Running Head: LOVE THY NEIGHBOR

"Love Thy Neighbor": Religiosity and Compassionate Love in a Sample of Older Hospice Patients, Nursing Home Residents, and Community-Dwelling Adults

Monika Ardelt, Ph.D.

University of Florida

*The research was supported by a Brookdale National Fellowship, a grant from NIH/NIA (R03 AG14855-01), the University of Florida Center for Spirituality and Health, and a Research Initiation Project Award from the College of Liberal Arts and Sciences at the University of Florida. Special thanks go to Carla Edwards, Cynthia Koenig, Dacia Caglin, Anna Campbell, Cathy Campbell, Mark Cohan, Heather Spring, Elizabeth Brown, Jen Crick, Rosina Everitte, Dana Federici, Nicolette Fertakis, Stephen Mayer, Amy Monk, Leah M. Polkowski, Brad Tripp, and Adeen Woolverton for their help at various stages of the research project and to the research participants for their time and commitment to the study. The paper was prepared for a conference entitled Works of Love: Scientific and Religious Perspectives on Altruism, May 31-June 5, 2003, hosted by the Institute for Research on Unlimited Love and the Metanexus Institute, Villanova University, Philadelphia, PA. Correspondence concerning this article should be addressed to Monika Ardelt, University of Florida, Department of Sociology, P.O. Box 117330, Gainesville, FL 32611-7330. E-mail: ardelt@soc.ufl.edu.

"Love Thy Neighbor": Religiosity and Compassionate Love in a Sample of Older Hospice Patients, Nursing Home Residents, and Community-Dwelling Adults

Abstract

All major world religions consider compassionate love as one of the most critical elements of the path to salvation. Hence, people who belong to a religious group should have more love for others than should those without a religious affiliation. Yet, the emergence of compassionate love might also require an intrinsic rather than an extrinsic religious orientation. Compassionate love and intrinsic religiosity, in turn, might increase subjective well-being and decrease fear of death, particularly at the end of life. Using a sample of 164 older hospice patients, nursing home residents, and community dwelling adults (age 58+) from North Central Florida, bivariate and multivariate regression analyses revealed that respondents with a religious affiliation did not tend to score significantly higher on compassionate love than did respondents without a religious affiliation, and there was no significant difference in compassionate love between respondents from different religious denominations. Moreover, only intrinsic religiosity tended to have a positive effect on compassionate love. Both, in turn, were positively correlated with subjective well-being, and compassionate love was negatively related to fear of death. Extrinsic religious orientation, by contrast, had opposite effects. This might explain why religious affiliation in itself is unrelated to compassionate love, subjective well-being, and fear of death. Two case studies of two female nursing home residents (ages 66 and 73) illustrate the association between religiosity, compassionate love, subjective well-being, and fear of death.

All major world religions consider compassionate love, which can be defined as sympathetic concern for others and a desire to secure their happiness and welfare without expecting anything in return, as one of the most critical elements of the path to salvation or enlightenment (Habito, 2002; Post, 2002). Hence, people who belong to a religious group should have more compassionate love for others than should those without a religious affiliation (Hendrick & Hendrick, 1987). For example, in a study by Hendrick and Hendrick (1987), religious college students were more likely to endorse compassionate and altruistic love than were antireligious students. Yet, religious affiliation by itself might not be enough for the emergence of compassionate love. Compassionate love might only grow through a spiritual orientation toward the divine, that is, it might require an intrinsic rather than an extrinsic religious orientation (Chau, Johnson, Bowers, & Darvill, 1990; Leak, 1993). Chau and colleagues (Chau, Johnson, Bowers, & Darvill, 1990) found that intrinsic rather than extrinsic religiosity was positively correlated with altruism, and Leak (1993) reported that intrinsic religious orientation was positively related to compassionate love. According to Allport and Ross (1967, p. 434), "… the extrinsically motivated person uses his religion, whereas the intrinsically motivated lives his religion" (emphasis in the original). Spiritual or intrinsic religiosity consists of a commitment of one's life to God or a higher power (Allport & Ross, 1967). Extrinsic religiosity, by contrast, is more self-oriented. It is a "religion of comfort and social convention, a self-serving, instrumental approach shaped to suit oneself" (Donahue, 1985, p. 400).

