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# Opening a hermeneutic space for spiritual care practices: introducing the Diamond Model to the Brazilian context

## Abrindo um espaço hermenêutico para práticas de cuidado espiritual: apresentando o Modelo Diamante ao contexto brasileiro

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**Abstract**

Spiritual care is considered an intrinsic aspect of good palliative care practices. However, this is a challenge for health professionals. There is a lack of scientifically based non-religious approaches to identify and meet patients' and families' existential/spiritual needs. This article aims to present a tool for spiritual care named Diamond Model, or *Ars Moriendi*, developed by a Dutch researcher who designed it from elements drawn from his empirical research. The model is theoretically based on non-moral and non-religious anthropological frameworks, and it is open to people from a variety of cultural and religious backgrounds. Both chaplains and the multidisciplinary teams can use this hermeneutic tool. It helps to better understand and meet the spiritual needs of patients and families in the dimensions that involve autonomy, suffering, relations, unfinished business, and hope. The presentation of the Diamond Model to the Brazilian audience is also an invitation to test and evaluate it in future studies investigating spirituality in palliative care in Brazil.

**Keywords:** Spiritual care. Inner space. Palliative Care. Multidisciplinary team. Spirituality and health.

**Resumo**

O cuidado espiritual é considerado um aspecto intrínseco às boas práticas de cuidados paliativos. Contudo, este é um desafio a profissionais de saúde. Há carência de propostas cientificamente embasadas e não religiosas para identificar e atender as necessidades existenciais/espirituais de pacientes e familiares. Este artigo tem como objetivo apresentar uma ferramenta de cuidado espiritual denominada Modelo Diamante ou *Ars Moriendi*, desenvolvida por um pesquisador holandês que a concebeu a partir de elementos extraídos de sua pesquisa empírica. O modelo é teoricamente baseado em estruturas antropológicas não morais e não religiosas e está aberto a pessoas de uma variedade de origens culturais e religiosas. Tanto capelães quanto equipes multidisciplinares podem usar essa ferramenta hermenêutica. Ela ajuda a melhor compreender e atender as necessidades espirituais de pacientes e familiares nas dimensões que envolvem autonomia, sofrimento, relacionamentos, questões pendentes e esperança. A apresentação do Modelo Diamante ao público brasileiro também é um convite para testá-lo e avaliá-lo em estudos futuros que investiguem a espiritualidade em cuidados paliativos no Brasil.

**Palavras-chave:** Cuidado espiritual. Espaço interior. Cuidados Paliativos. Equipe multidisciplinar. Espiritualidade e Saúde.

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## Introduction

According to the WHO-definition of palliative care from 2002 the care for people with a life-threatening disease should focus on quality of life, including treatment of the physical, psycho-social and spiritual dimension of pain and suffering. In the last two decades different tools and instruments have been developed to address this dimension of care, especially in the United States of America and European countries. In Brazil, “the notion of spiritual care is not only very recent, but also its theoretical reflection is still incipient” (ESPERANDIO; LEGET, 2020a, p. 39). As a result, there is a lack of practical approaches to spiritual care that are suitable for implementation in the context of palliative care.

In Europe, one of these instruments is the *Ars Moriendi* or Diamond Model; a framework for approaching the spiritual dimension of palliative care (LEGET, 2007; LEGET, 2016; LEGET, 2017a). The Diamond Model has been developed based on a specific view on what is characteristic for spirituality and the type of care that supports this dimension of life. In this paper the Diamond Model is introduced, and its theoretical and empirical foundations and practical applications are explained. This model is situated within the landscape of approaches and tools for spiritual care, and it is, now, being introduced to the Brazilian context as a possible approach to providing spiritual care in palliative care. In Brazil, the field of palliative care has been expanding rapidly since the publication of the Resolution No. 41 of 31 October 2018 (BRASIL, 2018) which established the guidelines for organizing these services in the Unified Health System.

