

# **The Social Cognitive Theory**

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# 4. The Social Cognitive Theory

- Social Cognitive Theory (SCT) started as the Social Learning Theory (SLT) in the 1960s by Albert Bandura. It developed into the SCT in 1986 and posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior. The unique feature of SCT is the emphasis on social influence and its emphasis on external and internal social reinforcement. SCT considers the unique way in which individuals acquire and maintain behavior, while also considering the social environment in which individuals perform the behavior. The theory takes into account a person's past experiences, which factor into whether behavioral action will occur. These past experiences influence reinforcements, expectations, and expectancies, all of which shape whether a person will engage in a specific behavior and the reasons why a person engages in that behavior.

- Many theories of behavior used in health promotion do not consider maintenance of behavior, but rather focus on initiating behavior. This is unfortunate as maintenance of behavior, and not just initiation of behavior, is the true goal in public health. The goal of SCT is to explain how people regulate their behavior through control and reinforcement to achieve goal-directed behavior that can be maintained over time.

The first five constructs were developed as part of the SLT; the construct of self-efficacy was added when the theory evolved into SCT.

**1. Reciprocal Determinism** - This is the central concept of SCT. This refers to the dynamic and reciprocal interaction of person (individual with a set of learned experiences), environment (external social context), and behavior (responses to stimuli to achieve goals).

**2. Behavioral Capability** - This refers to a person's actual ability to perform a behavior through essential knowledge and skills. In order to successfully perform a behavior, a person must know what to do and how to do it. People learn from the consequences of their behavior, which also affects the environment in which they live.

**3. Observational Learning** - This asserts that people can witness and observe a behavior conducted by others, and then reproduce those actions. This is often exhibited through "modeling" of behaviors. If individuals see successful demonstration of a behavior, they can also complete the behavior successfully.

**4. Reinforcements** - This refers to the internal or external responses to a person's behavior that affect the likelihood of continuing or discontinuing the behavior. Reinforcements can be self-initiated or in the environment, and reinforcements can be positive or negative. This is the construct of SCT that most closely ties to the reciprocal relationship between behavior and environment.

**5. Expectations** - This refers to the anticipated consequences of a person's behavior. Outcome expectations can be health-related or not health-related. People anticipate the consequences of their actions before engaging in the behavior, and these anticipated consequences can influence successful completion of the behavior. Expectations derive largely from previous experience. While expectancies also derive from previous experience, expectancies focus on the value that is placed on the outcome and are subjective to the individual.

**6. Self-efficacy** - This refers to the level of a person's confidence in his or her ability to successfully perform a behavior. Self-efficacy is unique to SCT although other theories have added this construct at later dates, such as the Theory of Planned Behavior. Self-efficacy is influenced by a person's specific capabilities and other individual factors, as well as by environmental factors (barriers and facilitators).

# Limitation of Social Cognitive Theory

There are several limitations of SCT, which should be considered when using this theory in public health. Limitations of the model include the following:

- The theory assumes that changes in the environment will automatically lead to changes in the person, when this may not always be true.
- The theory is loosely organized, based solely on the dynamic interplay between person, behavior, and environment. It is unclear the extent to which each of these factors into actual behavior and if one is more influential than another.
- The theory heavily focuses on processes of learning and in doing so disregards biological and hormonal predispositions that may influence behaviors, regardless of past experience and expectations.
- The theory does not focus on emotion or motivation, other than through reference to past experience. There is minimal attention on these factors.
- The theory can be broad-reaching, so can be difficult to operationalize in entirety.

# Summary

- This theory has been used successfully in many fields including communication, agriculture, public health, criminal justice, social work, and marketing. In public health, Diffusion of Innovation Theory is used to accelerate the adoption of important public health programs that typically aim to change the behavior of a social system. For example, an intervention to address a public health problem is developed, and the intervention is promoted to people in a social system with the goal of adoption (based on Diffusion of Innovation Theory). The most successful adoption of a public health program results from understanding the target population and the factors influencing their rate of adoption.
- For more on diffusion of innovation theory see "On the Diffusion of Innovations: How New Ideas Spread" by Leif Singer.