Ok. This school makes me confused. The summary of this week they posted like this:

**SUMMARY:**

This week introduced you to grand theories and middle-range theories that serve to articulate the voice of nursing within healthcare.

Here are the key points covered:

Grand theories are comparatively more abstract than middle-range theories since they are at a higher level of abstraction. Compared to grand theories, middle-range theories are made up of limited number of concepts that lend themselves to empirical testing. All theories help to explain human health behavior.

* Sister Callista Royï's adaptive model theory is built on the conceptual foundation of adaptation. It identifies the positive role that nursing plays in the promotion and enhancement of client adaptation to environments that facilitate the healing process.
* Leiningerï's culture care theory is pertinent in the current multicultural healthcare environment where nurses are exposed to diverse cultures.
* Penderï's health promotion and disease prevention theory can be called as a "direction setting exercise" for nursing professionals. It believes in fostering the spirit of health promotion and disease and risk reduction.

From the chapter, Models and Theories Focused on Nursing Goals and Functions, read the following:The Health Promotion Model: Nola J. Pender

From the chapter, Models and Theories Focused on a Systems Approach, read the following:

The Roy Adaptation Model

From the chapter, Models and Theories Focused on Culture, read the following:

Leininger's Cultural Care Diversity and Universality Theory and Model

SO, THAT IS WHY I ASSUMED THAT HAS TO BE ONE OF THEM (Pender, Roy Adaptaion or Leininger)

ANYWAY, I AM PUTTING INFORMATION TOGETHER.

**Week 4 Chapter 17**

**Models and Theories Focused on Nursing Goals and Functions**

**The Health Promotion Model: Nola J. Pender**

**Background**

Nola J. Pender was born in 1941 in Lansing, Michigan. She graduated in 1962 with a diploma in nursing. In 1964, Pender completed a bachelor’s of science in nursing at Michigan State University. By 1969, she had completed a doctor of philosophy in psychology and education. During this time in her career, Pender began looking at health and nursing in a broad way, including defining the goal of nursing care as optimal health.

In 1975, Pender published a model for preventive health behavior; her health promotion model first appeared in the first edition of the text Health Promotion in Nursing Practice in 1982. Pender’s health promotion model has its foundation in Albert Bandura’s (1977) social learning theory (which postulates that cognitive processes affect behavior change) and is influenced by Fishbein’s (1967) theory of reasoned action (which asserts that personal attitudes and social norms affect behavior).

**Pender’s Health Promotion Model**

McCullagh (2009) labeled Pender’s health promotion model as a middle-range integrative theory, and rightly so. Fawcett (2005) decisively presented the difference between a conceptual model for nursing and a model for middle-range theory. A model for middle-range theory is usually a graphic representation or schematic diagram of a middle-range theory. McCullagh’s (2009) rationale for labeling Pender’s model a middle-range integrative theory is that it portrays the multidimensionality of persons interacting with their interpersonal and physical environments as they pursue health while integrating constructs from expectancy-value theory and social cognitive theory with a nursing perspective of holistic human functioning (Pender, 1996). With the third edition of Health Promotion in Nursing Practice (1996), Pender revised the health promotion model significantly. This revised model is the subject of the discussion in this chapter.

Pender’s health promotion model includes three major categories: (1) individual characteristics and experiences, (2) behavior-specific cognitions and affect, and (3) behavioral outcome. Each of these categories will be considered here separately.

The first category includes each person’s unique personal characteristics and experiences, which affect that individual’s actions. Significant components within this category are prior related behavior and personal factors. Prior related behavior is important in influencing future behavior. Pender proposed that prior behavior has both direct and indirect effects on the likelihood of engaging in health-promoting behaviors. In particular, past behavior has a direct effect on the current health-promoting behavior through habit formation: Habit strength increases each time a behavior occurs. Prior behavior is proposed to indirectly influence health-promoting behavior through perceptions of self-efficacy, benefits, barriers, and activity-related affect or emotions (Pender, Murdaugh, & Parsons, 2006). Personal factors include biological factors such as age, body mass index, pubertal status, menopausal status, aerobic capacity, strength, agility, or balance; psychological factors include self-esteem, self-motivation, and perceived health status; and sociocultural factors include race, ethnicity, acculturation, education, and socioeconomic status. Some personal factors are amenable to change, whereas others are immutable (Pender et al., 2006).