## 1 The spiritual dimension of pain and suffering

According to a definition adopted by the reference group on spiritual care of the European Association for Palliative Care, spirituality can be characterized as “the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred” (NOLAN, 2011). This definition,

based on a North American consensus definition from 2009, is complemented by a statement about the multidimensionality of the field, comprising existential challenges, value-based considerations and attitudes (ethics), and religious considerations and foundations.

A definition like this is broad, referring to a dynamic dimension of human life. Seeing spirituality as a dimension – as opposed to a part, a field, a sector of segment – means that the phenomenon cannot be contained easily, since it can be found everywhere where human life is. The definition also refers to the way people express, seek, and connect to what is meaningful and valuable to them, thereby opening up a broad range of ways in which human beings inhabit the world. Before introducing the *Ars Moriendi* or Diamond Model, it is worth to briefly reflect on the nature of spirituality as a phenomenon in order to better appreciate why the model is designed the way it is. Four important features of spirituality as a dynamic dimension of human life are presented.

Firstly, spirituality is about meaning and connectedness. Meaning is a phenomenon that is central to human life, because it is fundamental to the way human beings inhabit the world. And being introduced in this world meaningful connections start long before we are able to understand language (GADAMER, 2013). Meaning is found in the way our body is a medium that connects us with the life world we find ourselves in (MERLEAU-PONTY, 2013). Meaning is already there before we have been able to put it into words. It is found in dreams, intuitions, longings, rituals, symbols, metaphors, and all kind of phenomena that connect the rational with the non-rational aspects of humanity.

Secondly, meaning – even when expressed into words – can be multi-layered, polyphonic, contradictory, or even pointing to beyond what can be spoken of or thought. Single words may be filled with a rich content of connotations and memories during a lifetime (e.g. the word ‘home’, that may be a safe haven for one person and a place of psychological abuse for the other), or carry contradictory connotations at the same time. People may unconsciously use metaphors for their situation, or patients and families may experience contrary meanings in one situation (e.g. the experience of ‘being a burden’ and loving someone at the same time).

Thirdly, the way we are open to discover meaning can be hindered, blocked or influenced by moods, emotions and psychological processes. A person who is very afraid of a particular way of suffering, may be so much focused on the object of their fear, that there is no room for a different perspective on the situation. The meaning of what is happening is very much colored and determined by the emotional state of mind.

Fourthly, spirituality is a phenomenon that has a transformative character (WAAIJMAN, 2002). The meaningful connectedness that is central to spirituality has an impact on the way human beings live their life, open themselves up to specific people, traditions, ways of experiencing things. Engaging with meaningful connections brings about a process of transformation that has impact not only on the things we do and don't, but also on the kind of person we are and aspire to more and more become. This transformative character of spirituality thus has impact on our identity.

Taking these four characteristics of spirituality together (1. being rooted in non-rational processes, 2. in need of hermeneutics and interpretation, 3. influenced by moods and emotions, and 4. potentially transformative) one might be aware of the specific qualities an approach or tool for spiritual care may need to have.

How can the *Ars Moriendi* or Diamond Model be situated in relation to these defining characteristics of spirituality? How was the model developed? And what theoretical and empirical foundation does the model have?

## 2 The origins of the model: inner space

The Diamond Model, a tool for spiritual care in the context of palliative care, is the result of an empirical research carried out by a Dutch researcher in the fall of 1998 and 1999 in palliative care wards of two nursing homes in the city of Rotterdam, Netherlands. Part of his research was done in the form of participatory observation. The researcher was involved in patient care as a helping nurse. Being trained as a theologian and having written a PhD on the relation between life on earth and 'life' after death in the theology of Thomas

Aquinas (LEGET, 1997), working in a nursing home was for him, a bit of a culture shock. Situated in the second largest city in the Netherlands, there was no framework of language for providing spiritual care. The goal of the research project was to develop an approach or model that was open to a wide variety of people from all cultural and religious backgrounds.

