

The Theory of Planned Behavior involves attitudes towards behavior, subjective norms, and perceived behavioral control, and emphasizes behavioral intentions (Kunaneck & Hegge, 2024). This cognitive theory suggests that an individual's decision to engage in specific behavior can be driven by their intention to do so (Brooks, 2023). This paper will discuss these key components and how they may be applied in education and clinical practice.

The first component of the Theory of Planned Behavior is attitude, referring to the extent to which a person views the behavior in question favorably or unfavorably, reflecting our knowledge, attitudes, and prejudices (Ajzen, 1991; Brooks, 2023). The next determinant of intention is a social factor known as the subjective norm, which alludes to our perception of social pressure from others' attitudes toward performing or not performing the behavior (Ajzen, 1991). The final element of the theory is perceived behavioral control, which considers how easy or difficult an individual believes it is to perform a behavior. This idea encompasses both intention and action, shaped by past experiences and anticipated barriers. Essentially, when individuals feel a strong sense of control, they are more likely to form intentions to engage in the behavior and to persist with sustained effort when challenges arise (Brooks, 2023).

A recent experience in my OT education was the semester-long learning project. In this project, I focused on making candles and perfumes from my own blend of essential oils. Through my successes and failures, I explored how my attitudes, subjective norms, and perceived behavioral control influenced my approach and behavior throughout the project. As the candle-making process became more challenging, my motivation to succeed strengthened, driven by the intention to save money by continuing to make my own candles. Additionally, the subjective norm that others were already succeeding in their projects despite my continuous failures pushed me to hold myself to a higher standard and prove to myself that I can do hard things. Most importantly, my perceived behavioral control influenced my persistence; even after several failed attempts, I believed that sustained effort would ultimately lead to success. This conviction motivated me to work harder, find solutions, and stay committed rather than quit.

This theory can influence my future development as an Occupational Therapy practitioner because my attitude toward becoming an Occupational Therapist has remained unchanged since I worked alongside licensed OTs to help children with physical and mental disabilities reach their goals at Intensive Therapeutics. This mentorship has motivated me to specialize in an outpatient pediatric clinic. My attitudes toward professional norms will influence whether I meet this goal, as professionalism is expected in healthcare. Finally, my lifelong attitude toward learning will influence the interventions I may choose to implement with my future clients as the field of healthcare continues to evolve and be researched. The areas where I currently feel less confident are my ability to interact with the families of my future patients and to recall exactly what their conditions are. Steps I can take to increase my perceived behavioral control include continuing to learn from my professors and from each clinical case we are given in class, asking questions, practicing interactions with client families during Fieldwork Levels 1 and 2, and trusting in my hard work and preparation from conditions class last semester.

References

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