Do cognitive-affective and family communication variables impact individual decisions to discuss organ donation wishes?

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Running head: Discussing organ donation wishes

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ABSTRACT

Family discussion of donation wishes is a critical driver of family authorisation of organ donation. However, few people discuss their wishes or feel certain of family member's donation preferences. Empirically, individual determinants of discussing donation wishes with family have been examined using the theory of planned behaviour (TPB). The impact of cognitive-affective (e.g., disgust) and family (e.g., family communication) variables are less well studied, and not integrated together in decision-making frameworks. To address this gap, the role of family communication and 'cognitive-affective' variables, integrated within the TPB, were examined as predictors of intended and actual discussion of donation wishes with family. Participants (N=201) completed baseline measures of family communication, cognitive-affective (disgust, bodily integrity, medical mistrust, fear of not being dead, anxiety about discussing), and TPB (attitude, subjective norm, self-efficacy, intention) variables. Two-weeks later, participants (N=111) self-reported their discussion behaviour ($n=42$, 38% discussed). A revised structural equation model provided a good fit to these data. In this model, less anxiety about discussion and positive attitudes toward discussion predicted self-efficacy ($R^2=0.67$). Positive attitudes, greater self-efficacy and perceived approval/support from important others (subjective norm) predicted discussion intentions ($R^2=0.70$). Intention predicted discussion behaviour ($R^2=0.22$). Cognitive-affective variables (except discussion anxiety) and family communication did not have a prominent role. Interventions which emphasise that family expect and approve of donation discussions, portray donation discussions as positively valued, and bolster self-efficacy are needed to increase discussion of organ donation wishes. Bolstering self-efficacy could be achieved by providing tangible strategies to assist individuals to reduce their anxiety about discussing their wishes, and

encouraging positive attitudes towards discussion and its importance in family authorisation for donation.

Keywords: Organ donation, consent, anxiety, family discussion, communication, myths

INTRODUCTION

Globally, efforts to increase the low numbers of organ donors have focused on changing the law on registration of consent for donation from opt-in to opt-out systems. However, evidence suggests that this change on its own is insufficient to solve the problem of low rates of organ donation.¹ Family authorisation which is often identified as a barrier to donation is still sought in practice regardless of the system.² Family discussion of donation wishes prior to the death of a loved one is a key driver of family authorisation for donation,² yet is the least researched aspect of organ donation.³ Moreover, few share their wishes with their partner/family, or feel confident they know their loved ones' donation preference.⁴

The Theory of Planned Behaviour (TPB)⁵ is the dominant framework applied to understand individual decisions to communicate donation wishes to family.³ According to the TPB, a person's attitude (positive or negative evaluation), subjective norm (perceived approval from others), and perceived behavioural control (PBC; belief in the level of control they have [perceived control], and personal capabilities [self-efficacy]), predicts their intention to act. A person's intention and PBC are expected to predict subsequent behaviour. Perceived control and self-efficacy which comprise PBC have been distinguished empirically as separate constructs.⁶ Self-efficacy better predicts intention, including intentions to communicate donation wishes,⁷ and more closely aligns with behaviour, than perceived control.⁶ As such, in this study we use self-efficacy rather than PBC.

Regarding the predictive ability of the TPB in relation to organ donation, students' more positive attitudes, higher subjective norm, and increased PBC, along with past behaviour, predicted their intention to perform organ donation behaviours (including family discussion).⁸ At follow-up, intention (but not PBC or past behaviour) predicted family discussion and other organ donation behaviours.⁸ In a review of theoretical approaches used to understand communication of organ donation wishes,⁹ TPB constructs of attitude,

subjective norm, and PBC (including self-efficacy) explained 56% to 76% of variance in intention to engage in family discussion, and intention explained 11% to 32% variance in family discussion behaviour.