The second category encompasses behavior-specific cognitions and affect, which serve as behavior-specific variables within the health promotion model. Behavior-specific variables are considered to have motivational significance. In the health promotion model, nursing interventions target these variables because they are amenable to change. The behavior-specific cognitions and affect identified in the health promotion model include (1) perceived benefits of action, (2) perceived barriers to action, (3) perceived self-efficacy, and (4) activity-related affect. Other cognitions fall into the category of interpersonal influences and situational influences. Sources of interpersonal influences on health-promoting behaviors include family, peers, and healthcare providers. Interpersonal influences include norms, social support, and modeling; they shape the person’s tendency to participate in health-promoting behaviors. Situational influences on health-promoting behavior include perceptions of available options, demand characteristics, and aesthetic features of the environment. Within Pender’s model, nursing plans are tailored to meet the needs of diverse patients based on assessment of prior behavior, behavior-specific cognitions and affect, interpersonal factors, and situational factors (Pender et al., 2006, pp. 54–56).

The third category within Pender’s model is the behavioral outcome. Commitment to a plan of action marks the beginning of a behavioral event. This commitment propels the person into the behavior unless that action is confounded by a competing demand that cannot be avoided or a competing preference that is not resisted. Interventions in the health promotion model focus on raising consciousness related to health-promoting behaviors, promoting self-efficacy, enhancing the benefits of change, controlling the environment to support behavior change, and managing the barriers to change. Health-promoting behavior, which is ultimately directed toward attaining positive health outcomes, is the product of the health promotion model (Pender et al., 2006, pp. 56–63).

**Major Concepts of Nursing According to Pender**

**Person**

The person in the health promotion model refers to the individual who is the primary focus of the model. In Pender’s model, each person has unique personal characteristics and experiences that affect subsequent actions. It is recognized that individuals learn health behaviors within the context of the family and the community, which explains why the model for assessment includes components and interventions at the family and community levels, as well as the individual level (Pender, Murdaugh, & Parsons, 2002, 2006). This is taken a step further in the latest edition (Pender, Murdaugh, & Parsons, 2011), in which the term client refers to individuals, families, and communities who are all viewed as active participants in health promotion.

**Environment**

In the health promotion model, the environment encompasses the physical, interpersonal, and economic circumstances in which persons live. The quality of the environment depends on the absence of toxic substances, the availability of restorative experiences, and the accessibility of human and economic resources needed for healthful living. Socioeconomic conditions such as unemployment, poverty, crime, and prejudice have adverse effects on health, whereas environmental wellness is manifested by balance between human beings and their surroundings (Pender et al., 2006, p. 9; Pender et al., 2011, p. 8).

**Health**

Health is viewed as a positive high-level state. According to Pender, the person’s definition of health for himself or herself is more important than any general definition of health (Pender et al., 2006; Sakraida, 2010). Health is viewed in the context of health promotion and disease prevention. Health promotion is behavior that is motivated by a desire to increase well-being and optimize human health potential, whereas disease prevention or health protection is behavior motivated by a desire to actively avoid illness, detect illness early, or maintain functioning within the constraints of illness (Pender et al., 2011, p. 5). Health promotion is viewed as a multidimensional concept that includes the dimensions of the individual, the family, the community, socioeconomic status, cultural factors, and environmental factors (Pender et al., 2011, pp. 6–8).

**Nursing**

The role of the nurse in the health promotion model revolves around raising consciousness related to health-promoting behaviors, promoting self-efficacy, enhancing the benefits of change, controlling the environment to support behavior change, and managing the barriers to change (Pender et al., 2006, pp. 57–63). A major function of the APN role is the focus on health promotion. This model serves as a significantly pragmatic process for APNs to use to encourage health-promoting behaviors by patients and to address the benefits of change.

**Analysis of the Health Promotion Model**

The analysis and critique presented here comprise an examination of assumptions and propositions, as well as the analysis of clarity, simplicity, generality, empirical precision, and derivable consequences of Pender’s health promotion model.

**Assumptions of the Health Promotion Model**

Assumptions of the health promotion model reflect both nursing and behavioral science perspectives. The seven major assumptions emphasize the active role of the patient in shaping and maintaining health behaviors and in modifying the environmental context for health behaviors:

 1. Persons seek to create conditions of living through which they can express their unique human potential.

 2. Persons have the capacity for reflective self-awareness, including assessment of their own competencies.

 3. Persons value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability.

 4. Persons seek to actively regulate their own behavior.

 5. Persons in all their biopsychosocial complexity interact with the environment, both progressively transforming the environment and being transformed over time.

