BANDURA'S SOCIAL COGNITIVE THEORY PART II

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This is Part II of Bandura's Social Cognitive Theory project. Bandura's Social Cognitive Theory emphasizes simultaneous and reciprocal effects of the environment and behavior, whereby humans are the product of a dynamic interplay of personal, behavioral and environmental influences. Two journal articles based their research experiments on Bandura's theory, and are the topic of discussion for the following paper. The articles are: "Using Theory to Interpret Beliefs in Migrants Diagnosed with Latent TB," and "The effect of Bandura's social cognitive theory implementation on addiction quitting of clients referred to addiction quitting clinics." The description of the experiments are listed below.

Research Article 1:

"Using Theory to Interpret Beliefs in Migrants Diagnosed with Latent TB"

The design being used in this research study was qualitative; conducted with 23 Hispanic migrants with latent TB infection. The goal of the research was to describe environmental, cognitive and social factors that were barriers to screening, diagnosis and treatment of these men.

The researcher's rationale for the study was to better understand the Mexican-American culture and impact of cultural communication within the migrant population. Through extensive exposure to the migrant population, researchers gained understanding of how migrants viewed their world and structured their experiences. The aim was to learn what the group believed, in order to gain an insider's view, from their own perspective (Wyss, 2006, p. 7). With this knowledge, researchers were able to make nursing recommendations to improve medication regimen adherence among the migrant farm workers who had been exposed to TB. It is extremely important, because when they don't complete their TB medication regimen, they pose a threat to the entire migrant population traveling across borders. Moreover, the studied

population is frequently obstructed by environmental barriers to complete their nine month medicine regimen for latent TB, such as no transportation to clinic, nowhere to stay when they are off season, and political and financial uncertainties involved with U.S. harvests (Wyss, 2006, p. 1). As a result, lack of adherence to the TB medication regimen poses a major health risk to the migrant population as a whole (Wyss, 2006, p. 4).

In this study, there were 300 workers from four farms who were tested with a Mantoux skin test. Those with positive Mantoux tests and non-active TB had a physical exam, chest x-ray and blood work for liver enzymes. 23 people had a final diagnosis of latent TB, and were chosen as informants. The others were excluded from the study. Each of the 23 TB clients was asked to take INH every day for nine months. One hour interviews that lasted for several months, were conducted on each person, to ascertain their beliefs, and likelihood they would adhere to the medication.

To translate in the permission process and interviews, a migrant interpreter who spoke English and Spanish was paid to assist. All 300 migrant workers were verbally asked for permission to be tested, without signing permission slips (since subjects were afraid of deportation). Protected by anonymity, they also agreed to let researchers take notes.

The main results of the study revealed that social aspects in the environment were a supportive factor for migrants; especially those with families. One woman explained that she and husband supported each other as a family unit; reminding one another to go to the doctor and take the medicine. Another migrant expressed stronger sense of efficacy by stating that he would follow instructions for medication, because he knew he had to. Another worker insisted he had no health problems, and that neither his wife nor anyone else have influence on him. Researchers noted this as an indication that he has a strong sense of control and infallibility.

Analysis of data considered environmental factors and cognitive/emotional beliefs and behaviors through using social cognitive perspective. This provided a better understanding of the barriers migrants face during TB treatment regimens. This included the extent the environment might be adapted to minimize these external barriers; and the extent to which social cognitive beliefs (strong sense of efficacy) can help the migrants overcome barrier (Wyss, 2006, p. 9).

Negative environmental factors were the (1) work schedule, (2) hard to get to the clinic and (3) language barrier. One man said he did not know how to get into town to get the blood work and no one spoke Spanish there. Besides environmental barriers, some men did not believe they were sick so the negative impact of the disease was not a factor for motivation to get the medication and keep up with the medicine regimen.

Using the Bandura social cognitive model as a foundation for this research study, Wyss knew that environmental factors would create barriers such as financial status, seasonal work, daily work schedule, and transportation. That is why he chose the Bandura social cognitive model. The social factors that might cause barriers were coworkers, members of the community, health professionals, family. As Wyss had predicted, the reciprocal determinism model from the social cognitive perspective was useful as a framework for assessing the factors that affected the adherence by migrant informants. In addition, Bandura's framework was better suited for this study as opposed to the Heath Belief Model which other studies have used to predict widespread failure of participants in programs to find or prevent TB. HBM has shown to be inconsistent in predicting adherence to medical regimen, so Bandura's model was deemed more appropriate by Wyss.

Wyss' findings made the following positive changes in the migrant farm environment they researched: evening clinical hours were added, transportation was added for those who need to get the medication regimen, interpreters have been included at the clinic and on the busses during x-rays and blood work; legal clinic has been expanded to help migrants gain permanent resident status in the U.S. (Wyss, 2006, p. 10).

<u>Research Article 2:</u>

"The effect of Bandura's social cognitive theory implementation on addiction quitting of clients referred to addiction quitting clinics."