Parallel to this research, ‘cognitive-affective’ variables such as anxiety, disgust, bodily integrity and medical mistrust have been linked to willingness to donate or register a donation preference.¹⁰⁻¹² These variables may also influence decisions to discuss donation wishes. For instance, anxiety about death which includes concerns about body integrity has been associated with self-efficacy and also intention to discuss donation wishes.¹³⁻¹⁴ Believing death is a taboo topic, and higher levels of medical mistrust, have been associated with less willingness to engage in family discussion, but did not have direct effects on behaviour.¹¹ Further, individuals may be concerned about family objection,¹⁵ having to defend their decision, or the conversation going poorly if they share their wishes.¹⁶ Individual anxiety regarding uncertainty about their family’s attitudes towards organ donation has also been shown to drive self-efficacy.¹⁷ However, anxiety specifically about discussing donation wishes has not been directly explored in relation to discussion intentions or behaviour.

Although individual determinants of discussion donation wishes are important, this behaviour is likely also impacted by family dynamics, such as communication processes.⁹ For example, despite having positive attitudes towards donation, if an individual perceived their family had a communication style favouring homogenous attitudes/values, they were less willing to have a family discussion about donation.¹⁸ Pitts and colleagues¹⁹ identified a family norm for all members to reach agreement in conversations about organ donation, and this was achieved most often via cooperative and collaborative conversation styles. Divergence from the norm through disagreement led to a conversation style that was challenging and involved long discussion, efforts to influence others’ opinions, and frustration. Thus, the degree to

which family communicate effectively, may impact individual decisions to discuss donation wishes.

Specific Aim and Research Questions

Research has explored separately the relationship of cognitive-affective and family communication to donation-related decisions. As such, the contribution of these cognitive-affective and family communication variables when included within the dominant framework used to understand organ donation decisions (TPB) has not been determined, and targets for intervention based on these variables not identified. Our objective was to examine the contribution of cognitive-affective (disgust, bodily integrity, medical mistrust, fear of not being dead, anxiety about discussing) and family communication variables within a broader TPB framework (attitude, subjective norm, self-efficacy), in predicting intended and actual discussion of donation wishes with family. We propose a model derived from prior donation discussion research and TPB model specifications (Figure 1). We hypothesised (H) the following:

H1) Concerns about not really being dead and body integrity (as components of death anxiety scales)¹⁴ will negatively predict self-efficacy.

H2) Positive family communication will positively predict intention.

H3) Medical mistrust, disgust, and anxiety about discussing donation wishes, will negatively predict intentions.

H4) Positive attitude towards discussing, perceived approval from important others, and self-efficacy will positively predict intentions.

H5) Positive family communication, self-efficacy, and intention will positively predict discussion behaviour, and anxiety will negatively predict behaviour.

The contribution of past discussion behaviour to intended and actual discussion of donation wishes was also explored consistent with Rocheleau's findings,⁸ and given that prior

performance of behaviour is associated with increased intended and actual future behaviour.²⁰ Past behaviour is known to attenuate model effects,²⁰ and, as such, we explored its effect in a separate test of the proposed model.

H6) Past discussion of donation wishes with family will positively predict intended and actual discussion behaviour.

MATERIALS AND METHODS

Design

This study comprised a prospective survey design. TPB, cognitive-affective and family communication variables, and past behaviour were measured at baseline (T1), and self-reported discussion behaviour was measured two weeks after baseline survey completion (T2). A two-week follow-up was used in order to give participants ample time to have a discussion whilst maximising participant availability for survey completion. After ethical approval (University #PSY7614HREC), participants received an information sheet describing the study, and were advised prior to commencing T1 and T2 surveys that completion of each survey would indicate informed consent to participate.

Setting

Participants were invited to the study via the Student Experiment Participation Scheme on two University campuses in one Australian state. This scheme gave first-year psychology students the opportunity to volunteer for research and receive course credit for their time. We used social media and professional and personal networks throughout Australia to distribute the survey invitation to community members who were not compensated for participating.

Sampling

Eligible participants were those aged 16 years or older residing in Australia. We used convenience sampling to recruit participants from the psychology student cohort, and

snowball sampling to recruit community members. Participants self-selected into the study by registering their interest (students only) and/or accessing the main and follow-up survey links provided within the study invitation.

Procedure

We collected data using an online survey platform (SurveyMonkey). After ethical approval, participants who met eligibility criteria took part in a study about communicating organ donation wishes with family. Participation comprised completing an online survey including measures of TPB, cognitive-affective, and family communication variables, past behaviour, donation-related experience and personal characteristics. Once participants completed the first survey, they provided their contact details if they were willing to complete a follow-up survey two-weeks later. In this follow-up they self-reported their discussion behaviour. Responses at each time-point were matched using a participant-generated identifier to maintain anonymity.

