PSYCHO-EDUCATIONAL GROUP THERAPY AND SELF-COMPONENTS TRAINING ON SEXUAL ABSTINENCE AMONG IN-SCHOOL ADOLESCENTS IN ONDO STATE, NIGERIA

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CERTIFICATION

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DEDICATION

This work is dedicated to God, my ALL in all, whose inspiration kept fueling my vehicle of success to complete the Ph.D. programme. This work is also dedicated to my precious treasure, Iretiayomide Adenegan, whose esteemed virtues are exemplary for the growing adolescents and emerging adults. It is equally dedicated to all contemporary adolescents and youths I am destined to influence with my sexual abstinence campaign.

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ABSTRACT

The consequences of early sexual debut such as sexually transmitted infections, HIV/AIDS and unintended pregnancies have brought the study of adolescent sexual behaviour to the fore of sexuality research. Attempts have been made at understanding why adolescents engage in sexual activity at an early age. However, studies on the enhancement of sexual abstinence have been under-reported in Nigeria. This study, therefore, applied Psycho-educational Group Therapy (PGT) and Self-Components Training (SCT) in encouraging sexual abstinence among in-school adolescents in Ondo State, Nigeria. It examined the moderating roles of gender and peer influence.

The study was anchored on the theories of reasoned action and planned behaviour. Partial mixed design with 3x2x2 factorial matrix and qualitative approach using Focus Group Discussions (FGDs) were adopted. Multi-stage sampling technique involving stratified random sampling was used to select 121 in-school adolescents (44 males and 77 females) from three randomly selected secondary schools. The participants were screened using Sexual Abstinence Test for Adolescents and were randomly assigned into PGT, SCT and control group. Ten FGDs, which lasted three weeks, were conducted with the groups. Sexual Abstinence Scale ($\alpha = 0.89$), Sexual Abstinence Test for Adolescents ($\alpha = 0.77$) and Peer Pressure Inventory ($\alpha = 0.80$) were used for data collection. The treatment programmes lasted eight weeks. The qualitative data were content analysed, while the null hypotheses were tested using Analysis of Covariance and Scheffe Post-hoc test at 0.05 level of significance.

Participants' age was 12.9 years ± 1.145 with 24% of them sexually debuted at a mean of 10.1 years. There was significant main effect of treatments on sexual abstinence ($F_{(2,89)} = 96.66$, $\eta^2 = .710$). The PGT had the highest mean score ($\bar{x}=167.91$) in sexual abstinence, followed by the SCT ($\bar{x}=145.74$) and control group ($\bar{x}=127.79$). However, the two way interaction of gender and peer influence was not significant. There were no significant interaction effects of treatments, gender and peer influence on sexual abstinence. Rape, curiosity, financial gain, and fear of offending the predator making the advances were major reasons for early sexual debut. Sexual abstinence improved psychological well-being and enhanced higher educational attainment.

Psycho-educational Group Therapy and Self-Components Training were effective in enhancing sexual abstinence among in-school adolescents in Ondo State, Nigeria. Counselling, clinical and educational psychologists, as well as non-governmental organisations should adopt the two techniques in helping in-school adolescents.

Keywords: Psycho-educational group therapy, Self-components training, Sexual abstinence, In-school adolescents in Ondo State Nigeria

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Background to the Study

Today, crucial moral battles are being fought in our culture. The average adolescent experiences many pressures in the formation of personal sexual standards. Today's teenagers are growing up in an age where our culture insidiously presents sex as a commercial asset, fun, weapon, and status symbol, cure for loneliness, and as the crowning expression of romantic love. At the same time, our culture still officially labels it sin – outside the bonds of matrimony. In this situation, the growing adolescents stand confused.

