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The Roy Adaptation Model: A Theoretical Framework for Nurses Providing Care to Individuals with Anorexia Nervosa

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The utilization of nursing theory as a framework in research is essential to knowledge development, and promotes theory-based nursing practice. Grounding nursing research in a theoretical framework facilitates a better understanding of human experiences with health and illness within the healthcare system. Over the past 50 years, the Roy Adaptation Model (RAM) has been used to guide interdisciplinary education, knowledge development, practice, and research.¹⁻² The purpose of this paper is to provide an overview of the RAM as a theoretical framework to better understand individuals with anorexia nervosa (AN) as they experience weight restoration (i.e. restoring or increasing body weight to healthy weight) during acute treatment (i.e., inpatient & residential), and the role of nursing interventions in the promotion of weight restoration.

AN is a severe psychiatric disorder with high mortality and suicide rates.³⁻⁵ Acute treatment is often required to intervene with potentially life-threatening medical consequences and starvation-induced cognitive impairment from significantly low body weight. Weight restoration is an established component of acute treatment for AN, with the standards of care and practice guidelines being primarily based on clinical expertise and consensus.⁶ Unfortunately, weight restoration is not guaranteed, and there is variability in rates of weight gain. Studies have shown that a subset of individuals experience an initial or overall weight loss,⁷⁻⁸ and other patients gain weight but do not achieve a healthy body weight.⁹ Moreover, a large percentage of patients leave treatment prematurely and fail to restore weight,¹⁰⁻¹¹ or relapse and lose weight shortly after discharge.¹²

Nurses are predominantly responsible for body weight assessments and protocol implementation,^{6,13} and play a critical role in the treatment process through daily interactions with patients.¹⁴⁻¹⁶ Nurses are expected to maintain a good therapeutic relationship with the patient,¹⁶⁻¹⁸ while simultaneously maneuvering the duality of roles as a member of the treatment team and an advocate for the patient.¹⁹ Consistency, directness, empathy, respect, and transparency are thought to be essential to establishing and maintaining a therapeutic alliance.^{16,20-21} According to nurses and patients with AN, effective nursing interventions include monitoring and supervising treatment adherence, offering encouragement and support, providing education about AN, and role

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modeling.^{13,16,20} To date, research has increased our understanding of the importance of the therapeutic relationship and nursing interventions that are perceived as effective by nurses and patients. Despite these advances, there is a scarcity of knowledge about specific nursing interventions during acute treatment for AN. Framing nursing interventions from the perspective of the RAM would provide structure and guidance to nurses as they provide care to individuals with AN. Hence, in this paper; the author will (1) provide a concise explanation of the RAM, (2) explicate specific aspects of the RAM particularly relevant to nursing care of patients with AN as they experience weight restoration, and (3) discuss the implications for nursing practice and research.

The Roy Adaptation Model

The theoretical assertion of the RAM is based on philosophic, scientific, and cultural assumptions derived from systems theory, adaptation-level theory, and cultural challenges of the 21st century.¹ Table 1 provides a summary of the principles and assumptions of the RAM.

The philosophical assumptions are characterized by the general principles of humanism, veritativity, and cosmic unity.¹ Humanism assumes that individuals behave purposefully, possess intrinsic holism, realize the need for relationships, share in creative power, and strive to maintain integrity. Veritativity complements humanism and affirms a common purposefulness of human existence. Veritativity assumes the activity and creativity for the common good, the purposefulness of human existence, the unity of purpose of humankind, and the value and meaning of life. Cosmic unity assumes that reality is based on people and the earth having common patterns and integral relationships. The scientific assumptions are based on the phenomena of living systems having complex processes of interaction and acting to maintain the purposefulness of existence in a universe.¹ The cultural assumptions are an integration of cross-cultural experiences, cultural needs and the necessity to eliminate culture-bound analysis of key concepts.¹

The major concepts of the RAM include: an individual as adaptive system, the environment, health, and the goal of nursing.¹ As an adaptive system, an individual is defined as a whole with parts that function as a unity for a purpose.¹ The environment is defined as all conditions, circumstances, and influences that surround and affect the development and behavior of humans as adaptive systems with particular consideration of human and earth resources.¹ Health is a state and process of being and becoming integrated and whole.¹ The goal of nursing is to enhance life processes to promote adaptation, with adaptation being the process and outcome of thinking and feeling individuals who use conscious awareness and choice to create human and environmental integration.¹

Similar to any complex adaptive system, an individual with AN has coping processes or defense mechanisms which serve to maintain adaptation in four critical modes: interdependence, physiological, role-function, and self-concept.¹ Figures 1 and 2 provide representations of human adaptive systems and individuals with AN as adaptive systems, respectively.