Measures

Time 1

Experience with organ donation. Self-rated knowledge about donation (“Overall, how would you rate your knowledge of organ donation”, excellent to very poor), donation preference (yes, no, unsure), and donor registration status (yes, no, unsure) were assessed using 1-item measures.

Participant characteristics. Participants self-reported their age in years, gender, country of birth, university/college-level education, relationship status, and living arrangement.

Past behaviour. Prior family discussion about donation wishes was measured with “have you told your partner or a family member about your preference for organ donation?” (yes, no, unsure). Participants then indicated using free-response who they had told.²¹

TPB variables. TPB constructs were assessed with 2-item measures of attitude (“It would be valuable for me to...”), self-efficacy (“It would be easy for me to ...”), and subjective norm (“People who are important to me think I should ...”), and a 3-item measure of intention (“I intend to...”).²¹ Items ended with “...tell my family my donation preference in the next fortnight”, scored 1 strongly disagree to 5 strongly agree.

Cognitive-affective variables. Disgust (“the idea of organ donation disgusts me”), bodily integrity (“my body should be kept whole for burial”), medical mistrust (“I trust that doctors and hospitals use donated organs as they are intended to be used”), and fear of not being dead (“I am scared that I would not really be dead if I am a donor and my organs are taken for transplantation”) were each measured with one item.¹¹ We adapted the 8-item Index of Dental Anxiety and Fear²² to measure anxiety about discussing donation wishes with family (“I generally avoid telling my family my donation preference because I know I will find the experience unpleasant or distressing”). All items were scored 1 strongly disagree to 5 strongly agree.

Family communication. The 10-item FACESIV Family Communication scale²³ was used to measure whether participants perceived they had healthy communication about information, ideas, thoughts, and feelings with family members (“family members can calmly discuss problems with each other”). Items were scored 1 strongly disagree to 5 strongly agree.

Time 2

Behaviour. Discussion behaviour was measured with the item, “In the past fortnight, did you tell your family your donation preference” (yes, no). Participants indicated who they told (partner/spouse, mother, father, sibling, child/ren, another relative/guardian, other), and how satisfied they were with their conversation (1 very dissatisfied to 5 extremely satisfied).²¹

Data analysis

We used descriptive statistics to analyse donation-related experiences and participant characteristics, and compared responses at T1 only with both time-points using chi-square analysis or ANOVA (Table 1). Scale reliability was determined with Cronbach's $\alpha \geq 0.70$ or Pearson's r ($p < 0.05$) (Table 2). Pearson's or Spearman's Rho correlations (for dichotomous variables) were examined between T1 predictors and T2 behaviour for participants completing both time-points (Table 2).

We performed structural equation modelling in Mplus 8.4²⁴ and used a robust weighted least-squares estimator to test the proposed model given the categorical discussion behaviour outcome (Figure 1).²⁴ There is no universally accepted guideline regarding sample size requirements for structural equation modelling or for models that use a robust weighted least-squares estimator and have categorical outcomes.²⁵ For these latter models, requirements depend on the model estimated and data from 50 or more participants can be sufficient.²⁵

We calculated goodness-of-fit indices for each model tested and evaluated these using recommended guidelines:²⁶ chi-square (non-significant), comparative fit index (CFI; ≥ 0.95), Tucker-Lewis index (TLI; ≥ 0.95), and root mean square error of approximation (RMSEA; < 0.06). The predictive power of the proposed model was evaluated with path coefficients and R^2 values, with significance determined by $p < 0.05$. We ran the proposed model with and without past discussion behaviour, given it is known to reduce model effects.²⁰

[Insert Figure 1]

Results

Participant characteristics

201 participants completed the Time 1 (T1) survey (49.8% students), of which 178 consented to contact for the follow-up survey (Time 2; T2). 111 (50.5% students) participants completed the T2 survey (62.4% response). Although the response at follow-up was lower than expected, it is consistent with other studies measuring discussion behaviour.²² Participant

characteristics at T1 only and both time-points are compared in Table 1. The only significant difference was that fewer participants who completed both time-points (vs. T1 only completers) had joined the donor register or discussed their donation wishes prior to T1.