This experimental study was a before-after two-group design; consisting of 60 eligible heroine/morphine addict clients selected from Imam Reza Hospital clinic in Mashhad, Iran. Referred by Reza Hospital, they were randomly assigned to two groups (test) and (control) of 30 people per group. Each participant completed a 16 question self-efficacy questionnaire before the intervention, and again after the intervention. The questionnaire solicited the subjects' problem-solving, decision-making, self-protection, and communication skills. Then the data was analyzed using t-test, Chi-square test, ratio differences, exact Fisher test, and paired t-test.

Intervention for the test group was based on Bandura's social cognitive theory, while the control group received conventional treatment. Quantitative data involved measurement of mean and standard deviation of clients' self-efficacy scores before and after intervention in the test and control groups, to render efficiency of Bandura's social cognitive theory in treating addiction.

The research goal was to examine the effect of Bandura's social cognitive theory implementation on addiction quitting of clients referred to Imam Reza Hospital addiction quitting clinic. Furthermore, addiction and addiction quitting is a main problem of health systems around the world, with an 80% recurrence rate. Clearly, the need is great to learn more about "the nature and therapeutic method of addiction" (Heydari, 2014, p. 19). Eliminating an

addiction is a matter of personal changes and modifications in a multi-dimensional perspective. Nurses are key players in identifying drug abusers and scheduling drug intervention. With their knowledge and skills, they greatly influence quality of care, success in client self-regulation, and self-efficacy to kick the habit (Heydari, 2014, p. 20).

The intervention on the test group was based on Bandura's social cognitive theory. It was conducted in eight group sessions that lasted from 60 to 90 minutes each. Step one was to assess educational needs, and then give test group some information on addiction and treatment. Step two divided them into groups of six to eight to inspire vulnerability, e.g., change attitude by group discussion. Step three lasted 4 sessions where they were taught problem-solving skills, self-projection skills, problem resolution, and communication skills. Fourth step was social support (two sessions), and last session was a summation of all the sessions, and gave the participants guidance for their future referrals. A follow-up for one month, consisting of weekly morphine-measurement test was conducted, and post test used addiction quitting self-efficacy questionnaire to analyze the effect of the educational course (Heydari, 2014, p. 21).

In the two groups, there was no significant difference in age, self-efficacy level before intervention, sex, marital status, educational level, etc. The only difference was that test group had 14.8% recurrence, and control group was much higher at 40.9% recurrence. The test group's education program that was based on Bandura's cognitive social theory did much better on successful quitting. The study revealed "although pharmaceutical treatment is the first choice for addiction, clients need non-pharmaceutical interventions and detoxification to experience stable and effective behavior" (Heydari, 2014, p. 21). Data scores also showed that 90% of clients in test group compared to 73.3% in the control group could experience addiction quitting. Between the two groups, the recurrence was at a 61.4% rate the first 12 months, and out of those 50.6%

occurred in the first 4 months. Overall, the aim of the treatment was to help them admit to their addiction as a chronic disease and then change their lifestyles to stop the disease progression.

Recurrence of heroine/morphine addiction is very high, not only in this study but many others mentioned by the researchers. The intervention sessions designed from Bandura's cognitive social theory were successful, because it increased addiction quitting over the other group's general intervention. Therefore, researchers were successful in proving their hypothesis that it would be a success (Heydari, 2014, p. 22).

Comprehensive Summary

Bandura's social cognitive theory is very effective for use in addiction intervention and chronic disease intervention, because the factors involved for health behavior change affect each other in a reciprocal way. The cognitive/personal determinant factors of how we see ourselves in relation to disease, healing, power to succeed and sense of control, are influenced by our environment. The environment is exposed, selected and structured. This is a wide spectrum of influence, but Bandura clearly believed that we have the power to succeed with education, support and skill mastery.

Motivation inspires humans to reach goals, but to have goals we need inspiration of some sort. Expectations are like a blueprint for completing a project – a goal that influences attainment. If a person is motivated to reach a goal to attain good health, the person has to admit to the disease and accept it before behavior change can take place. Bandura's social cognitive theory is founded on the understanding of reciprocal determinism; the view that cognition is critical in our ability to clarify reality, regulate our behaviors, and encode information. His theory is about thought and action, and why we react the way we do. There are variations in all actions, and all people. However, the basic tenets of his social cognitive theory put the

responsibility on the individual and give him/her the tools and support to be proactive and

engage in self-development. That is why I chose Bandura's social cognitive theory for research

– it is credible and useful for many applications. It is human psychology and very introspective.

His emphasis on self-reflection to self-regulate is something that people have always

done, whether they are aware of it or not. Examples are magazine and television ads to eat

healthy, exercise, look cool, be beautiful, smoke or don't smoke; drink beer or stop drinking, etc.

These environmental influences draw our attention to ourselves and we then take responsibility

to make our own choices (good or bad). Similarly, in the healthcare setting, changing health

behaviors and believing that we can achieve the right goals, is the key ingredient to successful

intervention.

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