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2005-6

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Original Publication Citation

Marks, L. D. (2005). Religion and bio-psycho-social health: A review and conceptual model. *Journal of Religion and Health*, 44, 173-186.

BYU ScholarsArchive Citation

Marks, Loren, "Religion and Bio-Psycho-Social Health: A Review and Conceptual Model" (2005). *Faculty Publications*. 4894.

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Religion and Bio-Psycho-Social Health: A Review and Conceptual Model

LOREN MARKS

ABSTRACT: This paper presents a research-based conceptual model respectively linking three dimensions of religious experience (religious practices, spiritual beliefs, and faith community) with three dimensions of health (biological, psychological, and social). The model is used as a framework to highlight findings in the religion-health knowledge base and to provide a broad survey of this domain of inquiry. Considerations for future research on religion and health are addressed.

KEY WORDS: religion; health; longevity; model.

Introduction

In the foreword of Koenig, McCullough, and Larson's (2001) landmark volume *Handbook of Religion and Health*, Jeff Levin reminds us that "there was a time...[circa 1985] when those of us actively investigating the linkages between religion and health could have fit around a single conference table. A very small one" (p. viii). In the 20 years since the "one table" days, research addressing the "faith factor" in health has begun to influence medicine, as well as sociology, psychology, and family studies. Even if we do not include religion-focused journals like *Journal of Religion and Health*, a forthcoming special issue on religion in *Research on Aging* will be at least the ninth social science journal in the last 5 years to dedicate an issue to religion.¹ The time has arrived when religion and health researchers not only need a larger conference table, we need a conference.

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¹These recent special issues include *Journal of Health Psychology* (vol. 4, no. 3), *Journal of Men's Studies* (vol. 7, no. 1), *Journal of Marital and Family Therapy* (vol. 26, no. 2), *Journal of Family Psychology* (vol. 15, no. 4), two issues of *Journal of Family Psychotherapy* (vol. 13, nos. 1–4), *Michigan Family Review* (vol. 8, no. 1) and *American Psychologist* (vol. 58, no. 1).

Statement of Purpose

The purpose of this paper is to review, analyze, and advance empirical social science research (as well as some medical research) addressing religion as it relates to individual biological, psychological, and social health. Recently, a marked increase in religion-related empirical research associated with physical and mental health (Koenig, 1998; Judd, 1999; Koenig et al., 2001), psychological coping (Pargament, 1997; Koenig et al., 2001), marriage and family (for recent reviews, see Christiano, 2000; Dollahite, Marks, & Goodman, 2004), and responsible fathering (Marks & Dollahite, 2001; Wilcox, 2002; King, 2003) has helped to move scholarly discussions regarding religion closer to the foreground of the social sciences. Such discussion is vital because although religion may not significantly impact the health of most Americans, Miller and Thoresen (2003) report that religion *is* “the single most important influence in [life]” for “a substantial minority” (p. 25). Based on this reportedly paramount influence, the religion–health connection continues to command empirical attention.

In this article, the author analytically reviews extant empirical literature with the aim of: (a) illuminating well-documented findings on religion–health connections, (b) indicating aspects of religion and health research that need additional exploration and research, and (c) encouraging increased dialogue on empirical and theoretical levels regarding the religion and health interface.

From Freud to “The Faith Factor”: An Historical Glance

For the first three-quarters of the 20th century, the prevalent view of religion’s relationship to health among both medical and social scientists was apathetic at best, and actively hostile at worst. This hostile camp is perhaps most conspicuously represented by Freud, who maligned religion as mankind’s universal obsessional neurosis (Freud, 1933/1961).² In the 1970s, however, empirical work began to challenge the prevalent idea that religion was pathological when Stark (1971) found that religiosity *inversely* correlated with psychopathology. By the mid-1990s, the pendulum of religion-related medical and social science publication seemed to have swung from (a) anti-religion conceptual work, to (b) empirical work that frequently correlated religious experience with a variety of beneficial health-related outcomes; as documented by Matthews and colleagues’ *The Faith Factor* series (1993a, b, 1995, 1997) which reviewed nearly 400 studies on the religion and health connection, the majority of which indicated a modest but positive correlation. However, although the transition from (a) accepting anti-religion hypotheses without supporting evidence, to (b) empirically investigating the religion–health connection was an important step, it was not a sufficient one.³

²Stark and Bainbridge (1996, p. 22) have pointed out that Freud once referred to religion “an ‘intoxicant,’ a ‘poison,’ and ‘childishness to be overcome’ – all on one page” (see Freud, 1927, p. 88).