Due to a reduction in self-centeredness and its corresponding negative affects, such as jealousy, greed, anger, and hatred, individuals' compassionate love and religious spirituality might increase their subjective well-being and decrease their fear of death, particularly at the end of life (Augustine & Kalish, 1975; Chau, Johnson, Bowers, & Darvill, 1990). Using a sample of 164 older hospice patients, nursing home residents, and community dwelling adults (age 58+) from North Central Florida, the following hypotheses are tested:

(1) Respondents with a religious affiliation tend to score higher on compassionate love than do those without a religious affiliation.

(2) However, no difference in compassionate love is expected between respondents from different religious denominations.

(3) Religious spirituality (i.e., an intrinsic religious orientation) is positively related to compassionate love. By contrast, an extrinsic religious orientation is unrelated or might even be negatively related to compassionate love due to its self-centered focus on religion.

(4) Compassionate love and religious spirituality have a positive effect on respondents' subjective well-being and a negative effect on their fear of death. An extrinsic religious orientation and religious affiliation are not expected to increase respondents' subjective well-being or to decrease their fear of death.

Methods

Procedure

Community-Dwelling Residents. Data collection for community-dwelling older residents initially took place between December 1997 and June 1998. Respondents were recruited from 18 close-knit social groups of older adults located in North Central Florida. Group members who volunteered for a "Personality and Aging Well Study" were visited at home by a member of the research team who delivered and explained the self-administered questionnaire. The research team member also offered to conduct the interview if the respondent needed assistance in completing the survey. Ten respondents accepted this offer. All other 170 questionnaires were returned by mail in stamped, pre-addressed envelopes.

Ten months after the initial interview, all respondents with known addresses were contacted by mail for a follow-up survey that also contained questions on religiosity and death attitudes. Participants who did not return the second questionnaire within two to three weeks were called by phone to remind them of the survey and to ask whether they needed assistance in filling out the questionnaire. Ultimately 123 respondents or about 70% of the initial sample with known addresses returned the follow-up survey. For the purpose of the present study, two community-dwelling respondents below the age of 58 at the

time of the follow-up survey were excluded from the analyses to make the sample compatible with the age range of hospice patients and nursing home residents. All data for community-dwelling adults were taken from the follow-up survey with the exception of the demographic variables.

Hospice Patients and Nursing Home Residents. Older hospice patients and nursing home residents were recruited through the local Hospice organization and local nursing homes, respectively, between August 1999 and September 2001. To received hospice care, a patient usually has a predicted life expectancy of six months or less. Thirty hospice patients and 27 nursing home residents participated in a study that consisted of qualitative and quantitative face-to-face interviews on "Aging and Dying Well." However, some of the hospice patients and nursing home residents were unable or unwilling to take part in the quantitative interview. Hence, the quantitative sample contains only the 20 hospice patients and 23 nursing home residents with completed quantitative questionnaires.

Sample

The sample consists of 164 White and African American older adults, ranging in age from 58 to 98 years with a mean and a median age of 74 years. Sixty-seven percent of the respondents are women, 77% are white, and 50% are married. Eighty-five percent of the respondents have a high school diploma and 26% have a graduate degree. Eighty-six percent of the adults in the sample are affiliated with a religious group.

There are no significant difference in age, gender, race, marital status, educational degree, and religious affiliation between hospice patients and nursing home residents at the .05 significance level. However, community-dwelling respondents are significantly more likely than are hospice patients to be younger and female. In addition, community respondents are more likely to be married and tend to possess higher educational degrees than do nursing home residents.

Measures

Compassionate love is measured by the affective dimension of the Three-Dimensional Wisdom Scale (Ardelt, 2003), which assesses compassionate love and concern for others. It is the average of 13 items (e.g., Sometimes I feel a real compassion for everyone. If I see people in need, I try to help them

one way or another. It's not really my problem if others are in trouble and need help.), measured on one of two 5-point scales and ranging either from 1 (definitely true of myself) through 5 (not true of myself) or from 1 (strongly agree) through 5 (strongly disagree). The scale of the positively worded items was reversed before the average of the items was taken. The reliability coefficient Cronbach's alpha is .69.

