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The Tree of Life Model of Faith-Based Living: A Practice Model for Faith Community Nursing

Marcus M. Gaut

The University of Southern Mississippi

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The art and science of nursing is supported and promulgated by a multitude of theories, conceptual models, and theoretical frameworks. Each theory, conceptual model, or theoretical framework addresses the concepts of the nursing metaparadigm (e.g. nursing, person, health, and environment) in unique ways. Faith Community Nursing (FCN) is a nursing specialty area that combines nursing practice and spiritual care (Church Health Center, n.d.). Scant literature exists that describes theories, conceptual models, or theoretical frameworks that support the intentional incorporation of faith and faith-based practices requisite FCN. The Activities of Living Model (ALM) was identified and adapted as a theoretical framework used to accommodate the needs of a doctoral project implemented within a faith community located in a southeastern rural community of the United States. The purpose of this paper is to provide evidence in the adaption of ALM to be used by Faith Community Nurses (Nurses) in the assessment and implementation of faith-based care to individuals, families, and communities.

ACTIVITIES OF LIVING MODEL

Roper, Logan, and Tierney (2000b) developed the ALM after an analysis of data which suggested the presence of a core of nursing that related to everyday activities of living and illuminated the unity and diversity of nursing. ALM asserts a holistic view of nursing from the perspective of a client's lifestyle and emphasizes better health outcomes via problem prevention and promotion (Tierney, 1998). Roper et al. (1996a) identified main components of ALM to include activities of living (AL), lifespan, dependence/independence continuum (continuum), factors influencing AL, and individuality in living.

Roper et al. (1996a) identified and defined five dimensions (DI) that influence AL to include biological, psychological, sociocultural, environmental,

and politico-economic. The biological dimension concerns an individual's anatomical and physical performance. The psychological dimension includes the intellectual and emotional aspects of an individual. The sociocultural dimension includes culture, religion, spirituality, ethics, role, relationships, and status in a community as expressed by an individual. The environmental dimension pertains to factors external to the individual that impact all other dimensions and the politico-economic dimension addresses legal, political, and economic factors. AL are divided into 12 categories that are assessed within each dimension and along the dependence/independence continuum and include:

- maintaining a safe environment,
- communicating,
- breathing,
- eating and drinking,
- eliminating,
- personal cleansing and dressing,
- controlling body temperature,
- mobilizing,
- working and playing,
- expressing sexuality,
- sleeping, and
- dying (Roper et al., 1996a).

The ALM identifies the nurse as a person who lives the AL with other persons and engages the nursing process (e.g. assessment, planning, implementation, evaluation). Nurses express and experience efforts to achieve each of the AL (i.e. maintaining a safe environment, communicating, sleeping) with those that they serve. A client's and nurse's experiences with AL provide

contexts supportive of holistic care planning. Care planning represents the individual efforts of the client served, the collective efforts of both client and nurse (i.e. patient-centered care), and opportunities for the nurse to model healthy behaviors in service to the client. The model suggests that life is a shared experience and defines nursing by what it is as opposed to what nurses do (Wills, 2011). DI, AL, lifespan, and continuum are interlinked and accommodate a person's individualized manifestations of living (Roper et al., 2000c). Therefore, the ALM supports individualized living and individualized nursing (Wills, 2011). The ALM offers a practical approach to the delivery of care and can be used in conjunction with the nursing process (Cardwell, Corkin, McCartan, McCulloch, & Mullan, 2011).

REVIEW OF LITERATURE APPLYING FRAMEWORK

A review of the literature suggests a dearth of evidence demonstrating application of the ALM in the U.S. Primary and secondary sources often predate the most recent ALM primary publications (e.g. Roper et al., 2000d; Roper et al., 1996b) and limits the availability of "observations and criticisms of others who have no personal investment in the model" (Roper et al., 2000a, p. 154). McCaugherty (1992) suggested evidence of ALM usefulness as a tool to guide and clarify nursing practice. Ben Hui (2012) asserts the ALM facilitates the identification of nursing problems, ensures holistic care planning, and supports the implementation of holistic nursing care. ALM provides for the systematic setting of objectives, prioritization of the delivery of care, a framework that is easy to understand and flexible to the needs of the patient and nurse, an outline of the scope of nursing practice, and a common ground for intraprofessional communication (Barnett, 2007; Girot, 1990; Healy & Timmins, 2003).