³In retrospect, it seems ironic that the anti-faith sentiments that dominated medical and social science for most of the 20th century were accepted largely “on faith” (i.e., without empirical evidence).

A Critical Analysis of Past Conceptualizations of Religion

Until approximately 15 years ago, operational definitions, conceptualizations, and measures of religiosity were frequently based on one of three different indicators: (a) *denomination*, or reported affiliation with a faith community; (b) quantifiable religious *behavior* such as church attendance; or (c) *values*. Unfortunately, many studies have included only one or two of these three types of indicators to conceptualize and represent religion or religiosity. Because religion was frequently little more than a token variable in many pre-1985 sociological studies it was measured with minimal breadth and depth, raising questions regarding the construct validity of religion as presented in many studies. A similar problem in many psychology studies identified by Miller and Thoresen (2003) is that “measurement of spiritual/religious constructs...has usually been poor in quality” (p. 26). On one hand, these points lead a scholar to read many religion-related studies (including this one) with a healthy skepticism. On the other hand, it is noteworthy that the construct of religion has—in spite of frequently limited and simplistic measurement—been a statistically significant factor in a myriad of studies; a point that seems to indicate a salient connection between religion and health, even if researchers cannot yet satisfactorily measure, much less explain, the processes at work.

Since the late 1990s, however, research in this area has come of age and a growing number of high quality publications have begun to carefully address both salutary *and* deleterious expressions and correlates of religion (e.g., Pargament, Smith, Koenig, & Perez, 1998b; Koenig et al., 2001; Mahoney, Pargament, Tarakeshwar, & Swank, 2001). Token measurement of religion with a handful of items is no longer acceptable practice and an entire volume of religion-focused measures has been compiled (Hill & Hood, 1999). At present, the connection between religion and health is receiving more rigorous, balanced, and comprehensive treatment than ever before.

Review of Literature and Discussion of the Conceptual Model

The conceptual model presented in this paper is grounded in: (a) a review of the religion–health literature; and (b) the author’s experience conducting in-depth qualitative research with Mormon (Dollahite, Marks, & Olson, 1998, 2002; Marks & Dollahite, 2001), Muslim,⁴ Jewish, and Christian individuals and families (Dollahite & Marks, 2004; Marks, 2003, 2004; Marks, Nesteruk, Swanson, Garrison, & Davis, under review). Subsequently, the conceptual model incorporates dimensions whose relevance is not confined to Christianity but are integral for, and applicable to, other world religions. These dimensions are: (a) *spiritual beliefs* (personal, internal beliefs, framings, meanings, and perspectives); (b) *religious practices* (e.g., outward, observable expressions of

⁴As research on religion and health has emerged, a conspicuous limitation of this work is a focus on Christianity. The paucity of social science research examining the influence of Islam is especially conspicuous, given the faith’s global membership of 1.3 billion (Sherif-Trask, 2004).

faith such as prayer, scripture study, rituals, traditions, or less overtly sacred practice or abstinence that is religiously grounded); and (c) *faith communities* (support, involvement, and relationships grounded in one's congregation or religious group).

Due to strong inter-relationships and overlap between these three dimensions there is some unavoidable ambiguity. However, the three dimensions jointly comprise a conceptualization of religion that is valuable for two reasons. First, the dimensions help define, conceptualize, and operationalize the nebulous construct of religion in connection with the individual. Second, the dimensions, when combined with a bio-psycho-social perspective, provide an integrated heuristic framework that illuminates findings, holes, and issues in extant research.

A Model of Religion and Bio-Psycho-Social Health

The conceptual model presented here (p. 177) is the author's effort to report, meta-analyze, and conceptualize the different dimensions of religion (religious practices, spiritual beliefs, and faith community) as they relate to health. First, however, the connections between these three dimensions will be briefly addressed.

