

Title: The role of perceived dignity and control in the wish to hasten death among advanced cancer patients: A mediation model

Short running title of fewer than 70 characters:

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Abstract

Objective: To test a model in which perceived loss of dignity and control are proposed, along with symptoms of depression and functional impairment, as risk factors for the wish to hasten death (WTHD) in advanced cancer patients.

Methods: This was a cross-sectional study of 193 patients in an oncology unit.

Outcome measures included perceived control, performance status, symptoms of depression, perceived dignity, and the WTHD. Structural equation modeling was performed.

Results: The WTHD correlated significantly with perceived control ($r_s = -.216$), performance status ($r_s = -.175$), symptoms of depression ($r_s = .351$), and perceived loss of dignity ($r_s = .308$). Structural equation modeling showed that perceived loss of control ($-.402$) and functional impairment ($-.21$) were risk factors for perceived loss of dignity. Loss of control ($-.385$) and functional impairment ($-.283$) were also risk factors for symptoms of depression. Perceived loss of dignity and symptoms of depression were the most proximal determinants of the WTHD, on which they had a direct, positive, and significant effect ($.246$ and $.209$, respectively). Therefore, both symptoms of depression and perceived loss of dignity independently predicted the WTHD and mediated the effects of perceived loss of control and functional impairment on this wish.

Conclusions: The hypothesized model provides evidence for the impact of the four aforementioned factors on the WTHD. Our results suggest that personalized care plans which are able to enhance the sense of dignity and control among advanced cancer patients could help to reduce the likelihood or intensity of a WTHD.

Key words: cancer, oncology, wish to hasten death, desire to die, perceived dignity, depression, functional status, perceived control, mediation model

INTRODUCTION

Patients with advanced disease sometimes express a wish to hasten death (WTHD), which can be understood as a response to suffering of multifactorial origin.^{1,2} Research on the factors associated with the emergence of a WTHD in these patients has highlighted the importance of considering the combined influence of factors related to different domains: physical (pain and physical symptoms, impaired functionality, etc.), psychological (depression, hopelessness, despair), existential/spiritual (loss of meaning in life, loss of purpose), and social (feeling like a burden to others, loss of social role).²⁻⁵ In addition, qualitative studies have shown how a patient's values, beliefs, and cultural background also need to be taken into account. Recent syntheses of qualitative studies in this field suggest that the expression of a WTHD can have several different meanings and functions: for instance, it might be a cry for help or a wish to put an end to suffering, or perhaps be seen by the person as a form of control, or even reflect a will to live but not in this way.² Accordingly, it has been argued that the WTHD should not be seen as synonymous with an explicit request to die.⁶

Patients who express a WTHD often allude to a loss of dignity.⁷⁻¹² This was highlighted in a recent meta-ethnography which found that a perceived loss of dignity was a central feature of the loss of self or identity that patients experienced in the context of a life-threatening condition. Research on the WTHD and perceived loss of dignity in these patients has also highlighted the importance of a sense of control over their circumstances and the dying process.^{13,14} In addition, various studies have found that for some people a perceived loss of dignity and of autonomy are key reasons why they wish to hasten death, especially in countries where euthanasia or assisted suicide have been decriminalized.¹⁵⁻¹⁷

Despite the extensive literature on the WTHD and perceived loss of dignity and control in advanced cancer patients, we are unaware of any study that has examined the interaction between these variables. It is generally agreed, however, that depression¹⁸⁻²¹ and physical impairment^{22,23} play an important role in relation to such a wish. In light of the above, the aims of this study were to analyze the influence that perceived loss of control, functional impairment, symptoms of depression, and perceived loss of dignity may have in relation to the emergence of a WTHD in advanced cancer patients, and to propose a theoretical model of functional relations between these variables.

METHODS

Subjects

Participants were recruited between January 2016 and June 2017 at an oncology unit in Barcelona (Spain). The inclusion criteria were: a) patients diagnosed with advanced cancer, defined by the American Society of Clinical Oncology (ASCO) as those with distant metastases, late-stage disease, cancer that is life limiting, and/or with a prognosis of 6 to 24 months,²⁴ b) age 18 or over, c) judged by their physician or nurse to be clinically stable, d) able to communicate adequately with research personnel, and e) signing of informed consent. The exclusion criteria were: a) an ongoing severe psychiatric disorder (e.g., severe depressive episode), as judged by the treating physician, and b) cognitive impairment, indicated by a score > 5 on the Short Portable Mental Status Questionnaire (SPMSQ).²⁵ It was also agreed that a patient would only be interviewed if there was consensus in the clinical care team that doing so would not cause significant, additional emotional distress. The study was approved by the corresponding ethics committee of the hospital (PR216/15).