A person with AN constantly interacts with changing internal and external environments, and experiences stimuli which activate defense mechanisms resulting in behaviors. Ineffective defense mechanisms in one or more of the critical modes impact a person's adaptation level. The ability of an individual to effectively adapt to stimuli is contingent upon the person's adaptation level, the situational demands, and pre-existing levels of functioning.¹ Functional life patterns are a person's response to health problems and are derived from life processes. In order to alter the health-illness trajectory of the person, nursing must have knowledge about life and functional health patterns and responses, and nursing interventions should be directed towards altering human responses, patterns, and life processes.¹ Given the essential role of nurses during acute treatment for AN, the application of the RAM to individuals with AN will provide a better understanding how weight restoration does not occur in isolation but rather reflects an adaptive process within external and internal environments. Figure 3 depicts the application of the RAM to individuals with AN during acute treatment. This perspective will direct nurses to assess specific mechanisms in each mode of adaptation to guide nursing interventions that promote weight restoration and thereby improve treatment outcomes.

The Individual with AN as an Adaptive System

Individuals with AN receive environmental input to support the belief that restriction of caloric intake is an effective way to manage internal emotional states and resolve challenges to sense of self and control. Over time, restricting caloric intake becomes an acquired defense mechanism that is deeply rooted as a learned response.²² During acute treatment, weight restoration is perceived as a threat, and patients may make the judgment to limit or prevent weight gain to manage internal emotional states and resolve challenges to sense of self and control. As the intensity of the threat exceeds the patients' ability to manage their emotional states, restriction of caloric intake is perceived as necessary and a vital coping strategy for survival.

Stimuli—Stimuli are a way to describe the environment, and the environment consists of complex patterns of interaction, feedback, growth, and decline.¹ Three classes of stimuli (i.e., contextual, focal, residual) make up the adaptation level, and are constantly shifting in response to interactions between humans and earth. Focal stimulus is internal or external, involves the immediate awareness of the individual and requires the use of energy and resources.¹ AN is characterized by significantly low body weight secondary to severe restriction of energy intake as well as a fear of or persistent behavior that interferes with body weight gain.²³ During acute treatment, individuals with AN tend to focus on thoughts, feelings, and behaviors related to body weight, resulting in the activation of defense mechanisms and behaviors to prevent or limit changes in body weight. Recent research hypothesizes that individuals with AN believe that food consumption will cause catastrophic weight gain, and any degree of weight gain stimulates a fear of uncontrollable and exponential weight gain.²⁴⁻²⁵ Persons with AN also fear that weight restoration will lead to intolerable emotions, or violate their sense of self.²⁴ Acute treatment for AN is often perceived as direct opposition to individuals' desire for control over body weight, which may result in power struggles between patients and nurses. Research has suggested that individuals with AN will disengage from treatment and turn to eating disorder behaviors

during periods of enforced treatment (e.g., nasogastric tube feeding) or power struggles.²⁶⁻²⁷ As patients repeatedly struggle to abate their fears and regain a sense of control, patterns of behaviors to prevent weight gain may become even more deep-rooted.

Contextual stimuli are internal or external factors that influence the ability to respond to the focal stimulus and contribute directly to adaptation but are not the focus of attention and energy.¹ Among individuals with AN, contextual stimuli may be characterized as the diagnosis of AN, related biological vulnerabilities, and impaired defense mechanisms. Studies have identified factors that are positively associated with weight gain during acute treatment, such as weight suppression,²⁸⁻²⁹ body mass index (BMI) prior to onset of AN,³⁰ and desired BMI at discharge by adolescent patients and their parents.³⁰ Research has also revealed factors that are negatively associated with weight gain include body dissatisfaction³¹ and number of prior hospitalizations for AN.³⁰ All of these factors may be considered contextual stimuli because they influence the individual's ability to adapt to the process of weight restoration during acute treatment.