 6. Health professionals constitute a part of the interpersonal environment, which influences persons throughout their life span.

 7. Self-initiated reconfiguration of person–environment interactive patterns is essential for behavior change (Pender et al., 2002, p. 63).

Propositions of the Health Promotion Model

The health promotion model is based upon 14 theoretical propositions. These theoretical relationship statements provide a basis for research related to health behaviors:

 1. Prior behavior and inherited and acquired characteristics influence health beliefs, affect, and enactment of health-promoting behavior.

 2. Persons commit to engaging in behaviors from which they anticipate deriving personally valued benefits.

 3. Perceived barriers can constrain commitment to action (a mediator of behavior), as well as actual behavior.

 4. Perceived competence or self-efficacy to execute a given behavior increases the likelihood of commitment to action and actual performance of behavior.

 5. Greater perceived self-efficacy results in fewer perceived barriers to a specific health behavior.

 6. Positive affect toward a behavior results in greater perceived self-efficacy, which can, in turn, result in increased positive affect.

 7. When positive emotions or affect are associated with a behavior, the probability of commitment and action are increased.

 8. Persons are more likely to commit to and engage in health-promoting behaviors when significant others model the behavior, expect the behavior to occur, and provide assistance and support to enable the behavior.

 9. Family, peers, and healthcare providers are important sources of interpersonal influence who can increase or decrease commitment to and engagement in health-promoting behavior.

10. Situational influences in the external environment can increase or decrease commitment to or participation in health-promoting behavior.

11. The greater the commitment to a specific plan of action, the more likely health-promoting behaviors will be maintained over time.

12. Commitment to a plan of action is less likely to result in the desired behavior when competing demands over which persons have little control require immediate attention.

13. Commitment to a plan of action is less likely to result in the desired behavior when other actions are more attractive and thus preferred over the target behavior.

14. Persons can modify cognitions, affect, and the interpersonal and physical environments to create incentives for health actions (Pender et al., 2002, pp. 63–64).

**Analysis: Clarity, Simplicity, Generality, Empirical Precision, and Derivable Consequences**

Pender’s health promotion model was formulated using inductive reasoning with existing research, which is a common approach to the building of middle-range theories. The research used to derive the model was based on adult samples that included male, female, young, old, well, and ill populations; this design allows the model to be generalized easily to adult populations (Sakraida, 2010).

The health promotion model is simple to understand, because it uses language familiar to nurses. The concept of health promotion is also popular in nursing practice and, therefore, is a practical principle for APNs’ use. The relationships among the factors are linked, and relationships are identified and consistently defined. Considering all of these factors, it is not difficult to see why Pender’s model is popular with practicing nurses and is frequently used as a tool in research. Nevertheless, it has not been used extensively in nursing education, where the emphasis is on illness care in acute care settings (Sakraida, 2010).

**Discussion**

Pender identified health promotion as a key global goal for the 21st century (Pender et al., 2011) and, through development of the health promotion model, has assisted in the delineation of the role of nursing in meeting that goal. Although Pender has now retired, her work on the health promotion model continues. Pender views the nurse’s role in health promotion as more important than ever considering existing health disparities and the challenges of our current healthcare system (Pender et al., 2011). The current scenario of increasing costs for health care associated with episodic illness treatment increases in chronic, preventable conditions within the population, and the focus on managing healthcare costs provide ample incentive to further explore the concepts of the health promotion model as APNs strive to improve health outcomes in patient populations.

Summary

Although the four nursing models described in this chapter were conceived by four very different nurses whose careers spanned more than a century, they share a common thread: All place emphasis on the function of nursing practice in relation to health outcomes. For Nightingale, the function of nursing is to alter the environment to allow for action on the person by natural laws of health; for Henderson, the function of nursing is to assist the person to perform activities to gain independence; for Johnson, the function of the nurse is to impose external regulatory mechanisms in order to facilitate restoration of system balance; and for Pender, the nurse functions to raise consciousness, promote self-efficacy, and control the environment to allow for behavior change resulting in high-level health. All four of these nursing models also conceptualize the goal of nursing care as a restoration of the health of the patient, however differently the concept of health—or, for that matter, the concept of the patient—may be defined in their respective theories.