Modernization has resulted in increasing numbers of adolescents relieved of fear of pregnancy by using pill. Bombarded by nudity and sex on all sides, for them, selecting a moral, code for sexual relations is a confusing and difficult task. There is no doubt that adolescents are seriously and eagerly trying to find a kind of life-style that incorporates and demonstrates their concern for one another and their search for identity. The fact that some standard must be chosen cannot be ignored. Sex is here to stay, and it remains a very basic force in human lives, and its presence cannot be ignored as can other ordinary human drives. It, therefore, becomes crucial to provide adolescents with adequate information about sex.

The period of adolescence is a very delicate phase of life from biological, psychological and social perspectives. It is a time when major lifestyle decisions have to be made including the decision to have or not to have sex. It is also the time adolescents integrate sexual impulse into self-concept. There is high sexual awareness, sexual activity and interest in the opposite sex. Adolescence is a period of transition between childhood and adulthood. It begins with physical changes during puberty. It ends when a person takes on adult roles and responsibilities. The sudden changes in adolescents may result in behavioural, social, peer and developmental problems, which are evident in early adolescence.

Sexual abstinence during adolescence and emerging adulthood stage is a moral virtue that is today welcomed with mixed reactions among adolescents (Odeyemi, Onajole & Ogunowo, 2009). Going by the inherent benefits of sexual abstinence, which includes safety from sexually transmitted infections and prevention of unwanted pregnancies, among others, adolescents would readily want to embrace the practice. On the other hand, the hormonal demands of their libido,

with the onset of puberty among other environmental factors, make it critical for the adolescent to avoid impulsive decision to initiate sex earlier than expected. An understanding of both sexual activity and sexual abstinence among young people is crucial in preventing the negative consequences of early sex initiation.

The increase in adolescent and young adult sexual behaviour during the last two decades has considerably attracted the concern and anxiety of parents and scholars alike globally. From a twelve year review of adolescent sexual behaviour across different parts of Nigeria, high level of sexual activity has been reported among unmarried adolescents of both sexes with progressively decreasing age of debut, risky sexual practices, including unprotected sexual intercourse with multiple partners (Aji, Aji, Ifeadike, Emelumadu, Ubajaka, Nwabueze, Ebenebe & Azuike, 2013). There appears to be a consensus among Nigerian researchers and observers that many cherished traditional values are changing rapidly and for the worse. One area of life in which the decline of traditional values is obvious is in the area of sexuality, which is evident in the acceptance of pre-marital sex most especially among youngsters (Koffi & Kawahara, 2008). In Nigeria, culture no longer has a grip on the youth as our society seems to be plagued with moral decadence and poor values (Oladepo & Fayemi, 2011). These seem to affect the youth, adolescents inclusive, more than any other group as this is manifested in the acceptance of sex before marriage, homosexual behaviour, lesbianism, abortion, drug addiction and indecent dressing.

One phenomenon among other things that corrupts the world is promiscuity most especially among the youth; and with its attendant effects (e.g. HIV/AIDS, STIs and adolescent sudden death syndrome). Adolescents' sexual activities are on the rise and rapidly emerging as a public health concern. Nnachi (2003) observed that in terms of behavioural problems, sex abuse appeared to be one of the most serious offences committed by children and adolescents. Obiekezie-Ali (2003) supported this stance with a United Nation's (2000) information on reproductive health, which shows that many Nigerian girls are known to start involvement in active sex at the early age of 13 years. For both boys and girls, Hammed and Adenegan (2009) reported that the mean age of initiating sexual intercourse was 13.1 years. The age of initial sexual experience and involvement thus becomes younger than 15 years as found by Esen in Egbochukwu and Ekanem (2008). Oladepo and Fayemi (2011) observed that today's situation

shows a sharp contrast to the traditional Nigerian societal context in which ladies avoided pre-marital sexual experiences for fear of social punishments usually meted out to girls who lost their virginity before marriage.