Procedures and Measures

Eligible patients were selected by their corresponding physician or nurse at the oncology unit, who described the study to them and invited them to participate. Those who agreed met subsequently with a researcher.

In addition to gathering sociodemographic data, the face-to-face interview involved assessment of the following:

- The WTHD was evaluated using a semi-structured clinical interview called 'Assessment of the Frequency and Intensity of the Desire to Die' (AFIDD).²⁶ The AFIDD consists of an initial (or lead) question that the interviewer puts to the patient: *Some people in your situation may involuntarily start to think that living like this is not worth it anymore. Lately (in the last week or two), have you thought that living like this is not worth it?* In the event of an affirmative response, the interviewer then asks the patient to indicate how often s/he thinks that life is not worth living (frequency). The patient's response is then assigned to one of the following categories for scoring: a) 'Every day' (4 points), b) 'Not every day but almost' (3 points), c) 'Occasionally/sometimes' (2 points), or d) 'Seldom/almost never' (1 point). After assessing frequency, the interviewer asks about the intensity of the WTHD and assigns the patient's response to one of the following categories for scoring: a) 'Has privately had such a wish' (1 point), b) 'Has talked about it or mentioned it to someone' (2 points), or c) 'Has wished to die and also thought about how he/she would put an end to his/her life' (3 or 4 points, according to the following criterion: 3 points if the patient has thought about how he/she would end his/her life but says he/she would never really do it; 4 points if the patient has a plan to end his/her life). The total AFIDD score is the sum of the frequency and intensity scores, and thus ranges from 2-8 points.

- Perceived dignity was assessed using the Patient Dignity Inventory (PDI),²⁷ an instrument designed to measure different sources of dignity-related distress at the end of life. It comprises 25 items, each rated on a five-point Likert scale from 1 to 5. The total score on the PDI therefore ranges from 25 to 125, and higher scores indicate a greater perceived loss of dignity. The validation study for the Spanish version of the PDI identified three dimensions: psychological and existential distress (score range 12-60), physical symptoms and dependency (range 9-45), and social support (range 4-20).²⁸

- Perceived control was assessed using the General Self-Efficacy Scale (GSE).²⁹ The GSE has 10 items that are rated on a Likert-type scale ranging from 1 to 4. The total score therefore ranges between 10 and 40, with lower scores indicating poorer perceived general self-efficacy.

- Functional impairment was classified according to the Karnofsky Performance Status (KPS),³⁰ a comprehensive 11-point scale correlating to percentage values ranging from 100 (no evidence of disease, no symptoms) to 0 (death).

- Symptoms of depression were assessed using the Hospital Anxiety and Depression Scale (HADS),³¹ a 14-item self-report scale with a four-point Likert-type response format (scored 0-3). The HADS provides separate scores for anxiety (HADS-A) and depression (HADS-D), and higher scores (range 0-21 on each subscale) indicate a higher level of anxiety or depression. In cancer patients, different cut-off scores have been proposed: ≥ 5 on the HADS-D indicates a case of depression, ≥ 7 on the HADS-A indicates a case of anxiety, and a total HADS score ≥ 13 suggests a mood disorder.³²

Statistical Analysis

This was an exploratory, cross-sectional study and we calculated descriptive statistics for the demographic and clinical characteristics of the sample. Categorical variables are presented as frequencies and percentages, while continuous variables are expressed in terms of either the mean (standard deviation), when normally distributed, or the median (interquartile range, IQR1-IQR3) when the distribution was skewed. A 95% confidence interval (CI) was used to define continuous variables. Non-parametric tests were used because the distribution of AFIDD scores was skewed. Correlations among variables were studied by calculating Spearman's rho for non-parametric data. Comparisons between two groups were performed using the Mann-Whitney U test if the distribution was skewed and the Student's *t* test if the distribution was normal. The level of significance was set at $p < .05$, and the analyses were performed using SPSS 21.0 (SPSS Inc., Chicago, IL).