**Discussion Questions**

 1. Nightingale and Henderson considered the discipline of nursing to be both an art and a science. Esthetic patterns of knowing and empirical patterns of knowing both constitute complex yet divergent ways of thinking. How can the APN perform simultaneously from an esthetic perspective and a perspective based on empiricism?

 2. Johnson’s behavioral system model has been used in practice and research; as a result, multiple adaptations of this model have appeared in the literature. In response to these additions and alterations, Johnson (1990, p. 27) stated, “[T]hese changes are such that they alter the fundamental nature of the behavioral system as originally proposed, and I do not agree with them.” Does a theory belong to the nurse theorist or to the discipline of nursing? Who has the right to add to or alter a theory? Should a theory be altered based on research evidence even if the original nurse theorist is not in agreement, or should the theory be maintained intact as a historical record?

 3. Considering a patient scenario from advanced nursing practice and using a middle-range theory such as the health promotion model, demonstrate the connection and reciprocal relationship between theory, practice, and research.

 4. The theories presented in this chapter, although they view nursing from various perspectives, have brought to light these theorists’ identification and development of the concepts of interest, thereby influencing the evolution of nursing as a discipline and framing nursing knowledge. How has the development of these and other nursing theories helped to frame knowledge and shape the role of the APN?

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**Leininger’s Cultural Care Diversity and Universality Theory and Model**

Leininger’s cultural care diversity and universality theory and the sunrise model that depicts her theory are perhaps the most well known in nursing literature on culture and health (Leininger & McFarland, 2006). The theory draws from anthropological observations and studies of culture and cultural values, beliefs, and practices. The theory of transcultural nursing promotes understanding of both the universally held and common understandings of care among humans and the culture-specific caring beliefs and behaviors that define any particular caring context or interaction. According to Leininger, this theory is intended to be holistic: Culture is the specific pattern of behavior that distinguishes any society from others and gives meaning to human expressions of care (Leininger, 2002).

The theory of cultural care diversity and universality is heavily used in education and research. It incorporates the following assumptions about care and caring as they relate to cultural competency (Leininger, 2002):

• Care (caring) is essential to curing and healing, for there can be no curing without caring.

• Every human culture has generic, folk, or indigenous care knowledge and practices and usually some professional care knowledge and practices that vary transculturally.

• Culture care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion and spirituality, kinship, social, political, legal, educational, economic, technological, ethno-historical, and environmental contexts of cultures.

• A client who experiences nursing care that fails to be reasonably congruent with his or her beliefs, values, and caring life ways will show signs of cultural conflict, noncompliance, stress, and ethical or moral concern.

• Within a cultural care diversity and universality framework, nurses may take any or all of three culturally congruent action modes: (1) cultural preservation/maintenance, (2) cultural care accommodation/negotiation, and (3) cultural care repatterning/restructuring.

According to Leininger, cultural care preservation/maintenance refers to assistive, supportive, facilitative, or enabling professional actions and decisions that help individuals, families, and communities of a particular culture retain and preserve care values so that they can maintain well-being, recover from illness, or face possible handicap or death. Cultural care accommodation/negotiation refers to assistive, supportive, facilitative, or enabling professional actions and potential decisions that help individuals, families, and communities of a particular culture adapt to or negotiate with others for satisfying healthcare outcomes with professional caregivers. Cultural care repatterning/restructuring refers to the assistive, supportive, facilitative, and enabling roles filled by nurses and other healthcare providers to promote actions and decisions that may help the person, family, or community change or modify behaviors affecting their life ways, thereby achieving a new and different health pattern (Leininger & McFarland, 2006). These three action modes are sometimes used with other cultural theories and models.

Leininger recognized the comparative aspects of caring within and between cultures—hence the theory’s acknowledgment of similarities as much as differences in caring in diverse cultures. Her transcultural model has implications for how nurses assess, plan, implement, and evaluate care of people from diverse cultural backgrounds. The sunrise model and theory have clarity, but they are complex. The model has generality for nursing, empirical precision, and derivable consequences. The sunrise model can be found on the Transcultural Nursing Society’s website (<http://tcns.org/Theories>).