Arrow A: The Practices-Beliefs Connection. Arrow A indicates the interrelationship between practices and beliefs. These interrelationships are significant because practices and abstinences, such as high risk sexual activity and the use or avoidance of alcohol, tobacco, and drugs, are often influenced by religious beliefs (e.g., "bodies are temples"; Hallen, 2000, p. 207). Conversely, religious beliefs are often manifested in or strengthened by religious practices (e.g., a sense of "connection" with the divine during prayer or sacred ritual; Marks, 2003, 2004).

Arrow B: Beliefs-Community Connection. The B relationship (beliefs-community) impacts psychological coping through social, emotional, and moral support a faith community can provide, particularly in times of stress, crisis, or bereavement (Bennett, Deleuca, & Allen, 1995; Dollahite et al., 1998). However, the faith community can also exacerbate certain kinds of stress, including stress resulting from behaviors unacceptable to the beliefs held by the faith community (Dollahite et al., 2004). Spiritual beliefs also impact faith community in that personal religious beliefs can influence what congregation an individual becomes involved in, or whether he becomes involved in one at all (Palkovitz & Palm, 1998; Palkovitz, 2002).

Arrow C: The Community-Practices Connection. In most world faiths, specific religious practices are promoted by faith communities (Eliade, 1959). Further, some of these practices are individual and some are marital or familial. However, some of these practices are inherently communal and literally bring a community together (e.g., Catholic mass, the Islamic call to prayer and Ramadan fast, the Jewish holy day of Yom Kippur) with a common unifying purpose (Dollahite & Marks, 2004; Marks, 2004).

The individual. Figure 1 depicts religion in association with the bio-psycho-social individual. More specifically, the three different dimensions of religion (*practices, beliefs, and community*) are respectively linked by arrows with the *biological, psychological, and social* aspects of individual health. These arrows indicate primary (but not exclusive) relationships based on extant research as discussed next.

Arrow 1: Religious practices and biological health. Arrow 1, which links the dimension of *religious practices* with the *biological* aspect of individual health, represents research that typically correlates certain prescribed and proscribed religion-related practices with biological benefits. High-risk sexual behavior is one research area that has offered a view of the religion and health connection. Although some veins of research in this area are quite nascent, Elifson, Klein, and Sterk (2003) recently found that “Religiosity was found to be a strong predictor of women’s involvement in HIV-related risky behaviors, with the greatest risk reported by women who were the least religious” (p. 47). These “risky” behaviors include not only sexual but also drug-related practices.

In connection with alcohol and drug abuse, Koenig et al. (2001) summarize their comprehensive review of literature by indicating that

FIGURE 1

Research Connections between Religious Beliefs, Practices, and Communities and Individual Biological, Psychological, and Social Well-Being

To date, there are nearly a hundred studies suggesting that religion may be a deterrent to alcohol or drug abuse in children, adolescents, and adult populations. The greater a person's religious involvement, the less likely he or she will initiate alcohol or drug use (p. 180).

Additionally, for those who do abuse these substances, studies indicate "more successful rehabilitation among the more religious" (Koenig et al., 2001, pp. 179–180). More specifically, relevant findings include the correlation of religious practices with lower rates of alcohol and marijuana use (Burkett, 1993) and lower rates of problem drinking (Perkins, 1987). The drug and alcohol factors mentioned above are significant not only in terms of their direct link with personal health but also because an estimated 65–80% of all domestic abuse is related to alcohol abuse (Gallagher, 1987). It is also noteworthy that avoidance of alcohol and drug abuse has positive employment implications; and job and financial stability offer additional health benefits (Burger & Youkeles, 2000).

Other biological correlates of certain religious practices and abstinences include significantly lower rates of cancer, better overall health, and increased life expectancy among some religious groups, most notably Seventh-Day Adventists (Koenig et al., 2001) and Mormons (Simmerman, 1993; Enstrom, 1998), due in part to strict dietary and health codes among these faiths. More specifically, "Mormons and Seventh-Day Adventists, have cancer rates about one-half to two-thirds those of persons in the general population" (Koenig et al., 2001, p. 317). Further, Mormons were found to exhibit longevity of four to seven years more than comparison groups (Simmerman, 1993; Enstrom, 1998). However, based on more recent research, Koenig et al. (2001) conclude that "religiously active persons of any denomination who live healthy lifestyles...appear to have the same low cancer rate as Mormons" (p. 303). Similarly, Hummer, Rogers, Nam, and Ellison (1999) found a 7.6 years increase in life expectancy among persons who attend worship services more than once a week compared with non-attenders. Apparently, significant health and longevity benefits extend to actively religious persons in general.