Popular opinion regarding the detrimental effects of adolescents' early sexual debut and teen parenthood is supported by empirical research. Specifically, several negative outcomes have been cited, including loss of wages and career opportunities, increased welfare dependency, interrupted education, single parenthood, psychological distress, increased medical complications during childbirth, and high likelihood of further unintended pregnancies (Bamidele, Abodunrin & Adebimpe, 2009; Ankomah, Mamman-Daura, Omoregie & Anyanti, 2011; Adenegan & Ogunlade, 2013). Children born to adolescents are also at risk for various negative outcomes, including low birth weight, infant mortality, and other health risks, as well as long term difficulties such as intellectual deficits, educational achievement and problem behaviours. Teenage childbearing is economically expensive as well. In 1985, it was estimated that the first child born to a teenager would cost the United States government at least $15,000 by the time that child reaches the age of twenty (Burt, 2000); one wonders what the cost implication would be in this age.

In addition, early sexual activity is also associated with an increased risk of sexually transmitted infections (STIs), reduced psychological and emotional well-being, lower academic achievement, teen pregnancy, and out-of-wedlock childbearing. Girls, most often, bear the consequences of early sexual activity in unwanted pregnancies, teenage births and abortions, often by quacks. Many of these risks are avoidable if teens choose to abstain from sexual activity. Abstinence has been remarkably observed as the surest way to avoid the risk of STIs and unwed childbearing.

In a world radically changed by the HIV/AIDS epidemic, many teens nevertheless choose to initiate sexual intercourse. UNAIDS (2013) reported that an estimate of 2.1 million adolescents (10 – 19 years) were living with HIV. In Nigeria, previous studies have validated the observation that sexual activity among unmarried adolescents and young adults is on the rise (Adetoro, Babarinsa & Sotiloye, 1991; Hammed & Adenegan, 2009; Oladepo & Fayemi, 2011).

The adolescent's sexual needs cannot be ignored. Sex, like many other human experiences, is a learning experience observed Adams (1976) and Adenegan (2010). The learning process in

the society has been hastened with the emphasis placed on heterosexual contacts at an early age. Even more unfortunate is the fact that many youths are unable to tolerate the waiting period. They desperately need the human closeness that the sexual experience can provide. The speed with which industrialized society has developed has removed many of the possibilities for human involvement and companionship that were available to many of the present day adults as they were growing to maturity. It is scarcely surprising that adolescents turn to their peers of the opposite sex for their emotional and physiological needs. In many respects it may not be desirable, but in every respect it should be understandable. If premarital sex and sexual debut are expected to decrease, the society that produces the situations which cause the need for the sexual involvement must first be looked into for change. In addition, the youth should be given both intellectual and emotional understanding of the implications of the sexual relationship.

Notably, like other aspects of psychosocial development, sexuality is not an entirely new issue that surfaces for the first time during adolescence. Young children are curious about their sex organs and at a very early age derive pleasure (if not what adults would label orgasm) from genital stimulation – as both Sigmund Freud and the famous sex researcher Alfred Kinsey pointed out long ago (Kinsey, Pomeroy & Martin, 1948). And, of course, sexual activity and sexual development continue long after adolescence. Although sexual development may be more dramatic and more obvious before adulthood, it by no means ceases at the end of adolescence. The fact remains that the 21st century has witnessed a geometric increase in the level of adolescent sexual initiation, with sexual abstinence and virginity as virtues being played down (Asuzu, 2009). This is not far fetched from the age of internet, in which cyber-sex has gravely exposed the innocent adolescents into various illicit practices.

Consequently, the adolescents are encumbered with many unanswered questions in their minds regarding their sexuality. From experiences with the adolescents, they are always seeking for answers to these unending questions. Today's young people face strong peer pressure to engage in risky behaviour and must navigate media and popular culture that endorse and even glamorize permissiveness and casual sex. Alarmingly, the government implicitly supports these messages by funding programmes that promote contraception and "safe-sex." Although many parents want schools to teach youths to abstain from sexual activity until they are in a committed

adult romantic relationship via marriage, which is the core message of abstinence education; these parental values are rarely communicated in the classroom (Oladepo & Fayemi, 2011).

