Psychiatr. Pol. 2019; 53(1): 7–22
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/OnlineFirst/86477

Measurement of pathological personality traits according to the DSM-5: A Polish adaptation of the PID-5. Part I – theoretical foundations

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Summary

The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) proposes a novel hybrid system of personality disorder diagnosis in addition to the one previously laid down in the DSM-IV-TR. This alternative diagnostic system, published within Section III of the DSM-5, was hoped to overcome the inherent limitations of categorical diagnosis by integrating the categorical and dimensional approaches to personality disorders. As such, it constitutes a bridge between psychiatric pathology classifications and findings from psychological research on the structure of normal personality.

At the core of the hybrid DSM-5 system lies a new model of pathological personality traits, operationalized using the Personality Inventory for DSM-5 (PID-5). This paper outlines the background and main features of the DSM-5 hybrid system of personality disorder diagnosis with a focus on the dimensional model of pathological traits and definitions thereof. The current status, application potential and limitations of the DSM-5 diagnostic system and the pathological traits model are also discussed. In another paper, the authors present the PID-5 inventory and report on a study investigating a Polish adaptation of this instrument.

Key words: personality disorders, DSM-5, PID-5

* The work of Jan Cieciuch was supported by Grants 2014/14/M/HS6/00919 from the National Science Centre, Poland

Categorical vs. dimensional approaches to personality disorder diagnosis

Psychiatric conditions, including personality disorders, are typically diagnosed along the lines of the categorical approach, which recognizes a set of distinct nosological units (categories). Diagnoses are made based on whether the patient meets a certain number of criteria specified in the latest versions of the diagnostic manuals (currently: ICD-10 [1] and/or DSM-5 [2]). The underlying assumption is that the various personality pathology categories differ qualitatively from one another, from other clinical conditions, and from normal personality (free from disorder). Although categorical diagnosis undoubtedly possesses many advantages, for some time now it has also drawn increasing criticism. The most serious limitations of this paradigm and the classifications it has embraced are: excessive comorbidity; arbitrary and unstable diagnostic thresholds for dichotomous criteria and categories, which do not enable reliable discrimination between disordered and non-disordered individuals; and inadequate scientific foundations – unconfirmed accuracy in empirical research combined with insufficient grounding in empirically verified, psychological personality models [cf. 3–12].

An interesting alternative is offered by the dimensional approach, according to which personality disorders arise from pathological levels of certain personality dimensions within a given theoretical model [cf. 5, 10, 12, 17]. While this paradigm is often praised as diagnostically more useful [5, 9, 13, 18], the sheer number of competing dimensional models [cf. 12] severely hinders the efforts to select the best or most useful one. In fact, this problem was already indicated in the DSM-IV-TR as a crucial impediment to the deployment of dimension-based personality disorder diagnosis [10, 19].

Some of the dimensional frameworks with the greatest potential for application in personality disorder diagnosis include [cf. 12] the Dimensional Assessment of Personality Pathology (DAPP, [4]), the Schedule for Nonadaptive and Adaptive Personality (SNAP, [18]), the Shedler–Westen Assessment Procedure (SWAP, [20]), Cloninger's psychobiological model [21], and the Personality Psychopathology Five (PSY-5, [23]), which drew both on the diagnostic scales of the Minnesota Multiphasic Personality Inventory (MMPI) and the Five-Factor Model (FFM, [22]) of normal personality (the five scales of PSY-5 are Aggressiveness, Psychoticism, Disconstraint, Negative Emotionality, and Introversion). All dimensional models and frameworks are underpinned by the assumption of a quantitative continuum between normal and abnormal personality, although some of them focus only on the dysfunctional dimensions of personality (e.g., PSY-5), while others may incorporate both adaptive and maladaptive traits (e.g., SNAP and SWAP). Finally, some dimensional models are based on "normal" traits found in all individuals, with pathology defined in terms of extreme levels of those traits (e.g., FFM).