Perhaps the most striking finding involving mortality and longevity by Hummer, Rogers, Nam and Ellison (1999), indicates that African-Americans who reportedly attended church services more than once a week *lived nearly 14 years longer* than African-Americans who reportedly never attended (80.1 vs. 66.4 years). This finding was based on a random national sample of over 21,000 and included controls for a number of health factors. Explanations underlying this 13.7 year disparity are the topic of a current qualitative study by Marks and colleagues (under review).

Increased longevity and lower cancer rates among the actively religious—and other related findings (Matthews, Larson & Barry, 1993a, b; Matthews & Larson, 1995; Matthews & Saunders, 1997; Koenig et al., 2001)—are relevant not only to individual health but to intergenerational issues because increased health and longevity are likely to provide

opportunities for a higher quantity and quality of interaction between for-bearers and subsequent generations.⁵

While empirical research on the religious practices-physical health connection has often indicated a positive correlation, this is not always the case, however. A recent study of the elderly by Meisenhelder and Chandler (2002) found that:

prayer, faith and religious coping, correlated strongly with positive mental health, but not with the other seven physical health categories...[Further, the] importance of one's faith had the strongest association with positive mental health, even after controlling for the effect of other significant variables, age and education... highlight[ing] attitudes rather than practices, as the stronger spiritual variables related to mental health in the elderly (p. 243).

This finding leads us to the second dimension of religion, spiritual beliefs, and its frequent associate in empirical study, psychological health.

Arrow 2: Spiritual beliefs and psychological health. The percentage of Americans who reportedly believe in God or a higher power has consistently been 90% or better (Princeton Religion Research Center (1996) reported that 96% believe, *The Harris Poll #11* (2003) reported a 90% belief rate among adults). Many social scientists, including the author, believe these figures are inflated due to social desirability effects but a belief in God is clearly the American norm.

Several influential social scientists have theorized that religious belief is a deterrent of mental health, with some going so far as to frame such beliefs as psychopathological (e.g., Freud, 1933/1961; Ellis, 1980a, b). Conversely, a large body of recent empirical research contradicts early conceptualizations that diametrically position religious beliefs and mental health (Koenig, 1998; Koenig et al., 2001).

Arrow 2, which links the dimension of *religious beliefs* with the *psychological* aspect of the individual's being, represents the abundant body of empirical literature correlating religious beliefs with a number of beneficial psychological outcomes. Following a global review and meta-analysis of the literature for *The Handbook of Religion and Mental Health*, edited by Koenig (1998), Levin and Chatters reported:

In large part, results from these studies have been consistent in indicating a salutary relationship between religious involvement and health status. . . Across this literature, the consistency of findings despite the diversity of samples, designs, methodologies, religious measures, health outcomes, and population characteristics actually serves to strengthen the inference of a positive association between religion and health. This finding has been observed in studies of old, middle-aged, and young respondents; in men and women; in subjects from the United States, Europe, Africa and Asia; in research conducted in the 1930s and into the 1990s; in case control, prospective cohort, cross-sectional and panel studies; in Protestants, Catholics, Jews, Muslims, Buddhists, Parsis, and Zulus; in studies

⁵The importance of intergenerational relationships in a variety of religious/cultural contexts is addressed by Agius and Chircop (1998).

operationalizing religion as any of over a dozen variables. . . and, in U.S. studies, among Anglo-whites, Hispanics, Asian-Americans, and African Americans . . . generally pointing to a salutary religious effect [on mental health] (pp. 34–35).