Residual stimuli are internal or external environmental factors that may affect the current situation, but the influence of such variables are unknown or unclear.¹ Residual stimuli constantly shift in response to the individual's interactions with the changing environment.¹ For example, negative affect is a risk factor for eating pathology,³²⁻³³ and more recent research suggests that variability in affective lability and intensity may be salient to eating disorder symptoms.³⁴⁻³⁵

Adaptation Level—As mentioned above, the ability of an individual to effectively adapt to stimuli is contingent upon the person's adaptation level, the situational demands, and pre-existing life processes.¹ Life processes are conceptualized as integrated, compensatory, and compromised.¹ Integrated is an adaptation level at which the structures and functions of a life process are working as a whole to meet human needs.¹ Compensatory is an adaptation level at which defense mechanisms have been activated by a challenge to the integrated life processes.¹ Compromised results from inadequate integrated and compensatory life processes, and is an adaptation problem.¹ If an integrated life process changes to a compensatory level of functioning, then the person will attempt to reestablish an integrated adaptation level. A compromised level of functioning is the result of the inability to reestablish an integrated adaptation level.¹ Healthy body weight is an anthropometric measurement that indicates adequate nutrition and caloric intake to maintain energy homeostasis. Healthy persons eat normal amounts of food to maintain a healthy body weight. Individuals with AN restrict caloric intake to manage emotional states and resolve challenges to personal control, leading to a compensatory adaptation level. Over time, persons with AN develop severe deficiencies and malnutrition indicated by significantly low body weight. As restriction of caloric intake persists as a deeply rooted defense mechanism, human needs are not being met and individuals with AN have a compromised level of functioning. During acute treatment, weight restoration is vital to reestablishing an integrated level of functioning in which all components of the individual function in unison to maintain health, or adaptation.

Behavioral Responses—Behavioral responses, or behaviors, are internal or external actions and reactions under specific circumstances and demonstrate how well an individual is adapting to stimuli.¹ Behavioral responses reflect defense mechanisms ability to adapt to the constantly changing environments, and also act as feedback and additional input to the adaptive system.¹ Behaviors can be observed, measured and subjectively reported. Unlike ineffective behavioral responses, effective behaviors promote the integrity of the person and the goals of adaptation including survival, growth, reproduction, mastery, and human and environment transformations.¹ For individuals with AN, the restriction of caloric intake tends to be a learned behavior to reflect the deeply rooted defense mechanisms to manage emotional states and resolve challenges to personal control.^{22,27} Unfortunately, for the overall human body system, such behavioral responses are ineffective and compromise health and overall adaptation.

Defense Mechanism—Defense mechanisms are internal ways of interacting with the environment, and are divided into two subsystems, regulator and cognator.¹ The cognator subsystem refers to learned defense mechanisms through repetition, and involves perceptual and informational processing, learning, judgment, and emotion.¹ Individuals with AN receive environmental input (e.g., relief from negative emotions, appraisal and/or increased attention from others) to support the belief that restriction of caloric intake is an effective way to manage internal emotional states and resolve challenges to self-control. As time passes, the restriction of caloric intake becomes an acquired defense mechanism that is deeply rooted as the learned response. The regulator subsystem refers to genetically pre-determined defense mechanisms that occur without human intervention, and is concerned with the individual's innate and automatic signals from neural, chemical, and endocrine system channels.¹ This subsystem responds to stimuli within the environment with a complex integrative central and peripheral signaling network of positive and negative feedback mechanisms to maintain energy homeostasis.¹ As individuals with AN continue to restrict caloric intake, they prevent weight gain or promote weight loss. As a result, the regulator subsystem is altered and unable to maintain energy homeostasis resulting in severe physical consequences and pervasive disturbances in most organ systems.³⁶⁻⁴¹

Adaptive Modes—Since it is not possible to directly observe the processes of the regulator and cognator subsystems, behavioral responses are manifested in four critical modes of adaptation: interdependence, physiological, role function, and self-concept.¹ Persons with AN tend to exhibit ineffective behavioral responses throughout each of the four modes, and a disruption in one mode significantly influences the others.