[Insert Table 1]

Descriptives for organ donation discussion behaviour

At T1, 51 participants (45.9%) had previously discussed their donation preference, most commonly with their mother (64.7%), partner (47.1%), or father (45.1%). At T2, 42 participants (37.8%) had discussed their donation preference since the T1 survey, most often with their mother (52.4%), partner (42.9%), father (31.0%), or sibling (26.2%). Over half were satisfied with their conversation ($M=3.55$, $SD=1.06$). Most were generally (31.0%), very (35.7%), or extremely (19.0%) satisfied (9.5% somewhat, and 4.8% very dissatisfied).

Correlations between predictor and outcome variables

As expected, cognitive-affective variables were significantly and negatively associated with self-efficacy. TPB and family communication were significantly and positively correlated with intention, and cognitive-affective variables significantly and negatively correlated with intention (except medical mistrust which was not significantly correlated; Table 2). Intention and self-efficacy significantly and positively correlated with behaviour. Family communication and anxiety were not correlated with behaviour. Collinearity statistics showed that all variables were within parameters for inclusion as predictor variables in the model (VIF 1.118-3.664, Tolerance 0.273-0.895).

[Insert Table 2]

Testing the model of intended and actual discussion of organ donation wishes

The model proposed (Figure 1) was a poor fit for these data, $\chi^2(14) = 114.13$, $p < 0.001$, CFI = 0.269, TLI = 0.000, RMSEA = 0.254 (90% CI = 0.212, 0.298). Modification indices suggested two revisions. The first included a pathway for self-efficacy on discussion

anxiety. This modification aligns broadly with the finding that anxiety about others' views regarding donation was a driver of self-efficacy.¹⁷ The second modification included a pathway for self-efficacy on attitude. Although inconsistent with TPB specifications, an association between attitude and self-efficacy has been reported previously amongst blood donors.²⁷ The addition of these pathways substantially improved model fit, $\chi^2(12) = 13.64$, $p = 0.324$, CFI = 0.988, TLI = 0.973, RMSEA = 0.035 (90% CI = 0.00, 0.106). In this revised model (Figure 2), discussion anxiety negatively predicted, and attitude positively predicted, self-efficacy for discussing donation wishes; attitude, subjective norm and self-efficacy positively predicted intention to discuss donation wishes; and intention positively predicted actual discussion behaviour at follow-up (Table 3). The revised model explained 67% variance in self-efficacy, 70% variance in intentions to discuss, and 22% variance in discussion behaviour.

[Insert Figure 2]

The proposed model including past discussion behaviour was also a poor fit, $\chi^2(15) = 106.33$, $p < 0.001$, CFI = 0.268, TLI = 0.000, RMSEA = 0.234 (90% CI = 0.193, 0.277). Modifications indices were identical to those described above, and their addition improved model fit, $\chi^2(13) = 13.66$, $p = 0.398$, CFI = 0.995, TLI = 0.988, RMSEA = 0.021 (90% CI = 0.00, 0.098). In this revised model, discussion anxiety negatively predicted, and attitude positively predicted, self-efficacy; past behaviour, attitude, subjective norm and self-efficacy positively predicted intention to discuss donation wishes. Past behaviour and intention positively predicted actual discussion behaviour (Table 3). The revised model explained 67% variance in self-efficacy, 71% variance in intentions, and 39% variance in discussion behaviour.

[Insert Table 3]

Discussion

This study extends prior research suggesting a role for family and ‘cognitive-affective’ variables in individual decisions to discuss organ donation wishes. We provided a novel test of the contribution of these variables within the TPB framework commonly used to explain donation decisions, and found that family communication did not play a role in individual’s choices to discuss their donation preference (H5 and H2 not supported). In contrast to H1 and H3, cognitive-affective variables often referred to as ‘ick’ (disgust) or ‘jinx’ (medical mistrust) factors¹⁰⁻¹² did not significantly predict people’s intended or actual discussion, and death anxiety (not really being dead, body integrity) did not predict self-efficacy.¹³⁻¹⁴ However, one cognitive-affective variable, anxiety about discussing donation wishes, had an indirect effect on intentions via self-efficacy, but no direct effect on discussion behaviour (H5 and H3 unsupported).