Religiousity. Religious spirituality is measured by one factor of the Spiritual Involvement and Beliefs Scale (Hatch, Burg, Naberhaus, & Hellmich, 1998). The factor is the mean of 13 items that assess the centrality of religious spirituality in a person's life through attitudes and behaviors (e.g., A spiritual force influences the events in my life. My spiritual life fulfills me in ways that material possessions do not.).[1] Ten of the 13 items are measured on a Likert scale ranging from 1 (strongly agree) through 5 (strongly disagree). The remaining three items are also assessed on 5-point scales: problem solving without using spiritual resources (1 = always; 5 = never); frequency of weekly prayer (1 = 10 or more times; 5 = 0 times); and frequency of monthly participation in spiritual activities with at least one other person (1= more than 15 times; 5 = 0 times). Before computing the average of the items, the scale of some of the items was reversed so that higher scores reflect a higher religious spirituality. Cronbach's alpha is .92 for the scale. Extrinsic religious orientation is assessed by Allport and Ross' (1967) Extrinsic Religious Orientation Scale. The scale is the average of 11 items (e.g., A primary reason for my interest in religion is that my church is a congenial social activity. Although I am a religious person, I refuse to let religious considerations influence everyday affairs.) with an alpha of .84. All items are measured on a 1 (strongly agree) through 5 (strongly disagree) Likert scale, which was reversed for all items. In addition, respondents were asked about their religious affiliation to obtain religious affiliation (1 = yes; 0 = no) and denomination.

Subjective well-being is measured by the two items of the life satisfaction subscale (e.g., "How happy , satisfied, or pleased have you been with your personal life during the past month?" ranging from 1 = "very dissatisfied" through 6 = "extremely happy") and the four items of the cheerfulness subscale (e.g., "How have you been feeling in general during the past month?" ranging from 1 = "in very low spirits" through 6 = "in excellent spirits") of the NCHS General Well-Being Schedule (Fazio, 1977). Five

of the six items are assessed on 6-point scales and one item is measured on a 0-10 interval scale. All scales are transformed into 0-5 scales and the scales of the negatively worded items are reversed before the average of all six items was taken. The combined scale has a Cronbach's alpha value of .88.

Fear of death was assessed by one factor of the Death Attitude Profile–Revised (Wong, Reker, & Gesser, 1994). It is the average of seven items (e.g., I have an intense fear of death. Death is no doubt a grim experience.) with an alpha-value of .85. The scale of the items ranges from 1 (strongly agree) through 5 (strongly disagree), which was reversed for all items.

Control variables are gender, race, age, SES, health concern, expected closeness of death (hospice patient), and nursing home residency.[2] Gender, race, and being a hospice patient or nursing home resident are coded as dichotomous variables. Age is assessed in years. Socioeconomic Status (SES) is the average of longest held occupation and educational degree. Longest held occupation was coded by three raters using Hollingshead's Index of Occupations (O'Rand, 1982). At least two raters discussed and jointly decided all ratings for occupations whose code designation was not clear. The scale ranges from 1 (farm laborers, mental service workers) through 9 (higher executive, large business owner, major professional). Educational degree ranges from 0 (no high school) through 4 (graduate degree). It was first transformed into a 1-9 scale before it was averaged with occupation. For respondents without an occupation, SES reflects their educational degree. Health concern is measured by another subscale of the NCHS General Well-Being Schedule (Fazio, 1977). The two items of that subscale assess health concern, worries, or distress ("Have you been bothered by any illness, bodily disorder, pains, or fears about your health?" ranging from 1 = "all the time" through 6 = "none of the time" and "How concerned or worried about your health have you been" ranging from 0 = "not concerned at all" through 10 = "very concerned"). Both scales were transformed into 0-5 scales and the scale of the first item was reversed before the average of the two items was computed. Cronbach's alpha is .75 for the two items.

Analysis

A t-test is used to test Hypothesis 1, and an analysis of variance (ANOVA) is performed to test Hypotheses 2. Hypotheses 3 and 4 are tested through bivariate and multivariate regression analyses. To

illustrate the results of the quantitative analyses in greater detail, the qualitative interviews of two female nursing home residents (ages 73 and 66) are analyzed and compared. The women were asked about their religion and spirituality, their attitudes about death and dying, and the good and bad things in their lives. The method of objective hermeneutics (Flick, 2002; Gerhardt, 1988; Oevermann, 1983; Oevermann, Allert, Konau, & Krambeck, 1979) is used to analyze the qualitative interviews. The method consists of a sentence-by-sentence analysis of the interview and the invention of as many plausible "stories" as possible about the statement and the determination of the common structural characteristics of those constructions. Those structural characteristics are compared to the next statement of the respondent and all constructions that do not fit are excluded. The second statement of the respondent is analyzed in the same way as the first statement, but now the general structural characteristics that emerged from the first step are taken into account. Constructions that do not make sense again are rejected and the third statement is analyzed, etc. This sequential structural analysis procedure leads to a systematic exclusion of meaningful explanations and to the appearance of a general (latent) structure of the case under investigation. The case specific structure emerges when the same possibilities are systematically excluded repeatedly. A team of three to four researchers analyzed the first interview. The second interview was analyzed by the author and in part by another researcher.