Working on the palliative care ward as a researcher it struck him that although a language for spiritual care was generally lacking, many times people used the word 'space' when referring to support patients in their psycho-social and spiritual struggles. Creating a safe and secure space for patients and families seemed to be the first prerequisite for good palliative care. But the metaphor space was also used to refer to the inner world of patients and loved ones. Living with the metaphor, the researcher felt that some healthcare professionals seemed to be very talented in creating such a space between people, or even in people. What this looked like became clear to him when he witnessed a conversation between a young doctor and an older woman who had just arrived at the nursing home (LEGET, 2017a).

The woman, who was in her eighties, confronted the physician with a euthanasia request upon arrival, once the physician would not be able to control the suffering that she feared. Witnessing the conversation, the researcher reports that he sensed a feeling panic, realizing that it would be highly unlikely that the physician would be prepared to honor such a demand: in the first place because according to the Dutch law at that time euthanasia was still not legalized; secondly because the woman had been admitted to a Roman Catholic nursing home that had a policy of not performing euthanasia. The author sensed a stalemate there and he could not see but a huge dilemma: either the physician would have to transgress professional and legal boundaries, or the patient had to be refused something that in the societal debate was seen as a humane way of responding to the autonomy of the patient. He could not see a way out there, and his emotional state and intellectual creativity were heavily impacted by the tension that built up in the room.

To his big surprise, however, the physician did not share his state of mind. She looked at the woman and asked her what she meant with the word

'euthanasia', explaining its Greek origins meaning "a good death" and adding that as a palliative care physician she had many options and alternatives to alleviate suffering. As the physician started to explore what had made the woman formulate this request, a change of tone could be felt in the communication. The woman began to explain that her husband had suffered a lot in the final stages of his chronic obstructive pulmonary disease (COPD), and she had promised her children not to suffer like that. Telling the physician how her former experiences around death and dying of a loved one had deeply impacted her outlook on her own dying process, the atmosphere in the room changed. The woman started to experience emotional support through the attentive, non-judgmental and compassionate listening of the physician. The researcher narrates that it looked like her 'autonomous' decision slowly changed moving away from active termination of life. Not because the physician had objected against her request, but because she had explored this request in an emotionally safe space.

Reflecting on this conversation, it struck the researcher how much the outcome of the conversation had been enabled by the inner attitude of the physician. But it also fascinated him how the request of the woman had changed from the moment that the fear for future suffering had been dealt with. In both conversation partners, it was this inner freedom that was decisive for the atmosphere and outcome of the conversation. Since this inner freedom comprised both the emotional state and cognitive capacities of both conversation partners, the researcher decided to name it with the metaphor of inner space. He sensed that this metaphor could help to give words to an important pre-rational and corporal dimension of spiritual care in a way that was not tied to any specific religious tradition, but open to many philosophies of life. And this was an important starting point for a model that should help patients and families from many cultural and religious backgrounds in a society as much secularized as the Netherlands (LEGET, 2017b).

Studying the interactions between patients, loved ones and healthcare professionals the researcher started to see the importance of inner space as a prerequisite for listening in an open minded and nonjudgmental way. But at the same time, it occurred to him that inner space could be seen as a fruit of spiritual

care. From the researcher's perspective, by sharing inner space in our interactions, we give each other, recognition, confirmation and inner freedom. Inner space can be seen as the seed and the fruit of spiritual care. It is most helpful to address the emotional and non-rational (even corporeal) dimension of spiritual care. But what about the hermeneutical dimension of spiritual care? How could this dimension be developed? Being familiar with the richness and wisdom of medieval thinking, the researcher started to look for models in history.

## 3 The art of dying well

One of the most well-known models to prepare for a good death was developed after the big plague of pestilence in the 14th century that was later called the 'black death'. According to estimations of historians around 50 million people (60% of the population of Western Europe) died within a few years. The sickbed was short: people died within a week's time. In the Middle Ages an unforeseen death was feared since it reduced the chances of entering heaven. Thus, some help to prepare for a good death was of great importance. One of these helps became widespread in the form of 11 woodblocks representing the ultimate spiritual struggle of the moribund (GIRARD-AUGRY, 1986). The spiritual struggle of the patient was depicted as angels and devils fighting to have the soul of the dying person. The art of dying well was seen as the art of making the right choices, not giving in to the demonic temptations and holding on to the inspiration and guidance of the angels and saints.