Consistent with prior research,⁹ attitude, subjective norm and self-efficacy directly predicted intentions (H4 supported). Attitude also had an indirect effect on intention via its contribution to self-efficacy. Moreover, intention (not self-efficacy) was a significant direct contributor to behaviour (partially supporting H5). As expected, adding past behaviour to the model attenuated the effect of intention on discussion behaviour, although the significant relationship between these variables still held (cf. Rocheleau).⁸ Past behaviour also predicted discussion intentions (H6 supported).

Although we did not find support for the role of family communication in decision-making, there may be other family variables not assessed that have an impact (e.g., degree of closeness, contextual factors that may limit opportunity for discussion). Future experimental work in which conversations occur in the presence or absence of family, as well as in-situ studies may help to clarify relevant family variables and their impact on discussion. The methodology used by Afifi et al.¹⁷ in which dyads were invited to a lab and given topic cards to facilitate discussion could be adapted to enable more naturalistic conversation that better

reflects the difficulties some individuals have discussing donation and captures spontaneous elements of conversations (e.g., less detailed prompts to start discussion).²¹

Contrary to prior research,¹⁰⁻¹¹ the expected association of cognitive-affective variables such as disgust, bodily integrity, and fear of not being dead, with self-efficacy or intentions were initially supported in correlations but did not remain significant when tested in the model. Previously these associations emerged when African American¹¹ people or those from Chinese,¹³ or Japanese¹⁴ backgrounds were surveyed, and it is possible that our findings may be due to sampling (i.e., most born in Australia, female, highly educated). Tests of the model with participants from culturally diverse backgrounds is needed. While traditional cognitive-affective variables did not have a direct role in decisions to discuss, having less anxiety about discussing donation wishes indirectly contributed to intention via self-efficacy. Thus, reducing discussion anxiety, as well as bolstering self-efficacy so that individuals feel more confident and capable to discuss, are key targets for future intervention to increase intended and actual discussion.

Surprisingly few studies have used interventions or persuasive appeals to encourage family discussion.³ Interventions that equip individuals with coping plans to support positive family communication when discussing donation wishes (e.g., example scripts) may be effective in overcoming anxiety when having a discussion and increasing efficacy beforehand.²¹ Similarly, communication strategies (use an external prompt e.g., news story; ask someone their wishes) could be embedded in persuasive appeals to encourage discussion and build efficacy.^{9,21} Given the key contribution of subjective norm to intention in this study, it may also be critical to emphasise that important others, such as family, would want the individual to have a conversation and would likely approve of them doing so. This approach could be combined with asking participants to reflect on instances of successful communication with their family to bolster positive feelings about family communication,

perceived normative support, and subsequent efficacy to improve discussion rates. Ensuring an immediate opportunity to discuss or notify family after such interventions is also critical.²⁸

Strengths and limitations

This study is one of few to examine both discussion intentions and behaviour, and provides a novel test of family communication and cognitive-affective factors within a broader social cognitive model. However, the results should be interpreted with study limitations in mind. Participants comprised a convenience sample of students and community participants. Although students are typically younger and are a key target group who are least likely to share their wishes, this recruitment approach produced a sample of mostly female, highly educated, Australian residents which limits the broader generalisability of results. Greater focus on participants who are men, younger, or from different ethnic/cultural backgrounds is needed since these groups are less likely to discuss their wishes.¹⁵

Participants indicated low levels of concern about body integrity or not really being dead, low levels of disgust, and low medical mistrust. As such, it is possible that only people comfortable with the topic of organ donation self-selected into the study. Single-item measures on cognitive-affective constructs are also a limitation. Future replication studies should include more diverse participants, and multi-item measures, to confirm the impact (or lack) of cognitive-affective variables on discussion. Self-report measures of behaviour were used in this study and objective measures should be incorporated in future research.

Conclusion

When tested within the dominant TPB framework, the degree to which family communication was perceived as 'healthy' did not contribute to intended or actual discussion about donation wishes. However, when people believed that important others, such as their family, were supportive of discussing donation wishes, they were more likely to share their wishes. Those who were less anxious felt more capable and confident to have a discussion

with family. In turn, feeling more confident and capable, positively valuing donation discussion, and perceiving that important others would want them to share their wishes, contributed to intentions to discuss, with intention contributing to subsequent behaviour. Continued examination of the role of family, discussion anxiety, attitudes, norms, and efficacy in decisions to communicate donation wishes, and development of theoretically-informed interventions to increase discussion are needed in order to facilitate the consent process for organ donation.