In order to assess the mediator effect of depression and perceived loss of dignity, the methodology suggested by Baron and Kenny³³ was adopted and performed as described by Bernardo et al.³⁴ and Petnji et al.,³⁵ who used structural equation modeling (SEM) instead of regression analysis. Preacher and Hayes³⁶ recommended the use of SEM for assessing mediation because it offers a reasonable way of controlling for measurement error, as well as some interesting alternative ways of exploring the mediation effect. Based on prior studies^{2,23,37} we hypothesized a path analysis model to assess the antecedents of WTHD using EQS 6.3 software. Overall data fit was verified through a set of indices: the Satorra-Bentler χ^2 /degrees of freedom, the comparative fit index (CFI), the root mean square error of approximation (RMSEA), and the Bentler-Bonett normed fit index (BB-NFI). The model was estimated by applying the robust maximum likelihood method to the asymptotic variance-covariance matrix. Our proposed theoretical model is shown in Figure 1.

Insert Figure 1 about here

RESULTS

Characteristics of Participants and Descriptive Statistics

A total of 522 patients were admitted to the unit during the study enrolment period. Of these, 337 (64.6%) patients were diagnosed with advanced cancer, of whom 193 (57.3%) were able to be assessed. Reasons for exclusion were: clinically unstable (71 patients, 21%), an active psychiatric disorder (29 patients, 8.6%), cognitive impairment (27 patients, 8%), and not being informed of their advanced cancer diagnosis (2 patients, 0.6%). Data were incomplete for 15 (4.5%) patients. Table 1 shows the characteristics of included patients.

Insert Table 1 about here

The mean age of the sample was 62.6 (SD 9.9) years, and 58.5% (n = 113) were male. Almost two-thirds of participants (n = 122, 63.2%) were receiving anti-tumor treatment at the time of the study interview.

Regarding functional status, 62.7% (n = 121) of patients were classified as being above 80 on the KPS. Of the remainder, 20.7% were in the range 60-70 and 16.6% scored below 50. The mean total score on the HADS was 11.1 (SD 8.7). In terms of the cut-off scores for cancer patients proposed by Singer et al.,³² 69 patients (35.8%) had a total HADS score ≥ 13 , suggesting a mood disorder. Regarding the two subscales, 61 patients (31.6%) scored ≥ 7 on the HADS-A, suggesting the presence of anxiety

symptoms, and 93 patients (48.2%) scored ≥ 5 on the HADS-D, indicating symptoms of depression.

The mean total score on the PDI was 38.6 (SD 12), suggesting that a perceived loss of dignity was only a mild problem in these patients. Mean scores on its three dimensions were 18.9 (SD 6.8) for psychological and existential distress, 14.9 (SD 5.5) for physical symptoms and dependency, and 4.7 (SD 1.3) for social support.

The mean score on the GSE was 31.2 (SD 5.9), suggesting a high level of perceived control in these patients.

The median total score on the AFIDD was 2 (IQR 1-3). Of the 193 patients we interviewed, 46 (23.8%) reported a WTHD.

Table 2 shows a comparison of patients according to whether or not they reported a WTHD. It can be seen that the two groups differed significantly in their scores for perceived loss of dignity, perceived loss of control, and the presence of symptoms of depression. There were no missing data for any of the variables considered in these analyses.

Insert Table 2 about here

Correlation Analysis

Table 3 shows the Spearman rho coefficients between the total score on the AFIDD and the other measures used (KPS, GSE, PDI, and HADS). The AFIDD total score was negatively and significantly correlated with the KPS ($r_s = -.175, p < .05$) and

scores on the GSE ($r_s = -.216, p < .01$), indicating that patients who report a stronger WTHD show greater functional impairment and lower perceived control. Positive and significant correlations were observed between the AFIDD total score and the PDI total score ($r_s = .308, p < .001$), indicating that patients who express a WTHD experience a loss of perceived dignity. The AFIDD total score was also positively and significantly correlated with two of the PDI subscales: psychological and existential distress ($r_s = .293, p < .001$) and dependency ($r_s = .302, p < .001$); the correlation between the AFIDD and the social support subscale of the PDI was not significant ($r_s = -.38, p > .05$). There was also a positive and significant correlation between the AFIDD total score and scores on the HADS: total score: $r_s = .354, p < .001$; depression subscale: $r_s = .351, p < .001$; anxiety subscale: $r_s = .258, p < .001$. These results indicate that the stronger the WTHD, the greater the symptoms of depression and anxiety.