THE TREE OF LIFE MODEL OF FAITH-BASED LIVING

The Tree of Life Model of Faith-Based Living (TOL) (Figure 1), an adaptation of ALM, demonstrates a conceptual model supportive of the unique, holistic, and specialized practice of FCN. TOL suggests that the concepts of the nursing metaparadigm are expressions of and experiences with faith and community. Further, TOL suggests that common AL are expressions of faith and health and that the health of an individual is a product of relationships shared with the individual, nurse, and community of faith.

TOL accommodates the application and assessment of varied interdisciplinary and intradisciplinary theoretical approaches to the care of individuals, families, and communities. TOL supports interdisciplinary, intradisciplinary, faith-based, and culturally sensitive interventions aimed at supporting individualized living and individualized nursing within faith communities.

NURSING METAPARADIGM

ALM adaptations include definitions of the nursing metaparadigm concepts. TOL suggests that nursing is a shared experience between a person, nurse, and faith community that supports health as an expression of faith. A person is an individual living and dying in relationship with a faith community. Health is defined as a faith-based, person-centered state of holism expressed in relationship with a Higher Being or Consciousness (Creator). Lastly, TOL identifies the environment as the totality of creation expressed by and interacting with the faith community.

UNDERSTANDING THE TREE OF LIFE MODEL OF FAITH-BASED LIVING

TOL consists of soil, roots, a tree, and the leaves of the tree. The leaves represent observable manifestations of health. Healthy leaves demonstrate beauty and evidence health (i.e. physical, psychological, emotional, and spiritual). Unhealthy leaves suggest compromised health and a need to engage the faith community in support of the individual's health. The tree is the individual. The tree represents the individual living and dying as an expression of the need for community along the continuum. The roots of the tree represent the DI. As components of the tree, the roots serve to categorize the ways in which the individual experiences life, and is impacted by the lived experience, within the context of local, national, and global faith communities. The individual reaches out to the faith community and receives feedback via the AL. The contextual interactions between the individual and faith community are represented by the earth.