Results

As Table 1 shows, respondents with a religious affiliation do not tend to score significantly higher on compassionate love than do respondents without a religious affiliation. The t-value of -.85 is not statistically significant ($p = .40$). Hence, Hypothesis 1 is rejected. However, as predicted in Hypothesis 2, there are no significant differences in compassionate love between respondents from different religious denominations (see Table 2). The F-score of the ANOVA analysis is .29, which is not statistically significant ($p = .88$).

--- Tables 1 and 2 about here ---

As expected in Hypothesis 3, religious spirituality is positively related to compassionate love in both the bivariate and multivariate regression analyses ($r = .36$, $p < .001$; $\beta = .19$, $p = .048$) and extrinsic religious orientation is negatively related to compassionate love ($r = -.27$, $p = .001$; $\beta = -.21$, $p = .030$). Interestingly, religious affiliation per se is unrelated to compassionate love, even after controlling for religious spirituality, extrinsic religious orientation, demographic characteristics, and health concern (see Tables 3 and 4). Almost all of the control variables have a significant effect on compassionate love in the multivariate regression analysis in Table 4. Women ($r = .29$, $p < .001$; $\beta = .18$, $p = .021$), African Americans ($\beta = -.18$, $p = .030$), and hospice patients ($\beta = .17$, $p = .037$) tend to score higher on compassionate love than do men, Whites, and community-dwelling adults. Age ($r = -.27$, $p = .001$; $\beta = -.16$, $p = .044$) and health concern ($r = -.25$, $p = .001$; $\beta = -.16$, $p = .037$) are negatively related and socioeconomic status ($\beta = .15$, $p = .059$) is positively related to compassionate love. The variables in Table 4 are able to explain 24% of the variation in compassionate love.

--- Tables 3 and 4 about here ---

As predicted in Hypothesis 4, compassionate love tends to have a positive effect on subjective well-being ($r = .38$, $p < .001$; $\beta = .26$, $p < .001$) and a negative effect on fear of death ($r = -.24$, $p = .002$; $\beta = -.17$, $p = .056$), even after controlling for the other variables in the model (see Tables 3 and 5). Religious spirituality is positively correlated with subjective well-being in the bivariate regression analysis ($r = .28$, $p < .001$) but not in the multivariate regression model. Contrary to Hypothesis 4, it is unrelated to fear of death. As expected, extrinsic religious orientation does not increase respondents' subjective well-being or decrease their fear of death. In fact, an extrinsic religious orientation is negatively related to subjective well-being ($r = -.26$, $p = .001$) and positively related to fear of death ($r = .43$, $p < .001$; $\beta = .32$, $p = .001$), although the effect on well-being is not significant in the multivariate regression analysis. Finally and as stated in Hypothesis 4, religious affiliation is unrelated to subjective well-being and fear of death in the bivariate analyses. Yet, contrary to predictions, religious affiliation

tends to have a positive effect on subjective well-being (β = .12, p = .081) and fear of death (β = .23, p = .013) in the multivariate analyses after controlling for the other variables in the model.

--- Table 5 about here ---

Not surprisingly, being concerned about one's health has a negative effect on subjective well-being (r = -.57, p < .001; β = -.39, p < .001), and hospice patients (r = -.27, p < .001; β = -.28, p < .001) and nursing home residents (r = -.40, p < .001; β = -.38, p < .001) tend to score lower on subjective well-being than do community-dwelling adults, even after controlling for the other variables in the model. However, hospice patients and nursing home residents are not more likely to be afraid of death than are community-dwelling adults if the effects of the other variables in Table 5 are taken into account. Among the control variables in Table 5, only health concern (r = .26, p < .001; β = .16, p = .052) and gender are positively related to fear of death, with a tendency of women to score higher than do men (β = .15, p = .061). Overall, 51% of the variation in subjective well-being and 22% of the variation in subjective health can be explained by the independent variables in Table 5.