**The Roy Adaptation Model**

The History

Sister Callista Roy recalled that the origins of her adaptation model date back to 1964, when she was a master’s-level student at Mount St. Mary’s College in Los Angeles. In 1970, she published the basic ideas of her conceptual model in an article titled “Adaptation: A Conceptual Framework for Nursing” in Nursing Outlook. In 1971 and 1973, the model was further explained in a chapter of Riehl and Roy’s (1974) book, Conceptual Models for Nursing Practice. A more comprehensive explanation of the model can be found in Roy’s (1976) book, Introduction to Nursing: An Adaptation Model. Further refinements of the model were published in the second edition of that book (Roy, 1984). Roy’s clinical experiences in pediatric nursing and neurological nursing were important influences in the development of her model (Roy, 2009).

The primary influencers for defining the key aspects of Roy’s adaptation model included the systems theory described by von Bertalanffy (1968) and the work of physiological psychologist Harry Helson (1964), who developed adaptation-level theory. Helson proposed that adaptation involves both psychological and physical processes when an individual faces environmental stimuli. He described three kinds of stimuli—focal, contextual, and residual—that come together and result in a pooled effect. Based on those principles, Roy described how adaptation could help people conserve the energy needed to heal and to cope with new life experiences (Roy & Whetsell, personal communication, 2005).

**The Philosophy and Assumptions**

Roy’s (2009) model was based on two underlying philosophical assumptions—humanism and veritivity. Humanism is the “broad movement in philosophy and psychology that recognizes the individual and subjective dimensions of human experiences as central to knowing and valuing” (p. 28). In 1988, Roy introduced the concept of veritivity—“a principle of human nature that affirms a common purposefulness of human existence” (Roy, 1988, as cited in Roy, 2009, p. 27). She described living systems as totalities made of parts that are unified by a purpose, not simply by cause–effect relationships. The veritivity principle is related to four aspects of human society: (1) human existence’s purpose, (2) humankind’s shared purpose, (3) activity and creativity for the common good, and (4) life sense value (Roy & Andrews, 1999).

Roy acknowledged that her spiritual orientation was a meaningful philosophical influence for development of her model. She also became interested in Teilhard de Chardin’s work in 1955, largely because of its characteristic reconciliation of science and spirituality. According to Roy, nurses assume the responsibility of believing in each person’s life purpose (Roy, 2009). People remain together in a common destiny and find sense in mutual relationships established with other persons, the world, and God. Roy emphasized the commonality that underlies people’s unity and diversity (Roy, 2006). Activity and creativity for the common good are involved in veritivity, and each single human being is different from each other human being—that is, each individual has a unique identity (Roy, 2009). The principle of veritivity allows the nurse to meet the social mandate to help change the system by contributing to the common good through the application of knowledge in practice (Roy & Whetsell, personal conversation, 2005). Roy’s last assumption about veritivity is life sense of value; thus the person is the main domain of interest (Roy, 1996). Similarly, Maritain (1966) viewed a person’s life as having a higher value than mere social utility.

**The Model**

Roy’s first three books—published in 1976, 1984, and 1991—highlighted the many colleagues and students who were involved in her work. In 1987, nursing scholars calculated that more than 100,000 nurses were taught by nursing faculty or had graduated from schools that used Roy’s model as a curricular framework (Roy, 1996).

Roy developed the Roy adaptation model while maintaining a unique focus on the changes that occur in the human adaptive system and in the environment. The model’s central feature is adaptation. According to this model, problems in adaptation materialize when the adaptive systems of a person are unable to respond to stimuli from internal or external environments (Roy & Andrews, 1999).

**Major Elements**

Roy did not define the metaparadigm concepts as human beings (person), health, environment, and nursing. Instead, Roy labeled the major elements as adaptation, person, environment, health, and goal of nursing.

Adaptation. Adaptation is the process and outcome in which individuals and groups become integrated with their environment through conscious choices (Roy, 2009). Adaptive responses promote integrity in terms of human beings’ goals, which are survival, growth, reproduction, mastery, and personal and environmental transformation. All responses that do not contribute to the integrity of the goals of the human system are recognized as ineffective responses.

Person. Early in the development of her model, Roy defined the person as “a bio-psycho-social being, in constant interaction with a changing environment” (Roy & Andrews, 1999, p. 19). An expansion of the concept of person along with the addition of groups was incorporated in the 1980s as part of the model, in the adaptation systems. Described as totality made of parts behaving purposefully, the person uses innate and acquired mechanisms for biological, psychological, and social adaptation. These mechanisms serve as the regulator and cognator subsystems for individuals and the stabilizer and innovator subsystems for people in groups (Roy, 2009).