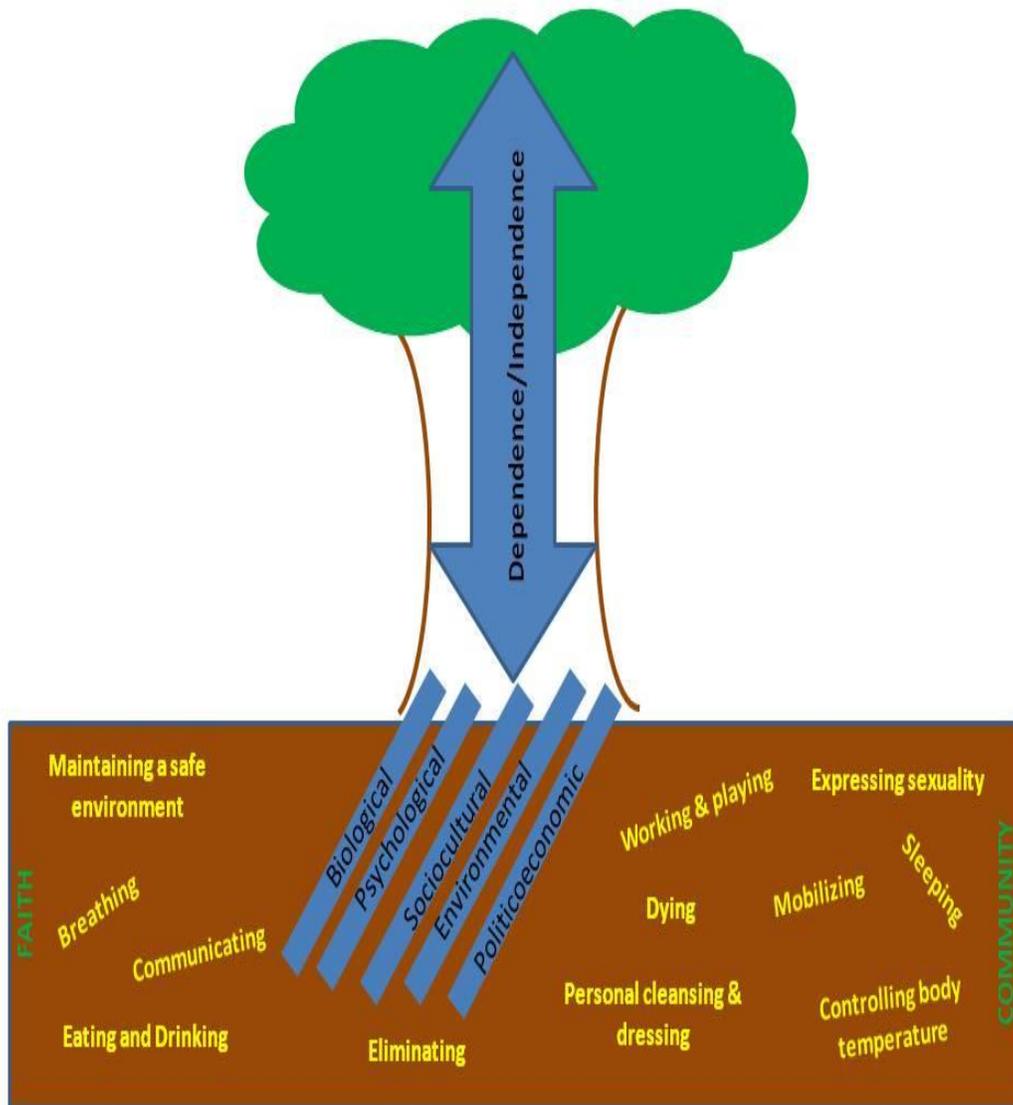


Figure 1 Tree of Life Model of Faith-Based Living

Membership in a faith community is not requisite to an individual's interactions with a faith community. Additionally, descriptions of a faith community cannot be restricted to denominational affiliations or individual faith traditions. TOL suggests that a faith community is the collective body of persons sharing a belief in the Creator. An individual may, or may not, be in relationship with a specific religious system (i.e. church, mosque, temple, ashram). However, the individual is always in relationship with persons sharing a faith in the Creator (i.e. relationship expressed through prayer, proselyte yielding efforts, faith-based advocacy, faith-based service or ministry). TOL suggests that living is an expression of and experience with faith and faith community. The lived experience may not always reflect an individual's faith. The lived experience of the individual will always express the hope and efforts of the faith community to realize a life of faith for the individual.

TREE OF LIFE MODEL OF FAITH-BASED LIVING ASSUMPTIONS

THE CREATOR

"For 'In him we live and move and have our being'" (*The New Interpreter's Study Bible*, 2003, p. 1989). A first assumption of TOL is that there is a Creator and that humankind lives in relationship with the Creator and Creation. The Christian Bible demonstrates this assumption suggesting that the heavens, the earth, and humankind evidence the work of the Creator (*The New Interpreter's Study Bible*, 2003, pp. 5-11). TOL purports that the concepts of the nursing metaparadigm are elements of Creation. As result of sin, and subsequent consequences, an adverse relationship exists between the metaparadigm concepts. TOL identifies the faith community as the physical manifestation of the Creator and that from which a person is born, lives, and dies. It is the life a person lives—everyday AL—that defines a relationship with the faith community and informs one's experience with health.