Due to its potential for integrating other models of normal and abnormal personality, and because of its impressive empirical foundations [cf. 10, 22, 24], of special interest to personality disorder researchers is the Five Factor Model [5, 11, 12, 17, 24],

also known as the Big Five, which consists of Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. While the FFM was developed on the basis of psychological investigations of normal personality structure, it is expected that certain configurations of extremely high or low levels of "normal" traits may be linked to personality disorders. Indeed, the FFM has been shown to have some potential for the differentiation, description, and diagnosis of personality disorders [5, 24–27]; however, its utility has ultimately been found to be limited in this area (as it is the case with other dimensional models) [13, 28–30]. The main problems include the determination of stable (replicable) configurations of personality traits indicative of different disorders and the arbitrary nature of diagnostic thresholds (levels of the particular dimensions separating normality from pathology) [cf. 25]. Therefore, the application of the FFM as well as other dimensional models and frameworks in the clinical practice remains problematic [cf. 4, 5, 9].

In summary, both categorical and dimensional approaches to personality disorders have their advantages and shortcomings. Indeed, it can be argued that the FFM did not live up to expectations about its ability to integrate research on normal and abnormal personality [cf. 30]. In this context, the alternative, hybrid diagnostic system developed by the DSM-5 Personality and Personality Disorders Work Group of American Psychiatric Association (APA) offers an interesting and promising alternative [2, 13, 14, 31], as it not only integrates categorical and dimensional paradigms [cf. 4, 31], but also builds a bridge between a psychiatric disorder classification and psychological personality research. The hybrid system essentially combines a new multidimensional model of pathological traits [2, 14], inspired by both the FFM and PSY-5, with a set of clear and substantiated criteria for categorical diagnosis of personality disorders as distinct nosological entities.

The hybrid DSM-5 diagnostic system for personality disorders

Some of the problems arising from categorical diagnosis were already recognized in previous editions of the DSM, and especially the DSM-IV and its revised version, the DSM-IV-TR [19], which incorporated certain elements of the dimensional approach. The ten categories described in the manual were grouped into three clusters: A, B, and C. While Section II of the DSM-5 [2] retained the classification of personality disorders and the diagnostic criteria from the DSM-IV-TR, Section III of the DSM-5 proposed an alternative, hybrid diagnostic system, which is being currently verified via research and clinical practice.

In the alternative DSM-5 model, central to diagnosing personality disorders are criteria A and B (C–G are standard clinical criteria designed to exclude situational, sociocultural, pharmacological/medical, and developmental factors, as well as other mental conditions, as responsible for the observed personality disorder symptoms). Criterion A concerns impairments in personality functioning in two main areas: (1)

the intrapersonal area (self), encompassing identity and self-direction; and (2) the interpersonal area, consisting of empathy and intimacy. Impairments relating to these four elements of personality functioning constitute the core of personality psychopathology. Criterion A already contains a dimensional aspect as personality functioning is conceptualized as a continuum with impairment severity assessed on a five-point scale ranging from 0 – little or no impairment to 4 – extreme impairment, using a descriptive instrument (the Level of Personality Functioning Scale). The diagnosis of a personality disorder requires at least moderate impairment in personality functioning (level 2).

Criterion B is based on a new model of pathological personality traits and requires the presence of at least one out of 25 trait facets organized in five broad factors (trait domains) clearly inspired by the FFM and PSY-5 models. Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism correspond to both the PSY-5 dimensions of personality psychopathology [cf. 32] and the FFM basic personality domains [e.g., 5, 33–36], being pathological variants of the latter. The close correspondence between the "Pathological Big Five" of the DSM-5 to the five factors describing normal personality is apparent in the names of the negative poles of the pathological domains, four of which are identical to the names of the FFM domains (cf. Table 1). On the other hand, the list of trait facets comprising those domains is an entirely new proposal based on a review of existing trait models and iterative empirical research. This taxonomy of facets and domains constitutes a new, comprehensive, and hierarchical model of pathological personality traits [2, 13]. Among the 25 facets, 21 are assigned to one domain only, while four (Depressivity, Suspiciousness, Restricted affectivity and Hostility), fall under two domains each. Moreover, two facets (Rigid perfectionism and Restricted affectivity) are assigned to particular domains with a negative pole. The pathological trait domains consist of three (Psychoticism) to nine facets (Negative affectivity). The names and definitions of all the trait domains and facets, complete with abbreviations proposed by the present authors, are given in Table 1.

Table 1. **Definitions of the five trait domains and 25 trait facets from Section III of the DSM-5**

	Abbr.	**DOMAINS and facets**	DEFINITIONS
NEGATIVE AFFECTIVITY	NA	NEGATIVE AFFECTIVITY vs. Emotional Stability	Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger) and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
	Emo	Emotional lability	Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.