In addition to a general “salutary religious effect,” certain religious practices have also been correlated with positive coping in connection with both “acute” and “day-to-day stresses” of life in a wide variety of contexts (Koenig et al., 2001, p. 94; cf. Pargament’s (1997) book-length study *The Psychology of Religion and Coping*). Religiosity also has been correlated with a number of specific positive mental health outcomes, including greater personal happiness and/or self-esteem (Bahr & Martin, 1983; Willits & Crider, 1988; Thomas & Cornwall, 1990; Ellison & George, 1994; Koenig, 1998) and lower rates of depression (Ellison & George, 1994). Koenig et al. *Handbook of Religion and Health* (2001) and other recent volumes similarly identify religious belief as a beneficial psychological coping resource or as a correlate of better mental health with a myriad of samples (Pargament, 1997; Koenig, 1998; Judd, 1999).

In spite of the large body of data linking certain forms of religiosity with mental health benefits, we cannot make the error of equating all religiosity as beneficial or even benign. Indeed, some expressions are unhealthy. For example, drawing from clinical case studies, Arterburn and Felton (2001) identify several hazardous religious beliefs that they characterize as *toxic faith*, the antithesis of healthy faith. Pargament and colleagues have systematically advanced scholarship by identifying, defining, and measuring both positive and negative religious coping patterns (Pargament et al., 1998b). With reference to negative religious coping (or “red flags”), Pargament, Zinnbauer, Scott, Butter, Zerowin, and Stanik (1998a) conclude that:

Although religion is often a source of help and integration, certain religious expressions appear to be part of the problem in coping rather than part of the solution (p. 88).

In retrospect, James (1902/1982) was well ahead of his time when he observed in *The Varieties of Religious Experience* that there seem to be both healthy and sick-souled versions of religious belief. Future research will be enriched by following the lead of James (and Pargament) and examining not only *if* religious belief is a boon or bane but what types and expressions of faith facilitate or denigrate biological, psychological, and social health (cf. Dollahite et al., 2004). It is to social health, including relationships and perceptions of others, that we now turn.

Arrow 3: Faith community and social health. Only about eight percent of Americans do not claim a faith affiliation of some sort, but there is tremendous variation in actual levels of involvement for those who *do* claim a faith affiliation (Kosmin & Lachman, 1993). Specifically, *The Harris Poll #11* (2003) indicates that 90% of American adults report a belief in God, but *The Harris Poll #59* (2003) indicates that only 36% attend a religious service once a month or more.

Arrow 3, which links the dimension of *faith community* to the *social* aspect of health, is grounded in literature that has examined the local faith community or congregation as a means of social and instrumental support for those who are actively involved in a faith community (e.g., Taylor & Chatters, 1988; Willits & Crider, 1988; Bohannon, 1991; Ellison, 1997). Watson, Bisesi, Tanamly, Sim, Branch, and Williams (2003) explain that "Faith communities in general, and African-American churches in particular, are a largely untapped, but potent, resource to reduce the toll of substance abuse and other health issues" through the means of social and spiritual support (p. 191).

Qualitative studies also indicate that religious community is often a meaningful and multi-faceted source of temporal and social support for individuals and families facing other types of challenges (Kaufman, 1993), including families with special-needs children (Bennett et al., 1995; Dollahite et al., 1998; Marks & Dollahite, 2001). In the latter study, fathers offer specific narrative accounts of how their faith communities have offered social, emotional, spiritual, financial, and temporal support (including transportation and housing) in times of need. However, when the parents' faith communities failed them "it was both disappointing and hurtful in ways that seemed to elicit deeper frustration and pain than failures by secular agencies and institutions" (Marks & Dollahite, 2001, p. 636). Thus, for some persons, faith community may be a social network that qualitatively differs from other groups; both in positive and negative ways (Dollahite et al., 2004).

In spite of documented challenges, however, active involvement in a faith community has been linked with improved perception and number of social relationships (Ellison & George, 1994), and greater social support (Koenig, 2002). Bahr and Martin (1983) similarly found that active participation in a religious community was correlated with more "faith in people" (p. 139). Further, in their comprehensive review of the literature, Koenig et al. (2001) found that 79 of 100 studies indicated "at least one positive correlation between religious involvement and greater happiness, life satisfaction, morale, or positive affect" with 20 studies yielding complex, mixed, or no relationship findings, while only one study found a negative correlation (p. 101). However, correlation does not yield causation and so we still know relatively little about the specific *influence* of faith communities on social health, including the underlying meanings individuals ascribe to their religious involvement (Dollahite et al., 2004).