HEALTH: A FUNCTION OF FAITH

"I have been crucified with Christ; and it is no longer I who live, but it is Christ who lives in me. And the life I now live in the flesh I live by faith in the Son of God, who love me and gave himself for me" (*The New Interpreter's Study Bible*, 2003, p. 2083). A second assumption suggests that health is a function of faith and a product of faith-filled living. TOL asserts that faith influences how a person engages AL in pursuit of personal interests and service of others. A healthy lifestyle reflects a life lived for the Creator. Every expression of self is a reflection of one's faith.

It should be noted that neither health nor a healthy lifestyle infers the absence of disease. A healthy lifestyle assumes efforts to reconcile one's health status and faith—a prosperity of body and soul. "Beloved, I pray that you may prosper in every way and [that your body] may keep well, even as [I know] your soul keeps well *and* prospers" (*Amplified Bible*, 1987, p. 1148).

HOLISTIC HUMAN EXPERIENCE

"For just as the body is one and has many members, and all the members of the body, though many, are one body, so it is with Christ.... If one member suffers, all suffer together with it; if one member is honored, all rejoice together with it" (*The New Interpreter's Study Bible*, 2003, p. 2053). The concept of spiritual care is not clearly established or embraced by nursing professionals and a multiple of approaches to spiritual assessment and intervention development exists (Draper, 2012; Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014). The human body, even the human experience, is complex and best understood when viewed holistically and in community.

TOL asserts that the relationships that exist between the concepts of the nursing metaparadigm (i.e. health disparities) evidence complexity and are best understood, managed, reconciled, and challenged in community. The metaparadigm concepts expressed and experienced within a faith community yield physical and spiritual benefits to include strength, healing, forgiveness, faith, hope, and love—an honoring of all parts of the body. Additionally, TOL recognizes that providence of the Creator and the value of all human life.

APPLICATION OF THE TREE OF LIFE MODEL OF FAITH-BASED NURSING

TOL provides a framework upon which competencies and standards of nursing practice can be developed by a nurse with a patient (i.e. individual, family, community). Patient-centered care is practiced by a nurse when the patient is empowered as the control agent and partner in the provision of care based upon recognition and respect of a patient's preferences, values, and needs (Cronenwett et al., 2007). TOL accommodates the shared needs of the patient and the nurse within the contexts of faith and community. A case study illustrating the use of the TOL is presented in Figure 2.

Kelvin James is a 68-year-old African American male. He has been a member of your faith community since his birth and until recently has been actively involved in the life of the faith community. Mr. James cannot read and does not trust “doctors.” As a result of chronic illnesses to include hypertension, diabetes, and obesity, Mr. James suffered a stroke 6 months ago. He has difficulty speaking and an inability to use the right side of his body. He is a widow of 5 years and his adult children are unable to return home to care for their father. Mr. James has shared with you that he feels lonely, like “less than a man”, and that he is not sure if the faith community can help him. As a member of the faith community, how would you assist Mr. James?

Using the *Tree of Life Model of Faith-Based Living*, complete the following:

What do you know or would like to know?

Assessment (choose a minimum of 2 applicable Activities of Living to guide your assessment to include gaps)

Activity of Living #1: _____

Activity of Living #2: _____

What would you do or like to do?

Planning (identify one Dimension of Influence to develop interventions and goals)

Dimension of Influence: _____

How would you implement the plan?

Implementation (identify implementation strategies to be used to engage the plan of care)

How would you know if the plan worked?

Evaluation (how would you evaluate the effectiveness of the plan of care)

Figure 2 Applying the Tree of Life

ASSESSMENT

ALM necessitates patient-centeredness and the establishment of a trusting relationship between the nurse and Mr. James. Assessment of Mr. James would include a spiritual assessment and other assessments reflective of his preferences, values, and needs (i.e. spiritual or religious practices, environmental, mental health, social support). The nurse and Mr. James would individually and collaboratively answer the question: “*What do you know or would like to know?*”.