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NEGATIVE AFFECTIVITY	Anx	Anxiousness	Feelings of nervousness, tenseness, or panic in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen.
	Sep	Separation insecurity	Fears of being alone due to rejection by – and/or separation from – significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally.
	Sub	Submissiveness	Adaptation of one's behavior to the actual or perceived interests and desires of others even when doing so is antithetical to one's own interests, needs, or desires.
	Host	Hostility	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior.
	Pers	Perseveration	Persistence at tasks or in a particular way of doing things long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping.
	Depr	Depressivity	See DETACHMENT
	Susp	Suspiciousness	See DETACHMENT
	Res	(-) Restricted affectivity	Restricted affectivity (lack of) The lack of this facet characterizes low levels of Negative Affectivity. See Detachment for definition of this facet.
DETACHMENT	DE	DETACHMENT vs. Extraversion	Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions (ranging from casual, daily interactions to friendships and intimate relationships) as well as restricted affective experience and expression, particularly limited hedonic capacity.
	With	Withdrawal	Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.

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DETACHMENT	Int	Intimacy avoidance	Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.
	Anh	Anhedonia	Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things.
	Depr	Depressivity	Feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
	Res	Restricted affectivity	Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations.
	Susp	Suspiciousness	Expectations of – and sensitivity to – signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others.
ANTAGONISM	AN	ANTAGONISM *vs.* Agreeableness	Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both an unawareness of others' needs and feelings and a readiness to use others in the service of self-enhancement.
	Man	Manipulativeness	Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
	Dec	Deceitfulness	Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
	Gran	Grandiosity	Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others.
	Att	Attention seeking	Engaging in behavior designed to attract notice and to make oneself the focus of others' attention and admiration.

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ANTAGONISM	Call	Callousness	Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others.
	Hos	Hostility	see NEGATIVE AFFECTIVITY
DISINHIBITION	DI	DISINHIBITION vs. Conscientiousness	Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
	Irr	Irresponsibility	Disregard for – and failure to honor–financial and other obligations or commitments; lack of respect for – and lack of follow-through on – agreements and promises; carelessness with others' property.
	Imp	Impulsivity	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress.
	Dis	Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behavior, including both planning and completing tasks.
	Ris	Risk taking	Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved.
	Rig	(-) Rigid perfectionism	Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order. Low level of this facet characterizes high levels of Disinhibition.

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PSYCHOTICISM	PS	PSYCHOTICISM vs. Lucidity	Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).
	Unu	Unusual beliefs and experiences	Belief that one has unusual abilities, such as mind reading, telekinesis, thought-action fusion, unusual experiences of reality, including hallucination-like experiences.
	Ecc	Eccentricity	Odd, unusual, or bizarre behavior, appearance, and/or speech; having strange and unpredictable thoughts; saying unusual or inappropriate things.
	Perd	Cognitive and perceptual dysregulation	Odd or unusual thought processes and experiences, including depersonalization, derealization, and dissociative experiences; mixed sleep-wake state experiences; thought-control experiences.

In the DSM-5 model, each trait is represented by a dimension scored using a dedicated instrument, namely the Personality Inventory for DSM-5 (PID-5 [14]). At the same time, the categorical component of the hybrid DSM-5 diagnostic system [cf. 31] ultimately enables clinical identification of specific personality disorder categories on the basis of high intensity of particular pathological traits (as long as Criterion A is also met). The DSM-5 does not directly specify thresholds for abnormal trait levels, but rather recommends comparing the obtained scores with population norms and/or weighing them against clinical evaluation (e.g., supported by interview data); however, some authors have adopted a threshold score of >2 (from the range of 0–3) on individual PID-5 scales [37; cf. 14, 38]. Finally, it should be noted that characteristic symptoms within each of the four areas of personality functioning are described by Criterion A separately for each personality disorder. For the criterion to be met, moderate or greater impairment in at least two out of four elements of personality functioning must be found.

Section III of the DSM-5 includes criteria for six personality disorder categories. The number of categories was reduced (from ten) due to criticism of their defining criteria and because of very high comorbidity among the DSM-IV-TR categories in diagnostic practice [5, 9, 13]. These six disorder categories included in the DSM-5 which were the least likely to coexist with each other and with other types of mental disorders were as follows: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality. The following personality disorders included in the DSM-IV-TR were eliminated: schizoid, dependent, histrionic, and paranoid personality.