The definition and application of each adaptive mode to persons with AN are shown in Table 2. The goal of RAM nursing practice is to promote adaptation in each of the four modes leading to integrated level of functioning.¹

Practice Application

During acute treatment for AN, the goal of nursing is to identify patients' adaptation levels and coping capacities, identify behaviors and stimuli that influence weight restoration, and provide interventions to alter defense mechanisms and promote adaptation in at least one of

the four adaptive modes. The adaptive modes applied to persons with AN and nursing interventions are shown in Table 3.

The interdependence mode involves interaction with others, and a central notion is the giving to and receiving from others, such as love, respect, value, nurturing, knowledge, skills, commitment, time, talents, and material possessions.¹ Interdependence consists of affectional adequacy and developmental adequacy, and difficulties in one or both components can lead to a compromised level of functioning.¹ Thus, for the interdependence mode, the nurse should focus on social support. In general, persons often seek assistance, or social support, when affectional and developmental challenges occur. Unfortunately, individuals with AN struggle with ineffective development of relationships and insufficient social support for affection and relationship needs.⁴² This population also tends to struggle with ineffective patterns of giving and receiving, ineffective patterns of dependency and independency, and lack of security in relationships.⁴²⁻⁴³ During acute treatment for AN, nurses and patients described how nurses facilitate interactions with peers, encourage support from and to peers, challenge irrational cognitions, and recommend active involvement in social activities in treatment and outside of treatment.^{16,20} Ongoing monitoring of social support will help to guide nursing interventions to develop and reestablish affectional adequacy and developmental adequacy as well as the central notion of the interdependence mode, the giving to and receiving from others.

For the physiologic mode, nurses should be “knowledgeable about normal body processes to recognize compensatory and compromised processes of physiologic adaptation” (Roy, 2009, p. 89). Within the physiologic mode, nutrition and fluid, electrolyte, and acid-base balance are essential for physiologic integrity.¹ Compromised processes related to these vital aspects of the physiologic mode include malnourishment, dehydration/over-hydration, electrolyte imbalance, and metabolic acidosis or alkalosis.¹ Thus, nurses should focus on monitoring vital signs, body weight, and caloric intake to provide information about the physiologic mode of individuals. Among individuals with AN, chronic restriction of caloric intake and low body weight can lead to significant physical consequences, cognitive deficits, and pervasive disturbances in most organ systems. Unfortunately, refeeding syndrome, characterized by a rapid shift from a catabolic to an anabolic state, can be a consequence of rapid nutritional rehabilitation leading to congestive heart failure, respiratory failure, coma, seizures, metabolic acidosis, and death.^{41,44} Ongoing and regular knowledge about nutrition and fluid, electrolyte, and acid-base balance, will guide nursing interventions to reestablish an adaptive state of homeostasis and avoid refeeding syndrome, while simultaneously challenging patients' beliefs about food consumption and catastrophic weight gain and how weight gain will lead to intolerable emotions, or violate sense of self.²⁴⁻²⁵

For the role function mode, nurses should focus on autonomy and sense of control. Autonomy is defined as a “core psychological need that transpires as individuals' ability to act in a self-determinant manner and with an internal perceived locus of control.”⁴⁵ Several theories have emphasized the role of specific family patterns in the development of AN, such as enmeshment, overprotection, rigidity, conflict avoidance, and involvement of the child in parental conflicts.⁴⁶⁻⁴⁷ More specifically, hypotheses suggest that the development of AN is a manifestation of individuals' inability to develop autonomy, and a maladaptive effort to

cope with emotions and regain control of self and personhood.⁴⁶⁻⁴⁷ During acute treatment, individuals with AN need to experience a sense of initiative and volition as well as mastery and effectiveness to foster autonomy and a sense of control, which will lead to the gradual acceptance of change and better outcomes.⁴⁸⁻⁴⁹ Studies that examined nursing care for adolescents with AN on an inpatient unit, described different phases of effective nursing care, including (a) the directional and controlling approach in which patients relinquish complete control over eating and exercise; (b) the supervisory approach in which patients gradually regain control and nurses are primary role modeling and challenging eating disorder cognitions, and (c) the supportive approach in which patients are encouraged towards independent decision making.^{13,16,20-21} Acute treatment requires individuals to relinquish control and adhere to treatment protocols. However, it is important to regularly monitor sense of autonomy and sense of control to help guide nursing interventions to promote social adaptation related to role function, inclusive of the facilitation of individuals' ability to act in a self-determinant manner and regain control of self and personhood.

