Exploring the Role of Religious Doctrine in Shaping Perception and Well-Being Among Elderly Recipients of Spiritual and Existential Care in Liberia and Sierra Leone

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ABSTRACT

Population ageing has increased the need for holistic approaches to elderly care that address not only physical health but also spiritual and existential well-being. This study explored the role of religious doctrine in shaping perceptions and well-being among elderly recipients of spiritual and existential care in Monrovia, Liberia, and Freetown, Sierra Leone. Guided by an interpretivist paradigm, the study employed a comparative qualitative design involving in-depth interviews and focus group discussions. Sixty participants, comprising elderly people, religious leaders, professional caregivers, and family caregivers, were purposively selected based on their involvement in spiritual and existential care. Data were analyzed using thematic analysis. Five major themes emerged: existential concerns framed through religious doctrine; the conflation of spiritual and existential care; religious doctrine as a source of meaning-making and resilience; the predominance of prayer-centered care over emotional engagement; and the dual influence of doctrine on well-being. Findings indicate that religious beliefs provide many elderly individuals with hope, purpose, emotional stability, and acceptance of mortality. However, certain doctrinal interpretations, particularly those associated with divine punishment, may contribute to anxiety and existential distress. The study concludes that religious institutions function as informal but significant providers of palliative and existential support in both countries. Strengthening collaboration between faith-based organizations, healthcare providers, and social welfare systems could enhance the delivery of culturally appropriate and holistic care for older adults in West Africa.

Keywords: Religious doctrine, existential care, spiritual care, elderly well-being, ageing, palliative care, Liberia, Sierra Leone.

INTRODUCTION

Ageing is a universal, multidimensional human experience that unfolds across biological, psychological, social, and existential domains. As individuals approach the end of life, their needs extend beyond symptom control to include emotional reassurance, spiritual meaning-making, relational connectedness, and moral reconciliation. Contemporary palliative care scholarship increasingly recognizes that alleviating physical pain alone is insufficient to preserve dignity at the end of life; quality care requires deliberate engagement with psychosocial, spiritual, and existential domains (Akdeniz et al., 2021; Puchalski et al., 2014). The World Health Organization estimates that more than 56 million people worldwide require palliative care each year, yet a substantial proportion, particularly in low- and middle-income countries, lacks access to comprehensive services (World Health Organization, 2020). This disparity underscores the need to examine context-specific models of elder care in structurally fragile environments such as Liberia and Sierra Leone.

In high-income settings, hospice and palliative care have evolved into structured, multidisciplinary systems in which existential care and support addressing meaning, purpose, legacy, reconciliation, and fear of death as a

central pillar of holistic practice (Boston et al., 2011; Tornøe et al., 2015). Interventions such as dignity therapy and life-review therapy are widely used to help older adults achieve ego integrity rather than despair, as theorized by Erikson (1959). However, much of this literature remains grounded in Western institutional infrastructures and individualistic cultural paradigms, leaving the transferability of such models to communitarian African contexts underexplored.

In Liberia and Sierra Leone, end-of-life care is predominantly informal, family-centered, and religiously mediated rather than institutionally structured. Extended family systems have historically functioned as primary caregiving institutions, with elders occupying esteemed positions as custodians of wisdom and cultural continuity (Gyekye, 1996; Mbiti, 2015). Yet socio-economic transformation, urbanization, labor migration, and post-conflict reconstruction have strained these traditional arrangements, leaving many older adults vulnerable to isolation and inadequate support (Bangura, 2016; Nouvet et al., 2021). Spirituality remains a central organizing framework in both countries: Christianity and Islam, alongside African Traditional Religion, shape cultural interpretations of suffering, illness, and mortality (Conteh, 2009; Keskinoğlu & Ekşi, 2019). Religious coping theory holds that faith traditions provide interpretive frameworks through which individuals construct meaning during crisis; positive religious coping can cultivate hope and resilience, while negative religious interpretations such as viewing illness as divine punishment may exacerbate existential anxiety (Pargament & Park, 2019).

Statement of the Problem

Although religion and spirituality play a central role in shaping meaning, resilience, and coping among older adults in Liberia and Sierra Leone, there is a notable lack of systematic documentation of how religious doctrine translates into the perception and well-being of elderly persons receiving spiritual and existential care. Elderly individuals in both countries frequently rely on informal faith-based or family care systems for comfort and hope during the end-of-life stage; however, these systems are fragmented, unregulated, and seldom aligned with professional social work or national health policy. The lack of structured collaboration among healthcare providers, social workers, and faith institutions increases the vulnerability of older people to loneliness and unaddressed existential distress, particularly where spiritual needs are integral to emotional well-being (Best et al., 2020; Puchalski et al., 2014).