Environment. Environment is defined as “every condition, circumstance and influence surrounding and affecting, particularly mutual, individual and group development and behavior” (Roy, 1984, as cited in Roy & Andrews, 1999, p. 31). The environment includes all focal, contextual, and residual stimuli (see the definitions in the subsection “Stimulus”).

Health. Over time, the concepts of Roy’s model were expanded, with health being one of the main foci. In 1964, Roy described health as an inherent dimension of a person’s life and noted how the health–sickness continuum may vary from severe illness to maximum well-being. More recently, Roy has described health as a “state and a process of being and becoming an integrated and whole person” (Roy, 2009, p. 48). The concept of health is unidimensional, whereas the concept of nursing is represented by science and art. In Roy’s systems theory, the scientific assumptions of the model link the adaptation-level theory described by Helson (1964) with the main concepts of her model. Individuals are regarded as holistic, adaptive systems that are more than the sum of their parts and that function as a whole in constant interaction with the environment (Roy & Andrews, 1999). Similar to how a system has inputs, processes, and outputs, people have stimulus inputs and an adaptation level.

Goal of nursing. According to Roy and Andrews (1999), nursing is “the protection, promotion, and optimization of health and abilities, prevention and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (p. 6). The goal of nursing is “to promote the health of individuals and societies” (Roy, 2009, p. 54). In pursuing this goal, nurses integrate specialized knowledge from the applied sciences to formulate health promotion and illness management strategies for people. Nursing knowledge is focused on how people—sick or well—interact with their environments to enhance well-being and flourishing.

**Adaptive Systems**

Adaptive systems include stimuli, adaptation level, and behavior. They are holistic systems that are defined in terms of human beings.

Stimulus. A stimulus is the trigger that provokes a response; it can be viewed as the point of interaction between the human system and the environment (Roy, 2009). The constructs of stimuli in Roy’s model are based on Harry Helson’s work relating to focal, contextual, and residual concepts. The focal stimulus evokes a primary internal or external awareness by the individual or the group, contextual stimuli are additional environmental factors that operate from within or outside the individual, and residual stimuli are other environmental factors that generate effects that may not be readily apparent in a given situation (Roy, 2009). Stimuli can change rapidly and often do so constantly because of the interactions between people and their environment.

Adaptation level. Adaptation level includes three conditions of the human adaptive system: (1) integrated, (2) compensatory, and (3) compromised. As Roy stated, “The level of adaptation conveys that the human adaptive system is not passive in relation to the environment and that the person and the environment are in constant interaction with each other” (Roy, 2009, p. 37). The integrated level means that the structures and functions of the life processes work as one whole to meet the needs of humans. The compensatory level is where the cognator and regulator subsystems for individuals have been activated; or for groups, it is where the stabilizer and innovator subsystems have been activated. The compromised level is initiated in response to the system’s diminishing adaptation, because the integrated and the compensatory levels are no longer working.

Behavior. Behavior is defined as internal or external actions and reactions that occur under specific circumstances (Roy, 2009). Behavior is sometimes objectively observed and measured or subjectively reported by individuals or people in groups. Output behavior indicates how well a system can adapt while interacting with the environment—this relationship is the target of nursing interventions.

The behavioral response is evident in the coping process, but it remains independent of this process. The processes involving the human being as an adaptive system underscore the various ways in which people deal with the demands of their environment. These processes specifically focus on those behaviors that meet the goals for adaptation; they relate to responses that promote the integrity of the human system in terms of adaptation goals (Roy & Andrews, 1999). Put simply, the behavioral response can be either adaptive or ineffective, as described in the previous section on model elements.

**Coping Processes**

Coping processes are “innate or acquired ways of interacting with—that is, responding to and influencing—the change environment” (Roy & Andrews, 1999, p. 41). The coping processes include the coping capacity, cognator and regulator subsystems for coping processes, and stabilizer and innovator subsystems for control processes.

Coping capacity. Coping capacity is viewed as an important stimulus to enhance adaptation. One’s coping ability as an adaptive system serves as a significant internal input for the person; output, in contrast, relates to the actual behavior. Coping involves the four dimensions already mentioned: regulator and cognator coping subsystems for individuals, and stabilizer and innovator control subsystems for groups.

Cognator and regulator coping processes. The cognator subsystem for individuals is a coping process that interacts primarily with the other three modes. This system includes four cognitive–emotive channels: (1) perceptual and information processing, (2) learning, (3) judgment, and (4) emotion.