During acute treatment for AN, nurses should also focus on monitoring shape and weight overvaluation, or undue influence of body weight or shape on self-evaluation, a key diagnostic feature of this disorder.²³ Nurses should have knowledge about the self-concept mode to assess behaviors and stimuli influencing individuals' self-concept because adaptation problems in integrity of self can interfere with the ability to recover.¹ It is noteworthy that both males and females with AN experience shape and weight overvaluation, but males tend to have a drive for muscularity and leanness compared to females who tend to have a drive for thinness.⁵⁰ Thus, to foster psychic integrity, nurses should collaborate with patients to challenge specific aspects of shape and weight overvaluation (e.g., drive for thinness vs. drive for muscularity and leanness) which may lead to shifts in self-concept and behaviors that promote weight gain and ultimately recovery. Additionally, shape and weight overvaluation is a potential residual stimulus in that patients may decrease their valuation of shape and weight throughout acute treatment, leading to shifts in patterns of behavior that promote weight gain. However, patients who endorse heightened valuation of shape and weight may have greater difficulty tolerating weight gain, resulting in poorer treatment outcomes (e.g., leaving treatment prematurely, minimal weight restoration).

Overall, nurses need to play a more integral role in facilitating change in all areas of functioning, and not focus primarily on the process of weight restoration. Individuals with AN are adaptive and holistic systems with life processes that are interrelated.¹ Thus, nursing interventions in at least one of the four modes will significantly influence the others and promote overall adaptation and reestablishment of an integrated level of functioning including weight restoration.

A Case Study

In this last section of the article, a case study will illustrate how nurses can play a more integral role in treating individuals with AN during acute treatment. The case study will provide a pathway for the application of the RAM to have more clinical relevance, and will help to synthesize the science and art of nursing in relation to treating individuals with AN.

Annie—Annie is a 19 year old single White female with history of AN (onset at age 16) and three admissions to inpatient, residential, and partial hospitalization programs for her eating disorder over the past two years. She was admitted to residential treatment after being discharged from an inpatient medical unit because of low body weight and a syncope episode while running. On admission, she weighed 99.5 lbs. (45.13 kg) with a height of 64 inches (1.63 meters), and a BMI of 17.1 kg/m². In the first week of being at the residential program, Annie refused to eat several of her meals, was constantly pacing the unit, and was exercising in her room and bathroom. When asked about her struggles to adhere to treatment, Annie replied that she had gained too much weight and could feel her stomach protruding, and she didn't want to be “fat again” because it made her more depressed. Restricting her caloric intake and excessive exercising had become acquired defense mechanisms and deeply rooted learned responses to support Annie's belief that these behaviors helped to manage her negative emotions. Annie perceived weight gain as a threat to this belief, and believed that food consumption would cause catastrophic weight gain and lead to intolerable emotions.

To challenge Annie's beliefs about food consumption and catastrophic weight gain, nurses collaborated with Annie to establish daily goals for meals (“I will complete 100% of meal plan at every meal”) and then informed Annie of whether she met weight gain expectations (“yes/no”) after being weighed (3 times per week). At times, she did not meet the weight gain expectations despite eating 100% of her meal plan. Annie slowly realized (with some resistance) that although she “felt her stomach protruding and fat,” she did not have catastrophic weight gain with increased food consumption and at times actually lost weight. Eventually, Annie agreed to journal for at least 5 minutes after meals; and, at least twice per week, with one of the nurses, she discussed her struggles with increased emotion regulation difficulties and challenged her belief that restricting caloric intake and excessive exercising were appropriate behaviors to manage her negative emotions. During these discussions, nurses also focused on shape and weight overvaluation, a key diagnostic feature of AN. Over time, Annie articulated how shifts in her valuation of shape and weight impacted her eating disorder behaviors, mood, and willingness to engage in treatment (e.g., complete meal plan, refrain from exercise). Finally, nurses discussed alternative strategies to manage negative emotions; and helped Annie develop daily and weekly goals to use new strategies. Nurses regularly assessed Annie's safety by inquiring about her mood and sense of hopelessness. If Annie had expressed worsening mood and hopelessness with increased suicidal thoughts, nurses would have discussed the need for a higher level of care to ensure her safety.