The medieval art of dying well was a great success, probably due to its clearly structured and simple presentation of a rich spiritual tradition. Compared to the requirements of the 21st century, however, the model has its shortcomings: it is exclusively focused on one religious tradition; it is morally charged, placing the dying process in a rigid dichotomy of heaven versus hell; it merely regards the spiritual process with no attention or integration into the socio-spiritual and physical dimension relevant for contemporary palliative care; and it used categories that are not very appealing or understandable to the majority of people dying in our days. Would it be possible to take inspiration from on this ancient tradition that has proved its merits and transform it in a way that meets the requirements of the 21st century, taking into account the four characteristics of

spirituality that are listed in the beginning of this article?

The transformation of the medieval art of dying approach into a contemporary art of dying is based on two changes. First of all, the moral oppositions between virtues and vices (as represented by the words of the angels and demons) were analyzed and reframed in terms of non-moral basic anthropological polarities in which we deal with the existential dimension of life: 1) the connection with myself and the others; 2) doing and undergoing; 3) holding on and letting go; 4) remembering and forgetting; 5) knowing and believing. These poles do not represent good and evil but are seen as fundamental polarities present in human life that are always at stake and help creating a perspective on the spiritual process of a human being. In making an autonomous decision e.g., one can be more inclined to be influenced by loyalties to others than the connectedness with oneself. Or one can be very much connected to oneself in one way, and at the same time loyal to others in another way. So, these polarities allow for an inner polyphony since different meanings may be simultaneously present, like in the medieval model both angels and demons were addressing the moribund.

Although the model was developed in care practices at the end of life, the universal polarities of the model allow it to be broadly used in any practice where the phenomenon of spirituality is studied. From its early beginnings, the five polarities with inner space at the center have been depicted in a diagram that has the shape of a diamond. Therefore, the contemporary *Ars Moriendi* model is also known as the Diamond Model, and rightly so, because the interpretation of a case through the five polarities fractures the different meanings inherent in a situation, like the many colors that become visible through the qualities of a diamond. How does that relate to the four features of spirituality we listed at the beginning of this article?

## 4 A space for interpretation

In the Diamond Model inner space is not developed as a psychometric construct enabling quantitative research, screening or assessment. Inner space is a metaphor that appeals to the art of conversation, listening and interpreting. The

metaphor is located at the center because the quality and amount of inner space will be reflected in the meanings that can be discovered when using the five polarities as an interpretative framework. In this way the Diamond Model can be helpful during the process of interpretation that takes place during a conversation. The more inner space one has when listening to another person, the less one's listening is unconsciously influenced by one's own mood, emotional and cognitive processes. With more inner space, one may be more receptive to the different layers of meaning that resonate in the story that is told.

Inner space will also help to have a sense for the non-rational dimension of spiritual processes: the variety of emotions, polyphonies, intuitions, and perspectives that do not really have been formed into thoughts yet and are hard to put into words. Inner space thus also concerns the ability to be in resonance with ourselves and the person we are in conversation with: picking up signals, feelings, facial and corporeal expressions that reflect this non-rational dimension of spirituality.

Concerning the hermeneutic quality of the Diamond Model: because the five polarities constitute a framework for interpretation, they provide five perspectives that broaden the possibilities of interpreting a single situation. Research has shown that according to health care professionals the five polarities are comprehensive for what they encounter in palliative care. Nevertheless, many of the subjects or themes that come up when being confronted with a life-threatening disease, can be interpreted in different ways, and touch on all four dimensions of palliative care (physical, social, psycho-emotional, and spiritual). By looking at one situation through the perspectives of the five polarities, one can discover how different layers of meaning are interrelated and can reinforce one another.