Insert Table 3 about here

Path Analysis Model

The assessment of model-data fit yielded the following indices: the Satorra–Bentler χ^2 was 10.077, with 3 degrees of freedom and a p-value of .028; the Satorra–Bentler χ^2 /degrees of freedom was 3.36; the RMSEA was 0.111 and its 95% confidence interval was 0.040-0.189; the CFI was 0.943; and the BB-NFI was 0.924.³⁸ Taking into account the significance of the robust χ^2 statistic, and given the values of the global indicators, the overall fit of the model was acceptable. Table 4 shows the decomposition of the total effects of the model.

Insert Table 4 about here

Figure 1 shows how the variables considered may contribute to the emergence of a WTHD. It can be seen that a perceived loss of control and functional impairment were risk factors for symptoms of depression and a perceived loss of dignity. Similarly, both symptoms of depression and perceived loss of dignity were risk factors for the WTHD. In other words, both the latter two factors have a direct effect in relation to the emergence of a WTHD, whereas the impact of a perceived loss of control and functional impairment on the WTHD is mediated by symptoms of depression and perceived loss of dignity (indirect effect). Thus, the model highlights how symptoms of depression and a perceived loss of dignity have a dual role in the emergence of the WTHD, that is, as variables which have a direct effect and also as mediators.

It can be seen in Table 4 that the coefficients for perceived loss of control and functional impairment (-.180 and -.111, respectively) indicate a similar and significant impact on the emergence of a WTHD (t-value < -1.94 or > 1.94). Note also that the impact of perceived loss of control on the WTHD is mediated by both symptoms of depression (-.080) and loss of perceived dignity (-.100), the two coefficients being of similar magnitude. The impact of functional impairment on the WTHD is likewise mediated by the same two variables, the coefficients in this case being -.059 and -.052, respectively. The coefficients for the impact of symptoms of depression and perceived loss of dignity on the WTHD are also similar (.209 and .246, respectively) and significant (t-value < -1.94 or > 1.94), indicating that the variables studied make a similar contribution to the emergence of a WTHD.

DISCUSSION

The results of this study enable us to propose an explanatory model of the role played by perceived loss of control, functional impairment, symptoms of depression, and perceived loss of dignity in relation to the emergence of a WTHD among advanced cancer patients.^{18,21-23} The model suggests that perceived loss of dignity and symptoms of depression have a direct effect as precursors of the WTHD, whereas the influence of perceived loss of control and functional impairment is indirect. More specifically, low perceived control is a risk factor that precedes (or fosters) stronger symptoms of depression and, indirectly, a stronger WTHD. Low perceived control is also a risk factor contributing to a perceived loss of dignity, which likewise results in a stronger WTHD. As for functional impairment, this also has an indirect impact on the WTHD, one that is mediated by symptoms of depression and perceived loss of dignity. In other words, increasing functional impairment would lead to stronger symptoms of depression and a perceived loss of dignity, and consequently to a stronger WTHD.

A perceived loss of dignity was the variable associated with the greatest impact on the WTHD. This is consistent with the results of previous studies that likewise identified a perceived loss of dignity as one of the main reasons given by some patients for the desire to die.^{37,39} The mediating role of perceived loss of dignity with respect to loss of control and functional impairment is also supported by previous research showing that functional deterioration is associated with a perceived loss of dignity.⁴⁰⁻⁴³ The model proposed here also shows that functional impairment does not directly trigger a WTHD, but has an impact once the patient's sense of dignity is undermined.

The authors of the PDI developed the instrument based on their own model of dignity in the terminally ill. This model supports the idea that multiple factors (some

related to the illness and its physical and emotional symptoms), a lack of social support, and a perceived loss of identity can undermine a person's sense of dignity. The consequences of a perceived loss of dignity include suffering, poor quality of life, and loss of meaning in life. The PDI was designed with the aim of assessing these aspects, which its authors consider as different sources of dignity-related distress at the end of life. In their view, a perceived loss of dignity is not only the manifestation or expression of suffering but also a source of suffering for that person. Studies that have analyzed patients' narratives regarding the WTHD suggest that suffering is a common denominator that is crucial to an understanding of how this wish is experienced; in other words, suffering is an inherent feature of any wish or desire to die.² In relation to our results, a perceived loss of dignity can thus be regarded as an important source of suffering that may foster a WTHD.