During the assessment the nurse must clarify her or his understanding of assessment findings and discern Mr. James’s agreement. The individual understandings of the nurse and Mr. James would be reconciled yielding a single understanding that reflects what Mr. James identifies as concerns upon which he wants to focus his efforts. A minimum of two foci would be chosen in an effort to facilitate the relationships that exist between the AL (i.e. how mobilizing impacts eliminating). These foci would become the areas which the nurse and Mr. James would concentrate on, allowing the nurse to show the varied roles of educator and advocate.

PLANNING

Planning with Mr. James would answer the question: “*What would you do or like to do?*”. After identifying AL upon which to focus care, Mr. James and his nurse would identify a DI to guide their planning. Choosing one specific DI would assist Mr. James and the nurse in:

- identifying appropriate resources for care;
- recognizing and respecting Mr. James’s available resources, preferences, values, and needs;
- identifying educational needs for the nurse and Mr. James; and,

- incorporating the strengths, weakness, preferences, values, and needs of the nurse.

Additionally, the choice of one DI would accommodate the development of specific, time-sensitive, and measurable goals affirmed by Mr. James.

The selection of one DI does not exclude the consideration of the others. The selection of additional DI suggests the need for development of additional goals and may, or may not, address the same AL. Addressing each DI supports the development of patient-centered goals as part of a holistic plan of care. Planning Mr. James's care will evidence considerations of interdisciplinary and intradisciplinary theoretical and practical approaches to addressing Mr. James's needs.

IMPLEMENTATION

Implementing the plan of care would represent the efforts of Mr. James and the nurse to answer the question: "*How would you implement the plan?*". As the nurse and Mr. James implement their plan of care, each will support teamwork and collaboration as a nursing competency. Cronenwett et al. (2007) suggested that nurses engage in quality and safe practice when they are able to function within interprofessional and intraprofessional teams that foster open communication, mutual respect, and shared decision making.

Interventions would include faith-based and culturally sensitive actions supportive of Mr. James's individualized expressions of living. Additionally, the interventions would support the nurse's individualized expressions of nursing within a faith community. Interventions would reflect collaborative efforts shared with members of the faith community and non-members of the faith community able to assist in interpreting the DI influence upon AL.

EVALUATION

“How would you know if the plan worked?”. Effectiveness of the plan of care would be determined by Mr. James with support of the nurse. It would be incumbent upon the nurse to assist Mr. James in interpreting the results of various interventions. If the planned goals were met, partially met, not met, or need to be revised is to be considered by Mr. James with his nurse. Evaluation of having met patient-centered goals would include considerations of congruencies between patient and nurse prioritization of goals, functionality within the therapeutic relationship, patient empowerment, and context of practice (Rosewilliam, Sintler, Pandyan, Skelton, & Roskell, 2016). Evaluation of the use of TOL includes assurances that Mr. James remained central to the assessment, planning, implementation, and evaluation phases of care. Effective care rendered by use of TOL yields increased health of the patient—healthy leaves as a result of quality nursing care.

CONCLUSION

TOL demonstrates a conceptual model supportive of the intentional faith-based specialty practice of FCN. TOL accommodates interdisciplinary and intradisciplinary approaches to faith-based care. A dearth of literature suggests the identification of a theoretical foundation to support the specialized practice of FCN. TOL provides a theoretical foundation for the practice of FCN and emphasizes the holistic import of AL as components of an individual’s faith and health. Further, TOL recognizes the complexity of health and the diversity of experiences that exist among individuals and faith communities. Health is a communal phenomenon that glorifies the Creator and furthers its work in, and through, Creation. TOL can be used to apply multidisciplinary theoretical assumptions (i.e. political, economic, psychosocial theories) in attempts to

address the complex and holistic health needs of individuals, families, and communities (i.e. health disparities). To the Creator be the glory!

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