Table 2 presents the six categories of personality disorders included in the DSM-5, as well as the characteristic sets of trait facets and diagnostic criteria for each of them.

Those criteria specify how many and what trait facets are necessary and/or sufficient to diagnose a given personality disorder. For instance, the high intensity of 6 out of the 7 defining trait facets is needed for a diagnosis of antisocial personality disorder, while both of the defining facets are necessary to diagnose narcissistic personality disorder. The patterns of pathological traits and the related diagnostic criteria were developed by the DSM-5 work group in a comprehensive manner based on meta-analyses and empirical data concerning relationships between traits and DSM-IV diagnoses.

Table 2. **Personality disorder categories and the pathological traits indicative of them (Criterion B) according to Section III of the DSM-5**

Personality disorder	Diagnosis criteria and pathological facets	Pathological domains
Antisocial	At least 6 out of: – Manipulativeness – Callousness – Deceitfulness – Hostility – Risk taking – Impulsivity – Irresponsibility	Antagonism Disinhibition
Avoidant	Required: – Anxiousness and at least 2 out of: – Withdrawal Anhedonia – Intimacy avoidance	Negative affectivity Detachment
Borderline	At least 4 out of the following; required 1 out of: – Impulsivity – Risk taking – Hostility and the other out of: – Emotional lability – Anxiousness – Separation insecurity – Depressivity	Disinhibition Negative affectivity (Antagonism Detachment)

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Narcissistic	Required both: – Grandiosity – Attention seeking	Antagonism
Obsessive-compulsive	Required: – Rigid perfectionism and at least 2 out of: – Perseveration – Intimacy avoidance – Restricted affectivity	Disinhibition (-) Negative affectivity Detachment
Schizotypal	At least 4 out of: – Cognitive and perceptual dysregulation – Unusual beliefs and experiences – Eccentricity – Restricted affectivity – Withdrawal – Suspiciousness	Psychoticism Detachment (Negative affectivity)

In addition to the six specific personality disorders mentioned above, Section III of the DSM-5 proposes a new diagnosis: personality disorder – trait specified (PD-TS) [2, cf. 6], replacing the category of not precisely defined (and often diagnosed) so-called personality disorder not otherwise specified (PDNOS) used in previous editions of the DSM. PD-TS is diagnosed when (1) moderate or higher impairment in at least two out of four elements of personality functioning (Criterion A) is accompanied by (2) at least one elevated pathological trait domain or facet (Criterion B) in the absence of (3) a pattern of traits consistent with a specific disorder (Criterion B) and/or a pattern of difficulties in personality functioning characteristic of a specific disorder (Criterion A). PD-TS could also encompass personality disorders which were removed from Section III of the DSM-5, such as histrionic personality; this particular psychiatric condition may be thus diagnosed as PD-TS coinciding with the trait facets of Emotional lability, Attention seeking, and Manipulativeness [as cited in: 6].

Moreover, in situations where the full diagnostic criteria for a personality disorder are met, the identification of some additional trait facets (not required for the diagnosis) may serve as a supplementary specifier of the individual's condition, affording a more complete clinical picture. For example, narcissistic personality (characterized by high levels of Grandiosity and Attention seeking) may be accompanied by other facets of Antagonism (e.g., Deceitfulness, Manipulativeness, Callousness) indicative of the more malignant form of this condition, or by some facets of the Negative Affectivity

domain (e.g., Depressivity, Anxiousness) suggesting a more vulnerable presentation [2]. Finally, assessment of the level of personality functioning (Criterion A) may also specify the category of disorder in greater detail.