When asked about what made her feel happy, she replied “running and losing weight.” Three years ago, as she started to lose weight, she felt happy and in control. Over the past two years, her friends had left for college. Since she was not allowed to graduate high school because of the amount of missed days, she felt “awkward” and declined or canceled most of her social plans. With regard to family dynamics, her father was a partner at a law firm and worked 90+ hours per week. “He's always busy.” Annie's mother worked in finances, and became part-time “because of me. She used to monitor all of my meals and wait for me after school. But now I'm an adult.” To facilitate relational integrity, nurses focused on promoting social support. Nurses encouraged Annie to reconnect with her friends via text message or

email. With the help of nurses and her peers, Annie drafted letters to her friends and parents that offered an apology, explained her eating disorder, and suggested how they may provide support. Towards the end of her admission, Annie articulated how insecurities about herself and her friendships fueled negative emotions and contributed to her increased isolation and eating disorder behaviors. Furthermore, by focusing on social support and having a collaborative relationship with Annie, nurses facilitated the fostering of autonomy and a sense of control and helped Annie to reevaluate the family dynamics in her individual and family therapy sessions.

Overall, nurses played an integral role in facilitating change in all areas of functioning, and did not primarily focus on Annie's behaviors that interfered with weight restoration. Through daily and sometimes weekly assessment of specific mechanisms in each adaptive mode, nurses were able to guide interventions that altered Annie's responses and patterns to promote weight restoration, and health. Although challenging within the residential environment, nurses provided opportunities and collaborated with Annie to develop goals to experience autonomy and a sense of control (*Role Function Mode*). Nurses regularly assessed and monitored Annie's body weight, caloric intake, and physical activity, and simultaneously developed interventions to discuss emotion regulation difficulties and seek out alternative strategies to manage negative emotions (*Physiologic Mode*). During her first week of treatment, nurses monitored Annie's electrolytes (i.e., potassium, calcium, phosphate, magnesium) to assess for possible refeeding syndrome and need to slow down the rate of feeding or replenish essential electrolytes (*Physiologic Model*). Throughout her treatment, nurses monitored urine specific gravity to evaluate hydration status and potential water loading (*Physiologic Model*). Nurses assessed and discussed how shape and weight overvaluation impacted Annie's self-concept and treatment, and collaborated with Annie to establish goals to challenge her self-concept (*Self-Concept Mode*). Nurses promoted social support to help Annie develop relationships that reestablished affectional adequacy and sufficient support in her friendships as an adult (*Interdependence Mode*). In essence, nursing interventions rooted in the RAM theoretical framework altered Annie's defense mechanisms, and promoted adaptation including weight restoration, and overall health.

Conclusion

Linkages between the major concepts of the RAM and individuals with AN are provided in this article, and nursing interventions based on the RAM are suggested. It is evident that the RAM functions as a theoretical framework in generating knowledge and research related to AN. There is a need for studies to determine whether the proposed nursing interventions significantly impact treatment outcomes, and establish the congruence of the RAM to the practice setting and draw attention to potential challenges in the clinical application. Furthermore, research studies are needed to explore the relationship between emotion regulation difficulties (*Interdependence*), autonomy and sense of control (*Role Function*), overvaluation of shape and weight (*Self-Concept*), and the process of weight restoration (*Physiologic*) among individuals during acute treatment for AN. Such knowledge will further our understanding of the underlying mechanisms that may contribute to the development and maintenance of AN. Moreover, utilization of the RAM as the theoretical framework may help to explicate the heterogeneity among individuals with AN, and

facilitate the development of novel treatment interventions that are more individualized and client-focused versus one-size-fits-all.

