation is why some children with selective mutism appear to be able to engage others nonverbally, sometimes with apparent ease. Perhaps this ability to comfortably, but nonverbally, interact with others is indicative of a subset of children with selective mutism who are not comorbid for social phobia. In this study, recruitment was based on the availability of free treatment; thus, parents who did not view their children as anxious may not have responded to the advertisement. However, the purpose of this study was to determine if there were differences among those with selective mutism and social phobia and those with social phobia alone. Thus, all children in this study had social phobia. A different recruitment strategy would be necessary to examine this different research question.

The purpose of this study was to determine if there were differences between children with social phobia and those with selective mutism and comorbid social phobia. Differences in level of social distress do not solely account for the lack of speech in the comorbid group; thus, other factors merit further investigation. For example, as noted in the introduction, there is a substantial literature on the relationship of developmental disabilities and selective mutism. To date, these studies primarily have examined the presence of comorbid conditions such as receptive and expressive language disorders. There also are clinical reports of a relationship between pervasive developmental disabilities and selective mutism. However, research into the specific relationship of these developmental disabilities to selective mutism has yet to be conducted. For example, is reluctance to speak a result of an inability to process speech or auditory stimulation? Studies such as these merit further investigation.

As noted above, the marginally higher scores on the CBCL Delinquency subscale for children with selective

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mutism are difficult to interpret. Although the scores were statistically significantly different, they are not likely to be clinically relevant. However, the Externalizing subscales of the CBCL assess serious delinquent behavior, and a follow-up investigation with a different, and perhaps more sensitive, assessment strategy might be worthwhile. For example, a specific and, thus, more sensitive, parental or self-report inventory or direct observation of parent-child interactions might reveal different, and perhaps more subtle, patterns of "oppositionality" that may reflect nothing more than behavioral avoidance of socially distressing situations. In summary, selective mutism is a disorder that often challenges and frustrates many clinicians. Future studies addressing parameters such as those identified in this study may further elucidate important aspects of this condition.

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