Illustrative Case Studies

To illustrate the association between religiosity, compassionate love, subjective well-being, and fear of death the following case studies of two female nursing home residents are compared.

Case Study 1: Ruth

Ruth[3] is a 73 year-old white nursing home resident who has never been married, has no children, and has been living in nursing homes for the last four years. Ruth is very thin and has malformed hands and feet. The malformations are the result of rheumatoid arthritis, which started five years ago. Due to her illness, she is in pain all the time, which is not completely controlled by the nursing home staff, although she continually wears a patch that delivers pain medication. Ruth scored 3.15 on religious spirituality, 3.36 on extrinsic religious orientation, 2.92 on compassionate love, and the maximum of 5.00 on fear of

death. All those scales range from 1 through 5, with 3 being the neutral midpoint. Ruth obtained a score of only .33 on subjective well-being, which ranges from 0 through 5.

When I ask Ruth about her religion and spirituality, she starts to cry. She feels that God has deserted her. She sees no reason for her suffering and cannot understand why God allows her to suffer. She says,

> Well, I was very much of a believer until all my sicknesses have been piled on me. And now I've become a doubter. [Tell me how this happened? … What did you believe in?] Well, I believed in a very present God and I believed and still believe in miracles, but I haven't experienced anything in this sickness that I feel is spiritual. I've lost a lot of my feeling about it. But I've had some good illnesses over a period of years that you could say were like miracles. I healed very fast, faster than the doctors thought I would, that kind of thing, you know.

Ruth is a "fair weather" believer. As long as things were good or at least turned out all right quickly after bad things happened, such as her previous illnesses, she believed in the presence of God. God has to perform a miracle and heal her to prove that He cares for her. She does not ask, what can I do to get closer to God or to live a more God-centered life (the intrinsic aspect of religiosity), but she tells God what He can do for her to become a believer again. She uses her religiosity as a means to a different end, in this case to become healthy again, which is the characteristic of an extrinsic religious orientation. As long as God does not physically heal her, she rejects him.

Case Study 2: Letitia

Letitia is a widowed 66 year-old African American nursing home residents who has five children. She has been paralyzed from the neck down for the last 25 years and has been living in the same nursing home for the last 17 years. Twenty-five years ago, Letitia was hit by a drunk driver shortly before Christmas, which first left her in a coma for two weeks and then paralyzed ever since. Letitia's scores on the 1 through 5-point scales (midpoint = 3.00) are 4.77 on religious spirituality, 2.82 on extrinsic religious

orientation, 4.38 on compassionate love, and 2.14 on fear of death. Her score on the 0-5 subjective well-being scale is 3.33, which is above the midpoint of 2.50.

When I ask her about her religion or spirituality, she responds as follows:

> I'm a believer. I believe there's a God. I believe, I know that, I'm certain of His existence. God is love, and that's the one thing I try to show every day of my life. I try to talk in love and show love in my actions, helping people. I know that He is my source of healing. I do believe that He is the reason that I have managed to be as long as I have, because I've been awful sick 25 years and I've been hurt with all different conditions.

Letitia is the opposite of Ruth. Both are in a nursing home and both are stricken by a condition that makes them helpless and dependent on others. Yet, Letitia has experienced God's love in her suffering, while Ruth is waiting for a miracle of physical healing to occur before she is willing to acknowledge God's presence for her again. Moreover, Letitia continues to serve God and to live a God-centered life by loving and helping others through her words and actions despite being a quadriplegic. Whereas Ruth is waiting for God, Letitia has found Him and gives his love back to the world.

Conclusion

In this sample of older hospice patients, nursing home residents, and community-dwelling adults only the spiritual/intrinsic aspect of religiosity tends to have a positive effect on compassionate love. Both, in turn, are positively correlated with subjective well-being, and compassionate love is negatively related to fear of death. Extrinsic religious orientation, by contrast, has opposite effects. It is negatively correlated with subjective well-being and positively related to fear of death. This might explain why religious affiliation in itself is unrelated to compassionate love, subjective well-being, and fear of death. Yet, after controlling for the other variables in Table 5, religious affiliation has a positive effect on subjective well-being and, surprisingly, also fear of death. It might be that people who do not necessarily

live a God-centered life but are exposed to religious doctrine and dogma through church are more afraid of death and an afterlife because they are aware of the possibly negative consequences of their life style.