Adolescence, a period of transition from childhood to adulthood, is probably the most challenging and tasking phase in the developmental process of the human organism. These challenges, which are often traumatic to most people stem from the fact that young males and females are faced with the task of biological, sexual and physical maturity as well as the adult society – induced demand for emotional stability; however, each of these invariable processes of maturation is independent of personal control of the adolescent which may often result in conflicts which the youngster may attempt to resolve by engaging in inappropriate and socially undesirable patterns of behaviour, especially sexual risk-taking behaviour (Uwakwe, 1998; Asuzu, 2014).

Despite all the huge investments of governments in sexual abstinence interventions, adolescents' rates of sexual activity increase rapidly during the adolescent years and many teens engage in sexual behaviour that places them at risk for unintended pregnancy and STIs, including HIV (Aji et al, 2013). Abstinence is a great choice for so many reasons. Having sex with an individual has psychological repercussions. If there is a breakup, increased chances of depression and unstable mental health are higher; and statistics show that teens who practise sexual abstinence are likely to do better in school; twice as likely to graduate from college than teens who do not practise abstinence (YLC, 2013). Only complete and consistent abstinence can totally prevent pregnancy and protect against STIs (Gavin, 2013).

Studies have shown that abstinent teens report, on average, better psychological well-being and higher educational attainment than those who are sexually active (Hallfors, Waller, Ford, Halpern, Brodish & Iritani, 2004; Hallfors, Waller, Ford, Halpern, Brodish & Iritani, 2005; Sabia & Rees, 2009). In other words, the benefits of sexual abstinence to in-school adolescents are evident in their academic performance. Delaying the initiation of or reducing early sexual activity among teens can decrease their overall exposure to risks of unwed childbearing, STIs, and psycho-emotional harm. Remarkably, sexual abstinence during adolescence and avoidance of pre-marital sex have been linked to sexual satisfaction in marriage and marital stability (Kim & Rector, 2010). Authentic abstinence programmes are therefore crucial to efforts aimed at reducing unwed childbearing and improving youth well-being.

Sexual abstinence has been identified as the best available option for preventing both pregnancy and sexually transmitted infections, including HIV/AIDS. Identifying the factors associated with sexual abstinence among adolescents would have meaningful implications in a generalized HIV epidemic country such as Nigeria in Africa. Notably, contextual and developmental issues influencing abstinence are poorly understood. Therefore, research needs to more clearly define sexual abstinence, as well as those factors that may promote or discourage early sexual activities.

Several studies (Sunmola, Dipeolu, Babalola & Adebayo, 2003; Jemmott, Jemmott & Fong, 2010; Oladepo & Fayemi, 2011; Rijsdijk**,** Bos**,** Lie**,** Ruiter**,** Leerlooijer & Kok, 2012) have been carried out to investigate the predictors of sexual abstinence among adolescents with diverse interventions to promote the practice. Major studies carried out have been surveys and not interventions. However, not much success had been witnessed in this direction. Majority of studies focused attention on the negative outcomes of premarital sex. There is paucity of researches on interventions in making adolescents remain virgins. It is therefore imperative that a research on promoting sexual abstinence among adolescents with quest for theoretically-based effective interventions is inevitable.

The first intervention for this study is psycho-educational group therapy. Psycho-education is concerned with the teaching of personal and interpersonal attitudes and skills which the adolescent applies to solve present and future psychological problems and to enhance his satisfaction with life regarding sexual abstinence. The Psycho-educational group therapy is a humanistic approach to changing the behaviour patterns, values, interpretation of events, and life outlook of individuals who are not adjusting well to their environment(s) (e.g. home, school, workplace, and in this case sexual stimuli). Inappropriate behaviour is viewed as a person's maladaptive attempt to cope with the demands of that environment. Appropriate behaviours are developed by helping the adolescent to recognize the need for change, and then helping the adolescent to display better behaviour choices regarding his sexuality.