The regulator subsystem for individuals constitutes a major coping process that includes an extremely linked physiological mode. The neurochemical and endocrine systems respond unconsciously to stimuli through neural, chemical, and endocrine coping channels; thus, they affect the fluid, electrolyte, and acid–base balance, as well as the endocrine system. These responses are interrelated and act in concert with one another, rather than in isolation, to maintain the equilibrium of the systems.

Stabilizer and innovator control processes. The stabilizer subsystem for groups is a control process associated with systems maintenance involving structures, values, and daily activities to fulfill the purpose of the social system. The innovator subsystem is a control process related to individuals in groups; it encompasses structures and processes associated with personal change and growth within social systems.

**Adaptive Modes**

The coping process responses constitute the outputs of the human adaptive system. These responses are reflected in behaviors, which are interrelated adaptive modes. As such, adaptation is evident in four adaptive modes for individuals: (1) physiological, (2) self-concept, (3) role function, and (4) interdependence. For groups, the four adaptive modes are (1) physical, (2) identity, (3) role function, and (4) interdependence. Thus “behavior in one mode may have an effect on or act as stimulus for one or all the other modes” (Roy & Andrews, 1999, p. 51).

Physiological/physical mode. The physiological mode reflects the way that individuals as physical beings interact with the environment. This mode consists of two components: the physiological mode and the physical mode. The physiological mode pertains to the individual. In this mode, persons manifest the physical processes and activities of living organisms (Roy, 2009). The behavior in this mode represents the physiological manifestations of a person’s cells, organs, and systems. This mode has nine components: five basic needs (oxygenation, nutrition, elimination, activity and rest, and protection) and four processes (senses, fluid and electrolyte balance, neurological function, and endocrine function). The basic need of the physiological mode is physiologic integrity.

By comparison, the physical mode relates to “the way the human adaptive system of the group manifests adaptation relative to basic operating resources, that is, participants, physical facilities and fiscal resources” (Roy, 2009, p. 43). The fundamental need of the physical mode is resource adequacy.

The self-concept/group identity mode. The self-concept mode reflects personal aspects of individuals related to behavior. A self-concept is “the composite of beliefs and feelings that an individual holds about him or herself at a given time” (Roy, 2009, p. 44). The basic need for the self is psychic and spiritual integrity—that is, the need to know who one is so that the person can live with a sense of unity and purposefulness in the universe (Roy, 2009). Self-concept includes three components: (1) physical self (body image and body sensations), (2) personal self (self-consistency, self-ideal), and (3) the moral–ethical–spiritual self.

The group identity mode reflects group aspects of behavior. It comprises four subdimensions: (1) interpersonal relationships, (2) group self-image, (3) social milieu, and (4) group culture. The basic need underlying this mode is identity integrity of the group.

The role function mode. Focusing on the roles that the person has in society, the basic needs underlying the role function mode have been identified as social integrity, role clarity, and the need to know who one is in relation to others so that one can act. This mode relates to the function or responsibility that an individual or group has in society.

The individual has three types of roles:

 1. A primary role, which is unchangeable because it is based on age, gender, and developmental stage.

 2. A secondary role, which is related to the expectations of the individual and the primary role. This role is an important one because it relates to the life project of each individual.

 3. A tertiary role, which is temporary, is linked to the first two roles. In general, the tertiary role can change and is derived from the secondary and primary roles. Tertiary roles are freely chosen and often relate to small tasks undertaken in the course of a person’s life.

In relation to groups, Roy (2009) established that the role’s functions are “the vehicle through which the goals of the social system are actually accomplished” (p. 44)—relating to their mission or the tasks associated with the functions of the group. The role function includes the function of administrators and staff, the management of information, and systems for decision making and maintaining order.

The interdependence mode. The interdependence mode is the category of behavior related to relationships that individuals and groups establish with others. For individuals, this mode focuses on those interactions through which the individual receives and gives love, respect, and valuation. The basic need of this mode is nurturing relationships. For groups, this category reflects the group’s social context.

The adaptive modes reflect the responses of the coping processes of the individual or group to the focal, contextual, and residual stimuli. These modes are interrelated, such that a response in one mode affects the responses in the other three modes and is expressed in an individual’s behavior. Roy’s adaptation model is a systems model, meaning that it has elements of an “interactional” model. It was developed specifically to be used in caring for individual clients, but it can also be adapted for use with families and communities.