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Figure 1. Proposed model of intended and actual discussion of organ donation wishes

Figure 2. Revised model of intended and actual discussion of organ donation wishes. Numbers on lines represent unstandardised coefficients, with standardised coefficients in parentheses. Significant ($p < 0.05$) paths shown only.

Table 1. Characteristics of participants completing Time 1 measures only vs. those completing measures at both time-points

Participant characteristics		Total sample (N = 201)	Time 1 only (N = 90)	Time 1 & Time 2 (N = 111)	Analysis
Age (years)	M (SD)	27.93 (11.43)	27.48 (10.93)	28.30 (11.86)	$F(1) = 0.25, p = 0.615$
	Range	17 – 64	17 – 59	18 – 64	
Gender	Male	46 (22.9%)	20 (22.2%)	26 (23.4%)	$\chi^2(1) = 0.04, p = 0.840$
	Female	155 (77.1%)	70 (77.8%)	85 (76.6%)	
Born in Australia	Yes	148 (73.6%)	71 (78.9%)	77 (69.4%)	$\chi^2(1) = 2.32, p = 0.128$
	No	53 (26.4%)	19 (21.1%)	34 (30.6%)	
University/college level education	Yes	165 (82.1%)	73 (81.1%)	92 (82.9%)	$\chi^2(1) = 0.11, p = 0.745$
	No	36 (17.9%)	17 (18.9%)	19 (17.1%)	
In a relationship	Yes	96 (47.8%)	45 (50.0%)	51 (45.9%)	$\chi^2(1) = 0.33, p = 0.567$
	No	105 (52.2%)	45 (50.0%)	60 (54.1%)	
Living with a partner or relatives	Yes	152 (75.6%)	67 (74.4%)	85 (76.6%)	$\chi^2(1) = 0.12, p = 0.726$
	No	49 (24.4%)	23 (25.6%)	26 (23.4%)	
Self-rated organ donation knowledge	M (SD)	3.53 (1.33)	3.48 (1.43)	3.58 (1.25)	$F(1)=0.27, p =0.602$

Participant characteristics		Total sample (N = 201)	Time 1 only (N = 90)	Time 1 & Time 2 (N = 111)	Analysis
	Range	1 – 7	1 – 7	1 – 7	
Preference to be an organ donor	Yes	137 (68.2%)	60 (66.7%)	77 (69.4%)	$\chi^2(1) = 0.17, p = 0.683$
	No/unsure	64 (31.8%)	30 (33.3%)	34 (30.6%)	
Joined the Australian Organ Donor Register	Yes	38 (18.9%)	23 (25.6%)	15 (13.5%)	$\chi^2(1) = 4.70, p = 0.030$
	No/unsure	163 (81.1%)	67 (74.4%)	96 (86.5%)	
Discussed organ donation wishes	Yes	107 (53.2%)	56 (62.2%)	51 (45.9%)	$\chi^2(1) = 5.29, p = 0.021$
	No/unsure	94 (46.8%)	34 (37.8%)	60 (54.1%)	

Table 2. Bivariate correlations, means (SDs) for predictor variables and discussing organ donation wishes ($N = 111$)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Family communication	-											
2. Disgust	-.06	-										
3. Bodily integrity	-.12	.61***	-									
4. Medical mistrust	.10	-.22*	-.14	-								
5. Not really dead	-.02	.45***	.44***	-.05	-							
6. Discussion anxiety	-.15	.32**	.29**	-.21*	.24*	-						
7. Attitude	.22*	-.18	-.22*	.23*	-.22*	-.56***	-					
8. Subjective norm	.22*	-.30**	-.26**	.21*	-.21*	-.50***	.73***	-				
9. Self-efficacy	.20*	-.27**	-.27**	.16	-.21*	-.73***	.75***	.66***	-			
10. Past discussion	.09	-.24*	-.34***	.20*	-.36***	-.33***	.47***	.55***	.50***	-		
11. Intention	.22*	-.26**	-.28***	.09	-.28**	-.52***	.73***	.73***	.70***	.58***	-	
12. Discussion behaviour (T2)	.13	-.10	-.17	.02	-.05	-.06	.19*	.23*	.19*	.40***	.30**	-
<i>M</i>	3.50	1.34	1.75	4.09 ^b	1.91	1.68	4.00	3.96	4.19	a	3.86	a
<i>SD</i>	0.77	0.67	1.06	0.88	1.18	0.81	0.96	0.81	0.92	a	1.01	a
α or Pearson's <i>r</i>	0.91	c	c	c	c	0.96	0.81***	0.56***	0.90***	c	0.90	c