Loss of control also plays an important role in the emergence of a WTHD. As a mediator variable, greater perceived control would act as a buffer against symptoms of depression and a possible perceived loss of dignity, both of which are direct antecedents of the WTHD. To put it another way, those patients who perceive (subjectively) that they are more capable of managing effectively the difficult or stressful situations in which they find themselves will be more likely to score lower on symptoms of depression and to preserve their sense of dignity. The sense of control does not, therefore, depend on the extent to which a patient's course of action is actually limited by the illness, but rather on his or her perception that scope remains for decision making and that his or her internal coping mechanisms allow a degree of personal agency to be maintained.

Studies that have analyzed the lived experience of patients with advanced disease suggest that there are three domains in which a loss of control may be

experienced.³⁷ One is related to functional impairment (incontinence, dependency, etc.), another concerns the loss of internal or psychological control (i.e., lack of control over one's life and the future), and the third refers to how taking control of the end-of-life process may be perceived by patients as a way of relieving suffering. The model proposed in this study is consistent with this framework, since it suggests that a loss of control may trigger a WTHD in patients with functional impairment, symptoms of depression, and a perceived loss of dignity.

A recent study of advanced cancer patients by our research group highlighted the mediating role that meaning in life and symptoms of depression play in the emergence of a WTHD.²³ The study by Rodin et al.²¹ similarly found that depression and hopelessness were relevant determinants of the WTHD. These results are consistent with the present analysis and underline the importance of considering emotional and psychological aspects, such as symptoms of depression, perceived loss of dignity, loss of control, or loss of meaning in life as antecedents of the WTHD. Furthermore, our path analysis suggests that rather than consider, for example, perceived control (often defined in terms of autonomy) as a fundamental personal value, it might be more appropriately regarded as an antecedent of symptoms of depression and as a psychological mechanism for coping with the suffering and uncertainty produced by an advanced illness.

Previous studies of the WTHD have described it as the expression of the multidimensional suffering that affects all aspects of personhood in these patients. In this respect, the use of structural equation modeling to analyze the mediating effect of direct and indirect variables is an appropriate way of achieving an integrated account of complex phenomena.^{23,45}

Limitations

One of the most important limitations of this study is that the cross-sectional design prevents us from establishing causal relationships between the variables considered. Longitudinal clinical studies are therefore required for a more robust examination of the phenomenon studied here. Another limitation concerns the low recruitment rate and the strict procedure for selection of patients, which required consensus among the clinical team. This is a common problem in studies carried out in this context,⁴⁶ and in our case it means that the sample may under-represent individuals struggling with distress or physical impairment. A third limitation relates to the use of the GSE. This scale is not specifically designed to assess perceived control at the end of life, although it has been used in other studies with similar populations.⁴⁷ It would be useful, however, to explore perceived control from the perspective of patients' lived experience.

CONCLUSIONS

Clinical Implications

The proposed model suggests that a perceived loss of dignity and symptoms of depression are important targets for assessment and intervention in advanced cancer patients, as they are the main antecedents of the WTHD. Given the indirect effect of a lack of control and functional impairment on the WTHD, both these variables could be regarded as indicators or warning signs, since they are antecedents of a perceived loss of dignity and symptoms of depression. Identifying and, as far as possible, alleviating a patient's functional impairment and loss of control could thus be important for preventing depressive states, a perceived loss of dignity, and a WTHD. An adequate

sense of control could help patients to maintain their sense of dignity, reducing the likelihood of symptoms of depression and, consequently, the possibility of a WTHD.

Our results highlight the need for personalized care plans which are able to enhance the sense of dignity among advanced cancer patients, not only through the input of health professionals and relatives, but also by allowing patients to retain a degree of personal agency wherever possible.

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Table 1. Characteristics of advanced cancer patients.