One word of caution: Intrinsic religiosity is not automatically beneficial (see 9-11, fanatic cult members, etc.) and does not automatically lead to compassionate love for all beings, rather than just in-group members. Still, the present study suggests that compassionate love is more likely to develop in people with a spiritual and intrinsic religious orientation but less likely in those with an extrinsic religious orientation. This means that going to church and following religious rites and rituals is not enough for compassionate love to grow. Without a commitment to a God-centered or spiritual life, compassionate love will not flourish in a religious person.

Endnotes

[1] Religious spirituality correlates .84 ($p < .01$) with Allport and Ross' (1967) Intrinsic Religious Orientation Scale. However, the religious spirituality scale used in this research has the advantage that it is less Christian-centered and more spirituality oriented than the Intrinsic Religious Orientation Scale.

[2] Marital status was also initially included in the analyses, but had no statistical significant effect on the dependent variables in the model.

[3] All names are pseudonyms.

References

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. Journal of Personality and Social Psychology, 5, 432-443.

Ardelt, M. (2003). Empirical assessment of a three-dimensional wisdom scale. Research on Aging, 25, 275-324.

Augustine, M. J., & Kalish, R. A. (1975). Religion, transcendence, and appropriate death. Journal of Transpersonal Psychology, 7, 1-13.

Chau, L. L., Johnson, R. C., Bowers, J. K., & Darvill, T. J. (1990). Intrinsic and extrinsic religiosity as related to conscience, adjustment, and altruism. Personality and Individual Differences, 11, 397-400.

Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. Journal of Personality and Social Psychology, 48, 400-419.

Fazio, A. F. (1977). A concurrent validation study of the NCHS General Well-Being Schedule. (Dept. of HEW Publ. No. HRA-78-1347). Hyattsville, MD: National Center for Health Statistics.

Flick, U. (2002). Qualitative research - state of the art. Social Science Information, 41, 5-24.

Gerhardt, U. (1988). Qualitative sociology in the Federal Republic of Germany. Qualitative Sociology, 11, 29-43.

Habito, R. L. F. (2002). Compassion out of wisdom: Buddhist perspectives from the past toward the human future. In S. G. Post, L. G. Underwood, J. P. Schloss, & W. B. Hurlbut (Eds.), Altruism & altruistic love: Science, philosophy, & religion in dialogue (pp. 362-374). London: Oxford University Press.

Hatch, R. L., Burg, M. A., Naberhaus, D. S., & Hellmich, L. K. (1998). The Spiritual Involvement and Beliefs Scale. Development and testing of a new instrument. The Journal of Family Practice, 46, 476-486.

Hendrick, S. S., & Hendrick, C. (1987). Love and sex attitudes and religious beliefs. Journal of Social and Clinical Psychology, 5, 391-398.

Leak, G. K. (1993). Relationship between religious orientation and love styles, sexual attitudes, and sexual behaviors. Journal of Psychology and Theology, 21, 315-318.

Oevermann, U. (1983). Zur Sache. Die Bedeutung von Adornos methodologischem Selbstverstaendnis für die Begruendung einer materialen soziologischen Strukturanalyse [The significance of Adorno's methodological understanding for the justification of a material sociological structural analysis]. In L. Friedeburg & J. Habermas (Eds.), Adorno-Konferenz [Adorno conference] (pp. 234-289). Frankfurt/Main: Suhrkamp.

Oevermann, U., Allert, T., Konau, E., & Krambeck, J. (1979). Die Methodologie einer "objectiven Hermeneutik" und ihre allgemeine forschungslogische Bedeutung in den Sozialwissenschaften [The method of "objective hermeneutics" and its general meaning in the research logic of the social sciences]. In H. G. Soeffner (Ed.), Interpretative Verfahren in der Soziology [Interpretative methods in sociology] (pp. 352-434). Stuttgart: Metzler.

O'Rand, A. M. (1982). Socioeconomic status and poverty. In D. J. Mangen & W. A. Peterson (Eds.), Research instruments in social gerontology (Vol. 2. Social roles and social participation, pp. 281-341). Minneapolis: University of Minnesota Press.

Post, S. G. (2002). The tradition of agape. In S. G. Post, L. G. Underwood, J. P. Schloss, & W. B. Hurlbut (Eds.), Altruism & altruistic love: Science, philosophy, & religion in dialogue (pp. 51-64). London: Oxford University Press.