Theoretical frameworks such as Pargament's (1997) theory of religious coping and Erikson's (1950) psychosocial model emphasize the role of spiritual and existential beliefs in old age as vehicles of integrity and meaning, while Maslow's hierarchy of needs places self-transcendence at the apex of human motivation. Yet little empirical research has explored how these frameworks find practical expression in culturally informed caregiving practices in African religious and cultural traditions. Studies confirming the efficacy of faith-based spiritual interventions for the terminally ill and elderly (Koenig, 2020; VanderWeele, 2017) are rarely applied within African contexts, where palliative and geriatric scholarship instead privileges biomedical and economic frameworks imported from Western societies. Recent evidence from palliative care systems in low-resource settings further highlights the importance of integrating spiritual support within health services (Knaul et al., 2022; Stephens & Rochmawati, 2022; Zoker & Sundufu, 2022).

There is little empirical evidence on how religious doctrine, as distinct from religious institutional presence, shapes elderly people’s perception of their circumstances and their subjective well-being in the socio-cultural settings of Monrovia and Freetown. It remains unclear whether doctrinal framing predominantly functions as a psychological resource that fosters hope and acceptance, or whether it can also become a source of existential distress when suffering is interpreted through a punitive theological lens. This uncertainty limits the capacity of religious leaders, caregivers, and policymakers to design culturally informed interventions that harness the benefits of religious doctrine while mitigating its potential harms.

METHODOLOGY

Research Design

This study adopted a comparative qualitative research design grounded in an interpretivist paradigm. The design was selected because it enabled an in-depth exploration of how elderly persons and caregivers construct meaning

around ageing, suffering, spirituality, and end-of-life experiences within distinct socio-cultural and religious contexts. The qualitative approach facilitated the examination of lived experiences, beliefs, emotions, and interpretations that could not be adequately captured through quantitative methods (Creswell & Plano Clark, 2018).

Study Area

The research was conducted in Monrovia, Liberia, and Freetown, Sierra Leone. These cities were purposively selected because of their religious diversity, urban population concentration, and limited formal palliative care services. In both contexts, religious institutions play a central role in providing emotional, social, and spiritual support to older adults. Population estimates and contextual demographic characteristics were informed by national census data and reports from the Liberia Institute of Statistics and Geo-Information Services (2022) and the United States Department of State (2022).

Population

Participants comprised elderly persons aged 75 years and above, family caregivers, professional caregivers, Christian clergy, Muslim religious leaders, and traditional spiritual leaders.

Inclusion Criteria

Participants were included if they were:

- Elderly persons aged 75–100 years residing in Monrovia or Freetown and currently receiving, or having recently received, spiritual, existential, or informal palliative support;
- Religious leaders actively engaged in providing spiritual or end-of-life care to elderly persons within Christian, Islamic, or African Traditional Religious communities; or
- professional or family caregivers are directly involved in the daily care of an eligible elderly person.

Exclusion Criteria

Participants were excluded if they:

- Were below the age of 75 and not serving in a caregiving or religious leadership capacity relevant to elderly spiritual care;
- Were healthcare professionals or policymakers whose roles did not directly intersect with spiritual or existential care delivery;
- Practiced religious traditions outside Christianity, Islam, or African Traditional Religion, given the study's thematic delimitation; or
- Were unable or unwilling to provide informed consent.

Sample Size

A total sample of 60 participants was recruited, 30 from Liberia and 30 from Sierra Leone. This sample size was considered adequate for a comparative qualitative study prioritizing information richness and thematic saturation over statistical generalization. The sample was distributed across four stakeholder categories: 20 religious leaders, comprising Muslim clerics and Christian leaders in equal proportion across both countries, 20 elderly individuals, 10 professional/social-work caregivers, and 10 family caregivers.

Sampling Technique

Purposive sampling was employed to identify information-rich participants with direct experience in spiritual and existential care. Sampling continued until thematic saturation was achieved, resulting in sixty participants distributed across the two study sites. The emphasis was not on representativeness but on obtaining diverse

perspectives capable of illuminating the phenomenon under investigation. The sampling strategy is consistent with qualitative inquiry approaches that emphasize information-rich cases (Angrosino, 2007).

Data Collection Instruments and Procedure

Semi-structured interviews allowed participants to narrate personal experiences relating to ageing, suffering, spirituality, death, and caregiving. Focus groups explored shared cultural and religious understandings of existential well-being. Interviews lasted between 45 minutes and were audio-recorded with participants' consent. Field notes were maintained throughout the study to document contextual observations and emerging analytical insights. Field notes and documentary materials were also reviewed to enrich contextual understanding, consistent with document analysis procedures described by Bowen (2009).

The researcher and trained research assistants conducted all face-to-face data collection, accommodating participants with low literacy levels to ensure accuracy and completeness of responses.