Recapitulation – the current status and potential of the hybrid DSM-5 system

As indicated by the APA Board, the hybrid system of personality disorder diagnosis contained in Section III of the DSM-5 is subject to further research and clinical evaluation. Its inclusion in the manual as an alternative to the traditional diagnostic system in Section II (adopted from the DSM-IV-TR) appears to be justified by the twin goals of preserving continuity with current clinical practice while addressing the numerous shortcomings of the conventional approach to personality disorders [2]. The alternative system developed by the APA [2] is particularly interesting in that it embodies the postulate of supplementing categorical frameworks with dimensional models. It should be noted that the debate between the advocates of the categorical and dimensional paradigms goes far beyond the field of personality pathology [cf. 39, 40]. Dimensional models have also been proposed for evaluation of such nosological entities as conduct disorder, ADHD, oppositional defiant disorder (ODD) [41], affective disorders [42], autism spectrum disorders [43], and psychoses [44, 45]. On the other hand, it has been suggested that the DSM-5 manual is essentially of provisional nature as the rapid progress of neuroscience in conjunction with advances in brain imaging, genetics, and studies of environmental factors are poised to substantially expand knowledge of the etiology of mental disorders in the coming years [46].

Previous studies have shown considerable transdiagnostic heterogeneity in etiological factors [47], with marked differences in manifestations of psychiatric disorders between age and gender groups and types of informants. Also in this context hierarchical dimensional approach including the DSM-5 alternative system, but for example also Achenbach's Child Behavior Checklist [41], makes it possible to address the above issues by defining cut-off points for these groups; such models are generally consistent with the assumptions and observations presented above.

Given its hybrid dimensional/categorical nature, the foremost strengths of the DSM-5 alternative system arise from the structure of Criterion A based on four elements of personality functioning and the empirical underpinning of the pathological trait model in Criterion B. The latter has revealed superior accuracy in personality disorder diagnosis, also in the Polish population [3]. As such, it should be recognized as a very promising endeavor to overcome the limitations of categorical diagnosis and bridge psychiatric disorder classifications with findings from psychological research on normal personality [cf. 3, 5, 16]. Nevertheless, further studies should address the following questions: (1) Is the proposed catalog of 25 trait facets sufficient to identify all personality disorders? [cf. 24, 48]; (2) Are the facet patterns

assigned to the six specific disorders optimal? [cf. 38, 49–51]; (3) Is the reduction of the number of specific personality disorders to six justified?; and (4) Is the hybrid DSM-5 system of personality disorder diagnosis suitable for clinical practice? Indeed, regardless of the scientific values of the hybrid diagnostic system with its dimensional pathological trait model operationalized in the PID-5, what matters most is its usefulness to clinicians. While the reliability and accuracy of the PID-5 has been amply corroborated by empirical studies on a variety of clinical and non-clinical groups in different versions and language adaptations [cf. e.g. 3, 14, 33–36, 52–59], little is still known about the utility of the alternative DSM-5 system and PID-5 in a clinical setting [60]. Significant difficulties undermining the main purpose of this diagnostic methodology, which is using it by clinicians, have been pointed out by a group of prominent researchers and therapists including Beck, Fonagy, Kernberg, Shedler, and Westen [60]. The chief objections raised by them concern the reduced number of explicit personality pathology categories/prototypes resulting in the omission of histrionic, dependent, and paranoid personality disorders, which are frequently encountered in clinical practice [cf. 61, 62]. The categories specified in the hybrid DSM-5 system do not seem to cover the entire spectrum of personality pathology, ostensibly disregarding a considerable body of research literature on the ignored conditions [cf. 5].

On the other hand, it should be borne in mind that it was primarily empirical studies that motivated the development of the alternative DSM-5 model and led to the reduction in the number of explicitly defined personality disorders due to the widespread diagnostic comorbidity of psychiatric categories and the excessive use of PDNOS [cf. 58]. Moreover, the concept of the PD-TS category, diagnosable with the PID-5, opened up the opportunity to reveal new personality pathology categories or prototypes, and add them to the six already defined disorders when new patterns of trait facets will constantly recur in academic research and clinical practice. Finally, also the existing trait criteria for specific personality disorders could be verified and possibly optimized in further studies [cf. 3, 38, 49].

The above considerations notwithstanding, the crucial issue is whether clinicians will be able or willing to implement the highly complicated alternative DSM-5 diagnostic procedure in day-to-day practice, as noted by the aforementioned critics of this system. While their objections should not be lightly dismissed, the complexity and laboriousness of this model do not seem to be much greater than those of its counterparts, including the novel models and tools (e.g., SWAP). Therefore, it seems likely that the future of the DSM-5 alternative diagnostic system and its dedicated inventory will be ultimately decided by a combination of inputs from academic research, empirical evaluations on different groups of patients, and clinical practice.

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