Wong, P. T. P., Reker, G. T., & Gesser, G. (1994). Death Attitude Profile-Revised: A multidimensional measure of attitudes toward death. In R. A. Neimeyer (Ed.), Death anxiety handbook. Research, instrumentation, and application (pp. 121-148). Washington, DC: Taylor & Francis.

Table 1: Mean Differences in Compassionate Love by Religious Affiliations; T-Test Analysis

	Compassionate Love		
Religious Affiliation	Mean	s	n
No	3.31	.51	23
Yes	3.41	.53	141
t-value		-.85	
df		162	
p		.40	

Table 2: Mean Differences in Compassionate Love by Religious Denomination; ANOVA Analysis

	Compassionate Love		
Religious Denomination	Mean	s	n
Baptist	3.35	.60	51
Methodist	3.47	.43	31
Other Protestant group	3.42	.50	34
Catholic	3.44	.45	13
Other	3.46	.45	12
F score		.29	
df		4,136	
p		.88	

Table 3: Correlation Matrix of Dependent, Independent, and Control Variables; pairwise deletion of cases

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	Mean	s	n
(1) Compassionate love	-												3.40	.51	16
(2) Religious spirituality	.36**	-											3.80	.79	15
(3) Extrinsic religiosity	-.27**	-.31**	-										2.96	.80	16
(4) Religious affiliation (1=yes)	.07	.53**	-.03	-									.86	.35	16
(5) Subjective well-being	.38**	.28**	-.26**	.05	-								3.68	.92	16
(6) Fear of death	-.24**	-.14	.43**	.12	-.37**	-							2.45	.84	16
Control Variables															
(7) Gender (1 = female)	.29**	.34**	-.19*	.16*	.08	.06	-						.66	.47	16
(8) Race (1 = white)	-.15	-.15	-.32**	-.13	-.01	-.19*	-.01	-					.78	.42	16
(9) Age	-.27**	-.18*	.27**	.01	-.19*	.06	-.11	.20*	-				74.43	8.25	16
(10) Socioeconomic status	.12	-.10	-.22**	-.07	.18*	-.19*	-.15	.13	.00	-			5.36	2.46	16
(11) Health concern	-.25**	-.26**	.26**	-.03	-.57**	.26**	-.12	-.07	.15	-.05	-		3.03	1.36	16
(12) Hospice patient (1=y)	-.10	-.17*	.29**	.10	-.27**	.05	-.21**	.06	.27**	-.08	.17*	-	.12	.33	16
(13) Nursing home resident (1=yes)	-.08	-.01	.18*	.11	-.40**	.17*	-.01	-.17*	.02	-.29**	.16*	-.15	.14	.35	16

** $p < 0.01$, * $p < 0.05$

Table 4: Effects of Religiosity on Compassionate Love; Multiple OLS Regression Analyses with Selected Controls

	Compassionate Love	
Independent Variables	b	beta
Religious spirituality	.13	.19**
Extrinsic religiosity	-.13	-.21**
Religious affiliation (1=yes)	-.11	-.07
Controls		
Gender (1=female)	.20	.18**
Race (1=white)	-.22	-.18**
Age	-.01	-.16**
Socioeconomic status	.03	.15*
Health concern	-.06	-.16**
Hospice patient (1=yes)	.26	.17**
Nursing home resident (1=yes)	.07	.05
Adjusted R^2	.24	
n	148	

*** p < 0.01; ** p < 0.05; * p < .10

Table 5: Effects of Compassionate Love and Religiosity on Subjective Well-Being and Fear of Death; Multiple OLS Regression Analyses with Selected Controls

	Subjective Well-Being		Fear of Death	
Independent Variables	b	beta	b	beta
Compassionate love	.48	.26***	-.27	-.17*
Religious spirituality	.03	.03	-.15	-.14
Extrinsic religiosity	.09	.08	.34	.32***
Religious affiliation (1=yes)	.38	.12*	.62	.23**
Controls				
Gender (1=female)	-.18	-.09	.27	.15*
Race (1=white)	-.04	-.02	-.10	-.05
Age	-.00	-.01	-.01	-.09
Socioeconomic status	.01	.04	-.02	-.06
Health concern	-.26	-.39***	.09	.16*
Hospice patient (1=yes)	-.77	-.28***	-.15	-.06
Nursing home resident (1=y)	-.98	-.38***	.07	.03
Adjusted R^2	.51		.22	
n	148		148	

*** p < 0.01; ** p < 0.05; * p < .10