Data Analysis

Qualitative data were transcribed verbatim and analyzed using content analysis, involving open coding, categorization, and the development of themes reflecting recurring meanings across the dataset. Atlas.ti software was used to support coding, organization, and retrieval of data.

Data Management

All data were assigned to identification codes at the point of collection; no personal identifiers were retained in interview transcripts. Audio recordings, transcripts, and completed questionnaires were stored securely in password-protected electronic files, with physical materials kept in locked storage accessible only to the research team. Data were used exclusively for the academic purposes of this study and were retained in accordance with African Methodist Episcopal University's data retention policy before secure disposal.

RESULTS

A total of 60 participants took part in the study (30 in Liberia, 30 in Sierra Leone). The qualitative findings presented below correspond to Objective Two of the broader study and address how religious doctrines and practices shape the perception and well-being of elderly persons receiving spiritual and existential care.

Religious Doctrine as the Primary Lens for Understanding Ageing and Mortality

Participants consistently interpreted ageing, illness, and death through religious teachings. Rather than viewing ageing as a biological process, many participants understood it as a spiritual journey toward divine judgment and eternal life.

R: *As I grow older, I think less about sickness and more about whether I have prepared myself to meet God.* (**Elderly participant in Monrovia**)

R: *Old age reminds us that our time is near. We focus on prayer because that is what prepares us for the next life.* (**Elder in Freetown**)

Blurred Boundaries Between Spiritual and Existential Care

Participants rarely distinguish between existential care and spiritual care. Discussions concerning purpose, fear, loneliness, regret, and death were almost always interpreted within religious frameworks.

R: *When an elderly person is worried, we pray. Prayer is the answer because all problems come back to God.* (**A caregiver**)

Religious Beliefs as Sources of Meaning, Hope, and Resilience

Many participants described faith as an essential source of comfort and emotional strength.

R: *When I remember God's promises, I do not fear death anymore. I believe my suffering has meaning*. (**Elderly in Monrovia**)

Religious practices such as prayer, scripture reading, confession, and communal worship were repeatedly described as mechanisms that fostered hope and emotional stability.

Prayer-Centered Care and the Absence of Deeper Emotional Engagement

Although participants appreciated religious support, many expressed a desire for more meaningful conversations regarding fears, regrets, and unresolved life experiences.

R: *People pray for me, but sometimes I just need someone to sit and listen to*. (**Elderly woman in Freetown**)

R: *Religious leaders often pray first. They may not ask what the person is feeling inside*. (**Caregiver in Freetown**)

The Dual Influence of Religious Doctrine on Well-Being

Religious doctrine emerged as both a protective and potentially harmful influence.

Many participants described religion as a source of peace and reassurance:

R: *My faith keeps me calm. I know God is with me*. (**Other participants**)

R: Sometimes elderly people think they are suffering because God is punishing them. (**Other participants).**

DISCUSSION

The findings indicate that religious beliefs serve as the primary framework through which older adults interpret ageing, illness, suffering, and mortality. Consistent with Pargament and Park (2019), participants relied on religious teachings to find meaning, hope, and reassurance when confronting existential concerns related to death and the afterlife. The study further revealed that spiritual care and existential care are largely viewed as synonymous. Most participants addressed existential distress through prayer, worship, and religious counseling, reflecting the central role of faith in West African societies. This finding supports Tornøe et al. (2015), who observed that spiritual and existential dimensions of care are often closely intertwined in end-of-life settings.

Religious doctrine was also found to promote resilience and emotional well-being by fostering acceptance, hope, and inner peace. These findings align with Erikson's (1959) concept of ego integrity and Koenig's (2020) assertion that religiosity contributes positively to psychological well-being among older adults. However, the predominance of prayer-centered interventions often limited deeper exploration of emotional concerns such as loneliness, fear, and regret. Additionally, some participants associated illness and suffering with divine punishment, which heightened anxiety and distress. These findings demonstrate that religious doctrine can function as both a source of comfort and a contributor to existential suffering, depending on how religious teachings are interpreted and applied.

CONCLUSIONS

This study found that religious doctrine plays a central role in shaping how elderly individuals in Liberia and Sierra Leone perceive ageing, illness, suffering, and mortality. Religious beliefs provide meaning, hope, emotional comfort, and resilience, making faith an important resource for coping with existential concerns. The findings also revealed that spiritual and existential care are often closely intertwined, with prayer serving as the dominant form of support. While religious teachings generally enhance well-being, some interpretations that

associate suffering with divine punishment may contribute to anxiety and distress. Overall, religious institutions remain significant providers of holistic support for older adults.

Recommendations

Governments in Liberia and Sierra Leone should integrate spiritual and existential care into policies and programs to improve the well-being of the elderly. Stronger collaboration between healthcare providers, social welfare agencies, and faith-based organizations is needed to ensure holistic and culturally appropriate care.