**The Nursing Process**

When implementing the nursing process according to the Roy adaptation model, human experiences and responses are approached in a nontraditional way. An individual or a group of individuals is viewed as a holistic adaptive system. Stimuli from the internal and external environments trigger the coping processes maintained by the four adaptive modes. The nurse assesses the behavior of the person or group and the influence of the stimuli on behavior; based on this assessment, the nurse then formulates nursing diagnoses.

Roy (2009) viewed the nursing process as relating to human beings as adaptive systems. This process includes six steps:

 1. Assessment of behavior

 2. Assessment of stimuli

 3. Nursing diagnosis

 4. Goal setting

 5. Intervention

 6. Evaluation

Assessment of behavior. The first step involves gathering behavioral data. During the assessment, the nurse systematically examines responses in each adaptive mode, uses observational skills, and compares current measurements to preestablished measurements. Effective communication and caring take precedence—an approach that contributes to the effectiveness of nurse–patient interactions.

Assessment of stimuli. The second step of the nursing process is an extension of the first and encompasses the identification of internal and external stimuli affecting particular behaviors. In completing this assessment, the nurse utilizes skills similar to those applied in the first step. Identifying the behavior that threatens the integrity of the system is the primary concern. During the identification process, the nurse pinpoints the focal, contextual, and residual stimuli that influence the response, as well as the adaptation level that contributes to adaptive or ineffective behavior.

Nursing diagnosis. Nursing diagnosis, according to Roy, is a judgment process that confirms the adaptation status of the person or the group. In formulating a diagnosis, the nurse primarily uses critical thinking. The nursing diagnosis must include behaviors with the most relevant influencing stimuli (Roy, 2009, p. 68).

Goal setting. Goal setting entails the establishment of clear statements vis-à-vis the outcomes of nursing care, as well as the time frame for the expected attainment of the goal. Goal setting is established following the nurse’s assessment. The statement of a goal helps it to materialize and ensures that the behavior of the person or the group becomes the focus.

Nursing intervention. The nursing intervention step requires that the nurse choose nursing interventions that promote the adaptation process. After the selection of nursing-appropriate interventions, nurses develop an approach to initiate the steps needed to change the focal stimuli and enhance coping abilities.

Evaluation. Evaluation is the last step of the nursing process; it involves an assessment of the effectiveness of the nursing intervention based on the previously established goals. This step could be the last one in the process, but it might also serve as a change agent to begin a new intervention if the previous goal was not achieved.

The most valuable feature of this process is the collaboration between the person or group and the nurse in every step of the nursing process. Under the auspices of the Roy adaptation model, the effectiveness of the intervention depends on the nurse’s knowledge of the situation and the way in which the nurse obtains collaboration from the person or persons involved.

**Application of the Model to Education, Research, and Practice**

The use of the Roy adaptation model for nursing education is well documented. This model is used not only in the United States, but also in Asia, Europe, South America, Central America, and Mexico. One of the benefits of using the Roy adaptation model in education is that it provides students with a solid structure for thinking in a holistic manner and developing critical thinking skills. Indeed, the benefit of using this model as a framework for nursing practice has been demonstrated throughout the world, although the level of integration of the model into practice varies among hospitals and countries. Roy’s model generally is found to be useful in focusing, organizing, and directing nurses’ thoughts and actions regarding client care, resulting in a perception that the quality of nursing and client outcomes are improved. An example is easing the patient into a state of adaptability to care. The nursing role in this adaptation process is pivotal in maintaining adaptive responses and converting ineffective responses to adaptive ones to achieve health.

Research indicates that the Roy adaptation model is a conceptual model of nursing being used in nursing practice in the United States, Japan, Brazil, Colombia, Mexico, Panama, and Peru. Collectively, the studies in these countries demonstrate that using the model leads to better adaptability to care by patients and improved healthcare outcomes (Moreno & Alvarado, 2009).

Literature has shown that the Roy adaptation model is most useful as a tool when used in nursing research. Numerous quantitative and qualitative research studies have been conducted using Roy’s model as a conceptual framework, and several research instruments have been derived from it (Fawcett, 2005). Many middle-range theories can be created and derived from Roy’s conceptual system. A review of the literature revealed that the model has been used in descriptive studies of personal responses to environmental stimuli and correlations between the modes, manifestations of the stimuli, and effects of nursing interventions that are linked to propositions of the model.