The potential influence of faith community involvement on health appears to be affected by gender, but more data are needed (Dollahite et al., 2004). In addressing gender and faith community involvement, Koenig et al. (2001) emphasize that

Women are more likely to attend religious services, pray privately, say religion is important in their lives and depend on religion as a coping behavior. Thus, it is possible that religious beliefs and practices are more deeply ingrained into the social and psychological lives of women and therefore confer greater health benefits (p. 329).

By way of comparison, the guest editors of a 2001 special issue of *Journal of Family Psychology* addressing religion summarized

On the basis of some of the findings of these articles, it may be that religion...has a greater impact on men's behavior and well-being than on women's (Snarey & Dollahite, 2001, p. 647).

Initially, these two statements may seem contradictory but Koenig et al. (2001) statement addresses *across-gender comparison* where data clearly indicate that more American women are religiously involved than men. Snarey and Dollahite's (2001) point, is drawn from studies that include *within-gender comparison* and summarizes that differences between religious and non-religious men are usually more pronounced than those between religious and non-religious women. Both statements, when contextualized, are substantiated and relevant in our understanding of religion and health.

Recommendations for Future Religion–health Research

The complexity of the above scenario foreshadows a multi-faceted future of scholarship on the religion and health connection. As scholars seek to shed light on the overarching question “what is the connection between religion and individual health?,” we need to integrate several other specific queries including: (a) “What type of religion?” (e.g., Catholic, Mormon, Muslim, Orthodox Judaism); (b) “What dimension of religion?” (i.e., beliefs, practices, or communities); (c) “What type of individual?” (e.g., gender, age,⁶ cohort,⁷ race, socioeconomic status, family structure, etc.); and (d) “What type of health?” (biological, psychological, or social). Dollahite et al. (2004) indicate:

Scholars differ in the questions they ask, the approaches they employ, and the motivations for their research. Researchers differ widely in the degree to which they are aware of and articulate their biases and agenda in their work ...[S]cholars should be aware of diversity in religiosity, family type, method, outcomes, and scholarly agenda. When all the permutations of the foregoing possibilities are considered, two implications arise: (a) Scholars should be as clear as possible with themselves and their readers on the issues mentioned above, and (b) *they should present their work within contexts* and their results as tentative (p. 414, emphasis added).

A Foundation for the Future Study of Religion and Health. In their monumental volume *Handbook of Religion and Health*, Koenig et al. (2001) present critical and methodological analyses of over 1,200 studies and 400 reviews and provide an empirical foundation for future work in this area. A concluding

⁶Some important work has been done in the area of religion and adolescence (see Regenerus, 2003; Smith, 2003), but research examining the influence of religion in childhood is needed. However, the Society of Research on Child Development (SRCD) began holding an annual pre-conference addressing religion and child development, and some related research comprises a 2003 special issue of *Review of Religious Research* (Vol. 44, Issue 4).

⁷Recent work indicates some marked differences between the Cold War and Baby Boomer cohorts, with the former's perceptions linking more closely with “religiosity” while the boomers perceptions are linked with “spirituality” (Sutherland, Poloma, & Pendleton, 2003).

section of the volume includes ratings “based on overall study design, sampling method, quality of religious measure, quality of statistical analysis, (and) interpretation of results” for hundreds of empirical studies (Koenig et al., 2001, p. 513). These critical analyses are a valuable guide to: (a) what has been studied, and (b) how rigorous the examination has been, and (c) designing future studies that replicate the strengths (but avoid the flaws) of the past.

Conclusion

In connection with the relationships between religion and health, we know much in terms of correlation. Correlations from the data indicate predominantly positive relationships between the three dimensions of religious practices, beliefs, and communities and bio-psycho-social variables including well being, physical health, longevity, mental health, psychological coping, and social support.

In this article, I reviewed a great deal of literature in a limited amount of text and have subsequently sacrificed depth for breadth. However, it is my hope that the final product (in spite of its two-dimensional nature) will be seen as an informative survey map of the rapidly developing religion–health research frontier. Vital work of the future will include research that explores the hows, whys, meanings, and processes behind several of the correlational findings overviewed in this piece. Such research will facilitate a collaboratively constructed topographic map of religion–health research that will add the much needed dimension of depth to the sketch I have offered here.

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