Religious leaders, family caregivers, and community volunteers should receive training in counseling, active listening, and emotional support to complement prayer-based interventions. Such capacity-building initiatives would help address loneliness, fear, grief, and other existential concerns commonly experienced by older adults. Faith-based organizations should also establish structured support programs that encourage meaningful conversations and social engagement among the elderly.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

All authors gave consent for publication.

Competing interests

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Data availability

Not applicable

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Authors Contribution

LT: Conceptualization, project design and administration, investigation, Writing first, second, and final draft, review and manuscript editing, supervision, and data assembly. revised draft following reviewers' and editors' comments, review, and manuscript editing

AEA: Writing first draft, review, and manuscript editing, data assembly, and supervision.

REFERENCES

1. Akdeniz, M., Yardımcı, B., & Kavukcu, E. (2021). Ethical considerations at the end of life: A palliative care perspective. Turkish Journal of Family Medicine and Primary Care, 15(1), 1–8.

2. Angrosino, M. (2007). Doing ethnographic and observational research. Sage Publications.
3. Bangura, Y. (2016). Gender, ageing and care in Africa. African Journal of Social Work, 6(2), 1–12.
4. Best, M., Leget, C., Goodhead, A., & Paal, P. (2020). Spiritual care education in palliative care. Palliative Medicine, 34(6), 777–789.
5. Boston, P., Bruce, A., & Schreiber, R. (2011). Existential suffering in palliative care. Journal of Pain and Symptom Management, 41(3), 604–618.
6. Bowen, G. A. (2009). Document analysis as a qualitative research method. Qualitative Research Journal, 9(2), 27–40.
7. Conteh, P. (2009). Religion, spirituality, and healing in African societies. Edwin Mellen Press.
8. Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). Sage Publications.
9. Erikson, E. H. (1950). Childhood and society. W. W. Norton & Company.
10. Erikson, E. H. (1959). Identity and the life cycle. International Universities Press.
11. Gyekye, K. (1996). African cultural values: An introduction. Sankofa Publishing.
12. Keskinoğlu, P., & Ekşi, H. (2019). Religious coping, spirituality, and end-of-life care: An Islamic perspective. Journal of Religion and Health, 58(6), 2051–2065.
13. Knaul, F. M., Farmer, P. E., Krakauer, E. L., De Lima, L., Bhadelia, A., Jiang Kwete, X., Arreola-Ornelas, H., Gómez-Dantés, O., Rodriguez, N. M., Ostrach, B., Radbruch, L., Foley, K. M., Frenk, J., & Rajagopal, M. R. (2022). Alleviating the access abyss in palliative care and pain relief—An imperative of universal health coverage: The Lancet Commission report. The Lancet, 399(10320), 1391–1454.
14. Koenig, H. G. (2020). Religion, spirituality, and health. Journal of Religion and Health, 59(5), 2351–2364.
15. Liberia Institute of Statistics and Geo-Information Services. (2022). 2022 Liberia population and housing census report. Government of Liberia.
16. Maslow, A. H. (1943). A theory of human motivation. Psychological Review, 50(4), 370–396.
17. Mbiti, J. S. (2015). African religions and philosophy (2nd ed.). Heinemann.
18. Nouvet, E., Sivaram, M., & DeLuca, S. (2021). Faith-based palliative care delivery in low-income settings. BMJ Global Health, 6(9), e006345.
19. Papaleontiou-Louca, E. (2022). Maslow's hierarchy of needs revisited: Self-transcendence and later life. Journal of Humanistic Psychology, 62(3), 345–362.
20. Pargament, K. I. (1997). The psychology of religion and coping. Guilford Press.
21. Pargament, K. I., & Park, C. L. (2019). Religion and coping. In J. Green (Ed.), Handbook of psychology of religion (pp. 213–232). Guilford Press.
22. Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. Journal of Palliative Medicine, 17(6), 642–656.
23. Stephens, M. T., & Rochmawati, E. (2022). Palliative care education and training in Liberia. Belitung Nursing Journal, 8(5), 453–461.
24. Tornøe, K. A., Danbolt, L. J., Kvigne, K., & Sørlie, V. (2015). Nurses' experiences of spiritual care. BMC Nursing, 14, 1–12.
25. United States Department of State. (2022). 2022 report on international religious freedom: Sierra Leone. Bureau of Democracy, Human Rights, and Labor.
26. VanderWeele, T. J. (2017). Religion and health: A synthesis. JAMA, 318(6), 519–520. https://doi.org/10.1001/jama.2017.8136
27. World Health Organization. (2020). Palliative care [Fact sheet].
28. Zoker, E. M., & Sundufu, A. (2022). Knowledge, attitudes, and practices toward palliative care among healthcare staff in Sierra Leone. Tropical Journal of Medical Research, 21(2), 115–126.