Variables	Value
Gender	n (%)
Male	113 (58.5)
Female	80 (41.5)
Mean Age, years (SD)	62.6±9.9
Marital Status	n (%)
Married/common law	133 (68.9)
Divorced/separated	26 (13.5)
Single	16 (8.3)
Widow/widower	13 (6.7)
Other	5 (2.6)
Family situation	n (%)
Lives alone	20 (10.4)
Lives with partner/family	106 (54.9)
Lives with children	7 (3.6)
Other	60 (31.1)
Education	n (%)
No education	17 (8.8)
Primary education	94 (48.7)
Secondary education	61 (31.6)
Higher education	14 (7.3)
Other	7 (3.6)
Cancer diagnosis	n (%)
Lung	53 (27.5)
Gastric and colon	29 (15)
Kidney and genitourinary system	23 (11.9)
Breast	16 (8.3)
Female reproductive system	12 (6.2)
Mouth and pharynx	11 (5.7)
Bone	4 (2.1)
Pancreas	18 (9.3)
Skin	3 (1.6)
Liver	2 (1)
Brain	3 (1.6)
Other	19 (9.8)
Time since diagnosis	n (%)
<3 months	76 (39.4)
4-6 months	15 (7.8)
6-12 months	23 (11.9)
1-3 years	35 (18.1)
>3 years	44 (22.8)

Table 2. Differences in the mean score obtained on the various measures according to whether or not patients expressed a WTHD.

	WTHD (n = 46)	No WTHD (n = 147)	p-value
KPS: median (IQR 1-3)	70 (50-90)	80 (70-90)	<.05
HADS Total score: mean (SD)	16.3 (8.9)	9.5 (7.9)	<.01
HADS-Depression: mean (SD)	9 (5.6)	4.7 (5.1)	<.001
HADS-Anxiety: mean (SD)	7.3 (4.7)	4.8 (4.1)	<.001
PDI Total score: mean (SD)	45.3 (13.9)	36.5 (10.5)	<.001
Psychological & existential distress: mean (SD)	22.8 (8.4)	17.7 (5.8)	<.001
Dependency: mean (SD)	17.7 (5.8)	14.1 (5.2)	<.001
Social support: mean (SD)	4.9 (1.7)	4.7 (1.1)	.532
GSE total score: mean (SD)	29.1 (6)	31.8 (5.7)	<.01

KPS: Karnofsky Performance Status scale; HADS: Hospital Anxiety and Depression Scale; PDI: Patient Dignity Inventory; GSE: General Self-Efficacy Scale.

Table 3. Spearman's rho coefficients for the AFIDD in relation to the measures of functional status (KPS), perceived control (GSE), perceived dignity (in terms of PDI total score and scores on its three dimensions: psychological and existential distress, dependency and social support), and symptoms of anxiety and depression (HADS total, HADS-D, and HADS-A).

	KP S	GSE	PDI Total score	PDI Psychologi cal and existential distress	PDI Depende ncy	PDI Socia l supp ort	HAD S Total score	HAD S-D	HAD S-A
AFID D	- .175 *	- .216 **	.308 **	.293**	.302**	.38	.354 **	.351* *	.258* *

* $p < .05$; ** $p < .01$

Table 4. Decomposition of the model parameters.

	Total effect (t value)	Partial indirect effect	Total indirect effect (t value)	Direct effect (t value)
(a) V1 Perceived control → V2 Symptoms of depression	-.385 (-5.04)	-	-	-.385 (-5.04)
(b) V3 Functional status → V4 Perceived dignity	-.210 (-2.88)	-	-	-.210 (-2.88)
(c) V2 Symptoms of depression → V5 WTHD	.209 (2.14)	-	-	.209 (2.14)
(d) V4 Perceived dignity → V5 WTHD	.246 (2.94)	-	-	.246 (2.94)
(e) V1 Perceived control → V4 Perceived dignity	-.402 (-5.26)	-	-	-.402 (-5.26)
(f) V3 Functional status → V2 Symptoms of depression	-.283 (-3.77)	-	-	-.283 (-3.77)
V1 Perceived control → V5 WTHD	-.180 (-3.00)	a * c = -.080 e * d = -.100	-.180 (-3.00)	-
V3 Functional status → V5 WTHD	-.111 (-2.66)	f * c = -.059 b * d = -.052	-.111 (-2.66)	-
(g) Correlation between V1 Perceived control and V3 Functional status	.269 (3.44)			

Standardized parameter (t-value) (sig. < -1.94 or > 1.94)

The letters correspond to the notation in Figure 1.

Figure 1. Mediation model linking performance status, perceived control, symptoms of depression, perceived loss of dignity, and the wish to hasten death.