An example of how a combination of the five perspectives may enhance an understanding of the complexity and multi-layeredness of a spiritual process is the situation of a woman with stomach cancer from a specific Dutch reformed tradition, who asked for continuation of her treatment, although she was terminally ill, not able to eat and vomiting all day (LEGET, 2017a, p. 191-193). Interpreting her situation through the five polarities, it turned out there seemed

to be at least five reasons for her not to let go of life, despite her unbearable situation (doing and undergoing): a deep desire the meet her grandchild that was kept away from her because of a family conflict (holding on and letting go); a split in her role as a mother, wife and member of her church (myself and the others) and a number of guilt issues relating to that (remembering and forgetting); and lastly, the fact that she was afraid of dying because she feared having to burn in hell eternally, and hoped to be accepted by God's saving grace despite her sinfulness (knowing and believing). Analyzing the case of this woman it is not only possible to gain insight of how much spirituality is a dimension of suffering connected with all other dimensions, but also to understand how various layers of meaning can reinforce a certain way of acting, and how spiritual care may help to address spiritual suffering in a medically hopeless situation.

Finally, the dynamic and transformative dimension of spirituality can be discovered by using the same model in various stages of the spiritual process. Discovering changes over time can be pursued by using the same model in different moments. With the five polarities, however, it is also possible to interpret the content of the transformation. Since the quality and amount of inner space has impact on the way a spiritual process develops, one might see a development or transformation from a position where a polarity helps discovering stress, tensions or painful polyphonies, towards a position where polarities are integrated, and stress and tensions are gone because there is more inner space. In the polarity between holding on and letting go, e.g., it may be very hard to let go of life as long as someone is very much attached to dear ones. In that situation someone might hold on to life without much inner space, and this may have the form of desperately clinging to life at whatever costs, just like the woman in the example above did. If this attachment to loved ones is confirmed and explored by spiritual conversations, more inner space may be developed and the nature of holding on might change from desperately clinging to life, to generously holding on to life with open hands, integrating the polarity of holding on and letting go into an attitude of love and surrender.

Every model or conversation tool has an implicit or explicit normative dimension. In the Diamond Model this normative dimension is related to the

metaphor of inner space. The model values inner freedom of human beings and is designed to help developing this inner freedom. In contrast to its medieval predecessor, the poles in the model do not represent a good and a bad position. The contemporary version of the model was developed to support spiritual reflection and conversation about processes of spiritual transformation. For some people this might mean an integration of polarities. For other people it might mean that they are better able to live with an inner polyphony of conflicting ideas or emotions.

## 5 Working with the Diamond Model

The Diamond Model can be used in many different ways. This flexibility is based on two features: firstly, at the center of the model is a metaphor, inner space, that can be easily connected with a broad number of approaches, ranging from mindfulness and awareness centered deep listening to phenomenology. Second, the five polarities are abstractions of fundamental anthropological tensions that can help to interpret a great number of concrete situations, using the terms that are used in that specific context. The polarity between doing and undergoing, e.g., covers a wide range of human actions from activity to passivity and from intervening to being receptive. Although the five polarities are framed in easy-to-understand oppositions, the logic they refer to can be expressed in many different ways. In the last twenty years a number of ways to work with the model have been developed.

From the beginning the model has been proven to be very useful for education. The metaphor of inner space is easy to recognize and relate to, and the five polarities are helpful to get an idea what the spiritual dimension is all about. Introducing health care professionals into the model can be done in 1,5 hours. For instance, after having worked with the model in their own practice a group of general practitioners and nursing home physicians reported a deepening of their conversations and an increased attentiveness and self-confidence engaging with spiritual care (LEGET, 2013).