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Figure 1. Representation of Human Adaptive Systems

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Figure 2. Representation of Individuals with Anorexia Nervosa as Adaptive Systems

Figure 3. Application of the Roy Adaptation Model to Individuals with Anorexia Nervosa during Acute Treatment

Table 1
Principles and Assumptions of the Roy Adaptation Model

Philosophical Assumptions	
<ul style="list-style-type: none">■ Persons have mutual relationships with the world and a God-figure■ Human meaning is rooted in an omega point convergence of the universe■ God is intimately revealed in the diversity of creation and is the common destiny of creation■ Persons use human creative abilities of awareness, enlightenment, and faith■ Persons are accountable for entering the process of deriving, sustaining, and transforming the universe	
Scientific Assumptions	
<ul style="list-style-type: none">■ Systems of matter and energy progress to higher levels of complex self-organization■ Consciousness and meaning are constitutive of person and environment integration■ Awareness of self and environment is rooted in thinking and feeling■ Human decisions are accountable for the integration of creative processes■ Thinking and feeling mediate human action■ System relationships include acceptance, protection, and fostering interdependence■ Persons and the earth have common patterns and integral relations■ Person and environment transformations are created in human consciousness■ Integration of human and environment meanings results in adaptation	
Cultural Assumptions	
<ul style="list-style-type: none">■ Experiences within a specific culture will influence how each element of the RAM model is expressed■ Within a culture there may be a concept that is central to the culture and will influence some or all of the elements of the RAM to a greater or less extent■ Cultural expressions of the elements of the RAM may lead to changes in practice activities such as nursing assessment■ As RAM elements evolve within a cultural perspective, implications for education and research may differ from experience in the original culture	

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Table 2
Definition of Adaptive Modes & Application to Individuals with AN

Mode	Definition	Applied to Individuals with AN
Interdependence	Need is relational integrity. To feel secure in nurturing relationships through the giving & receiving of love, respect, & value.	Struggle with trusting others. Struggle to establish & maintain friendships or intimate relationships. Social withdrawal & isolation.
Physiologic	Need is physiologic integrity. Manifestation of all physiologic activities comprising the human body.	Human body downregulates to preserve homeostasis, leading to significant & potentially life-threatening medical consequences & cognitive deficits.
Role Function	Need is social integrity. Pertains to roles & expectations of the person in society in relationship to others.	Struggle with autonomy and sense of control. Struggle with identity in society.
Self-Concept	Need is psychic & spiritual integrity. Composite of beliefs and feelings about oneself that directs all behavior.	Struggle with shape and weight overvaluation, which has negative impact on self-esteem, self-worth, and self-confidence.

Table 3
Adaptive Modes Applied to Individuals with Anorexia Nervosa and Nursing Interventions

Definition of Mode	Applied to Individuals with AN	Intervention/Nursing Therapeutics
Interdependence Need is relational integrity. To feel secure in nurturing relationships through the giving & receiving of love, respect, & value.	Struggle with trusting others. Struggle to establish & maintain friendships or intimate relationships. Social withdrawal & isolation.	Regularly assess & monitor emotion regulation difficulties. Discuss emotion regulation difficulties as individuals experience the process of weight restoration. Mimic & teach alternative strategies to manage emotions; and develop plan to use alternative strategies.
Physiologic Need is physiologic integrity. Manifestation of all physiologic activities comprising the human body.	With low weight, the human body downregulates to preserve homeostasis, leading to significant & potentially life-threatening medical consequences & cognitive deficits.	Monitor body weight and vital signs. Record & monitor caloric intake. Monitor and provide structure surrounding meals. Regularly discuss emotions associated with body weight & food intake.
Role Function Need is social integrity. Pertains to roles & expectations of the person in society in relationship to others.	Struggle with autonomy and sense of control.	Regularly assess perception of autonomy & sense of control. Collaborate with patients and develop goals to experience autonomy. Provide opportunities to promote a sense of control (e.g., offering options at meals).
Self-Concept Need is psychic & spiritual integrity. Composite of beliefs and feelings about oneself that directs all behavior.	Struggle with shape and weight overvaluation, which has negative impact on self-esteem, self-worth, and self-confidence.	Regularly assess & monitor severity of overvaluation of shape and weight. Discuss how overvaluation of shape and weight impacts self-concept and treatment. Collaborate with patients to establish incremental goals to challenge overvaluation of shape and weight