* $p \leq 0.05$. ** $p \leq 0.01$. *** $p \leq 0.001$. a = dichotomous measure. b = Item has not been reversed and reflects medical trust. c = One-item measure.

Table 3. Unstandardised coefficients for the revised models including and excluding past behaviour predicting intended and actual discussion of organ donation wishes

	Estimate	Standard Error	Two-tailed <i>p</i> value	95% Lower CI	95% Upper CI
Final model without past behaviour^a					
Self efficacy on:					
Bodily integrity	-0.033	0.069	0.638	-0.168	0.103
Not really dead	-0.017	0.056	0.755	-0.126	0.092
Discussion anxiety	-0.488	0.068	< 0.001	-0.621	-0.355
Attitude	0.387	0.051	< 0.001	0.286	0.488
Intention on:					
Family communication	0.057	0.093	0.540	-0.126	0.240
Disgust	-0.004	0.120	0.973	-0.240	0.231
Medical mistrust	-0.148	0.095	0.119	-0.335	0.038
Discussion anxiety	0.136	0.104	0.192	-0.068	0.334
Attitude	0.204	0.087	0.019	0.033	0.376
Subjective norm	0.479	0.128	< 0.001	0.228	0.729
Self-efficacy	0.525	0.088	< 0.001	0.352	0.697
Behaviour on:					
Intention	0.521	0.181	0.004	0.166	0.877
Self-efficacy	0.096	0.263	0.715	-0.420	0.612
Family communication	0.178	0.198	0.370	-0.210	0.566

	Estimate	Standard Error	Two-tailed <i>p</i> value	95% Lower CI	95% Upper CI
Discussion anxiety	0.312	0.244	0.201	-0.166	0.790
Final model with past behaviour^b					
Self-efficacy on:					
Bodily integrity	0.006	0.069	0.928	-0.130	0.142
Not really dead	0.003	0.055	0.953	-0.104	0.110
Discussion anxiety	-0.498	0.071	< 0.001	-0.637	-0.359
Attitude	0.381	0.052	< 0.001	0.279	0.483
Intention on:					
Family communication	0.061	0.092	0.506	-0.119	0.242
Disgust	-0.041	0.116	0.721	-0.269	0.186
Medical mistrust	-0.130	0.091	0.156	-0.309	0.049
Discussion anxiety	0.100	0.113	0.376	-0.121	0.320
Attitude	0.225	0.088	0.010	0.053	0.397
Subjective norm	0.334	0.139	0.017	0.061	0.607
Self-efficacy	0.470	0.085	< 0.001	0.304	0.635
Past behaviour	0.383	0.186	0.039	0.020	0.747
Behaviour on:					
Intention	0.366	0.167	0.028	-0.040	0.693
Self-efficacy	-0.008	0.230	0.972	-0.460	0.444

	Estimate	Standard Error	Two-tailed <i>p</i> value	95% Lower CI	95% Upper CI
Family communication	0.235	0.217	0.280	-0.191	0.660
Discussion anxiety	0.220	0.257	0.391	-0.283	0.724
Past behaviour	1.120	0.348	0.001	0.438	1.802

CI = Confidence interval.

^a Final revised model: $\chi^2(12) = 13.64$, $p = 0.324$, CFI = 0.988, TLI = 0.973, RMSEA = 0.035 (90% CI = 0.00, 0.106), SRMR = 0.163.

^b Final revised model: $\chi^2(13) = 13.66$, $p = 0.398$, CFI = 0.995, TLI = 0.988, RMSEA = 0.021 (90% CI = 0.00, 0.098), SRMR = 0.159.