In the Netherland, within the hospice setting, the model has been integrated in the Utrecht Symptom Diary (USD-4D), enabling patients, family

members and caregivers to monitor not only the physical and psychosocial needs, but also the spiritual dimension of their needs. The five questions of the USD-4D have been validated and by integrating the hermeneutic model with an existing tool to monitor non-spiritual dimensions, the tool is more easily used by the interdisciplinary team, and there is a shared language and continuity within the team to engage with spiritual care according to one's profession (DE VRIES, 2021).

Next to the USD-4D, in many hospice care facilities in the Netherlands and Belgium, the Diamond Model is used for reporting and discussing the spiritual dimension in the multi-disciplinary team. In one hospital in the Netherlands, in the city of Arnhem, a flyer presenting the model is given to patients in order to help them organize their minds and discover what existential subjects they might want to talk some more about.

By chaplains and spiritual caregivers the model is used for both having conversations with patients, filing and reporting about these conversations, and reflecting on their own predilections and biases when having a conversation about the spiritual dimension. Chaplains e.g. discovered that they were less likely to talk about the polarities related to subjects as guilt, atonement, faith and hope. Using the model as a mirror for their own functioning helped them to become more aware of their professional performance.

## 6 Synthesizing the Model: applicability in Palliative Care in Brazil

In Brazil, Palliative Care services are in the process of being established. In 2014, the WHO classified Brazil at level 3A of development in Palliative Care, characterized by "the isolated provision of Palliative Care" (CONNOR et al., 2014, p. 36). Three years later, a mapping carried out in 198 countries showed that Brazil had moved to level 3B (CLARK et al., 2020), defined by the generalized palliative care provision, funding sources, availability of morphine, provision of some training centers, and more services available to the population. The 2nd. edition of the Global Atlas of Palliative Care (CONNOR, 2020, p. 52) confirmed this last classification. However, Brazil is still far from level 4B of the advanced integration into mainstream service provision. The launch of Resolution 41 of

October 31, 2018, which establishes the guidelines for implementing palliative care in Primary Care, was a strategic action to expand palliative care services in the country. The mapping recently published by the National Association of Palliative Care counted 191 Palliative Care services, an increase of almost 8% compared to 2018, a year earlier (SANTOS; FERREIRA; GUIRRO, 2020). Along with this exponential development, several challenges must be overcome, including the proper integration of spirituality in care practices. Although Brazil is a deeply religious country, spiritual/religious issues have been left aside in the palliative care scenario (also in Mental Health and other contexts). However, some studies demonstrate that sometimes professionals integrate spiritual/religious issues based on their beliefs and values (ESPERANDIO, 2014; ESPERANDIO; MACHADO, 2018). The difficulties also include: “lack of training”; "lack of time"; “fear of imposing one's beliefs”; “fear of offending patients”; “ethical dilemmas”; “fear of being disapproved of by their peers”. (TOMASSO; BELTRAME; LUCCHETTI, 2011; LUCCHETTI et al., 2013; ESPERANDIO; MACHADO, 2018; ESPERANDIO; LEGET, 2020a; ESPERANDIO; LEGET, 2020b; ESPERANDIO et al., 2021).

It is thus observed, on the one hand, that the discussion on spirituality in the context of Palliative Care has been appearing more and more since 2015, in parallel with the expansion of Palliative Care services (ESPERANDIO; LEGET, 2020b). On the other hand, deepening theoretical and practical knowledge has made little progress. In general, empirical research corroborates findings from previous studies that highlight, as mentioned above, the lack of training and knowledge of tools that contribute both to identifying and meeting spiritual needs. A literature review shows that the notion of spiritual care is unclear; available models are rare and largely dependent on the health professionals' goodwill, intuition, and own religious experience (ESPERANDIO; LEGET, 2020a). Thus, the Diamond Model presents itself as a possible approach for application in the Brazilian context, and its consistency and scope can contribute to future studies on its practical effectiveness.

The five following keywords synthesize the five dimensions of the Diamond Model. Some questions are also suggested to guide the spiritual care, as follows (Figure 1):

1) Autonomy (Polarity: Myself & the Other)

Who I am? What do I really want?

2) Suffering (Polarity: Doing & Undergoing)

How do I deal with pain and suffering?

3) Attachment/Relations (Polarity: Holding on & Letting go)

How do I say goodbye?

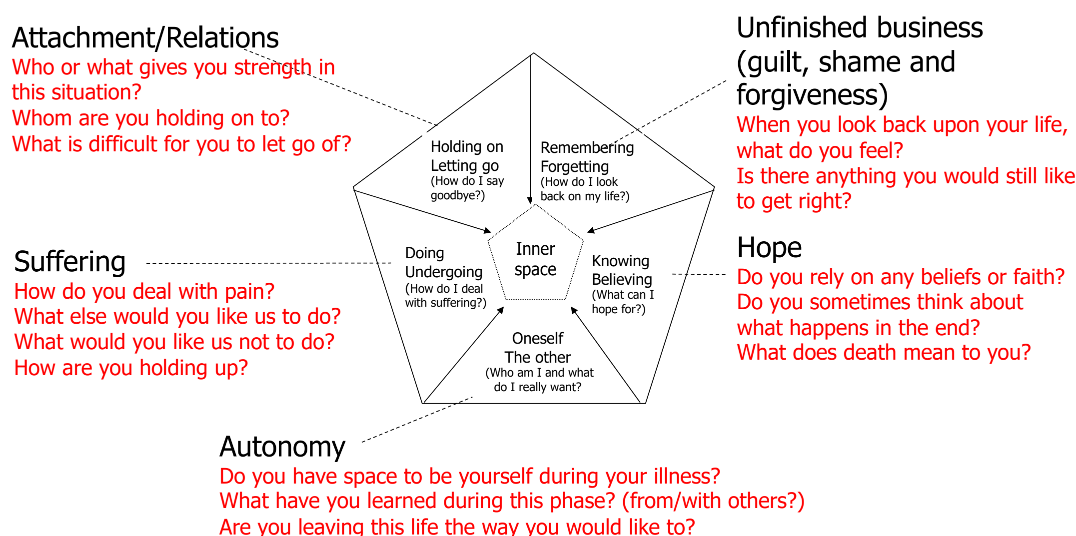
4) Unfinished business (Polarity: Remembering & Forgetting)

How do I look back on my life?

5) Hope (Polarity: Knowing & Believing)

What can I hope for?

**Figure 1 – The Diamond Model**




**Source: Adapted from LEGET (2007); VAN DE GEER; LEGET (2012)**

The last demographic census carried out in Brazil, ten years ago, showed significant changes in the national religious map (NERI, 2011; NERI; MELO, 2011). The religious disengagement trends observed in such census are likely to be exacerbated, with a possible increase in the number of people self-identified as spiritual but not religious (believing without belonging). Thus, introducing the

Diamond Model to the Brazilian audience is opportune, given its non-moral and non-religious anthropological foundations. It reinforces the intention to meet the spiritual needs of patients and families, alleviating their suffering, promoting more dignity in situations when health and life are threatened and more vulnerable. In addition, it is an invitation to expand research in this field. Future studies may investigate how the application of this Model impacts health decision-making and the process of coping with a severe disease that threatens the continuity of existence.

## Final Considerations

Although open to people from all religions and philosophies of life, the Diamond Model can also be used enabling a conversation in either a specific religious context or bridging the communication about spirituality between people from different cultural and religious background. This model has been adjusted to provide spiritual care for patients and families with a Muslim background coming from Turkey and Morocco, patients and families from a Surinam heritage, and patients suffering from dementia in an early stage. It is now being presented to the Brazilian context and can be used not only by chaplains but by the entire multidisciplinary team.

A last remark: The "*Ars moriendi*" were actually "an art of living" as preparing for death was a way of life in the ancient traditions. Therefore, the model does not apply only for people in palliative care or facing death, but "for healthy people as well, because what is really worth living for is discovered best in the light of one's mortality" (LEGET, 2007, p. 38).

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