Psycho-educational interventions tend to be "packaged" plans that are implemented and modified to the needs of the adolescent to address surfaced crisis in the participants' sexual desires. The Psycho-educational viewpoint seeks to understand the adolescent who is engaged in a struggle to adequately handle life situations. In doing so, it looks at both individual and social

explanations for inappropriate, anti-social, and otherwise unacceptable sexual behaviour patterns. The roots of psycho-educational orientation can be found in the humanitarian writings of the early to mid 1800 by individuals such as Pestalozzi, Itard, and Howe, among others. However, it was the 'mental hygiene' movement in the early 1900 that strengthened and promoted this humanistic approach for the treatment of those who experience psychological and behavioural disorders.

Psycho-educational group had been notably used to treat sexual addiction among adolescents with significant impact and extremely beneficial in addiction and mental health (Griffin-Shelley, 1994). It provides information, validation and support, help reduce distress, and help families develop better problem-solving and coping strategies (CAMH, 2004). Psycho-education as a pycho-behavioural intervention had been successfully used to increase the use of condom among sexually active adolescents (Fishbein & Ajzen, 2011) and adolescents living with HIV/AIDS (Walsh & Tiffany, 2013). Psycho-education has helped in raising awareness of adolescents about teenage pregnancy and prevention (Moore & Rosenthal, 2007); found effective as intervention among children victims of sexual abuse (Martine & Marc, 2010) and of use in promoting healthy sexuality among young adults (Hebert & Tourigny, 2010). It is, therefore, considered a veritable treatment that can be used to promote sexual abstinence among the adolescents.

This study employed psycho-educational group therapy to provide information designed to have a direct application to the participants' lives – to instill self-awareness, suggest options for growth and change, identify community resources that can assist them in recovery, develop an understanding of the process of recovery, and prompt adolescents engaging in risky sexual thoughts to change their negative thought patterns. The major purpose of Psycho-educational groups is expansion of awareness about the behavioural, medical, and psychological consequences of early sexual involvements.

The second treatment is self-components training modelled by the researcher as a follow up to the model of Schalet (2011). It is a treatment package that makes the individual adolescent to have a grasp of sexual self-concept, sexual self-esteem, sexual self-efficacy and sexual self-determination regarding sexual abstinence. Self-components consist of several psychological

variables or constructs such as self-concept, self-esteem, self-efficacy, self-determination, self-standard, among others, in relations to adolescent sexuality.

Sexual self-esteem and sexual self-efficacy are significant factors in discussing sexual health. Sexual self-esteem or self-worth is integral to sexual health because people must have some level of self-respect in order to develop the confidence to make independent, healthy decisions about the actions and behaviours in which they choose to engage. Sexual self-esteem has been positively linked to sexual communication including partnered discussions of STIs and sexual history while global self-esteem appears to be too broad a construct to relate (Oattes & Offman, 2007; Rosenfeld, 2004). Sexual self-efficacy, including perceived behavioural control and motivation, is also important: individuals need to have a sense of capability as well as knowledge (Meaney, Rye, Wood & Solovieva, 2009). Higher levels of sexual self-efficacy are predictive of positive attitudes regarding contraception and engagement in safe sex (Weiser & Miller, 2010). Sexually self-efficacious individuals also experience a greater sense of control in sexual experiences, including advocacy for one's sexual interests, lower levels of sexual anxiety, and higher levels of sexual self-awareness and sexual-subjectivity (Horne & Zimmer-Gembeck, 2005).

Self-components training is a novel technique by the researcher, though some of its indices (self-concept, self-efficacy and self-esteem) have been used and significantly found to enhance sexual abstinence among adolescents in various studies (Kowaleski-Jones & Mott, 1998; Hammed & Adenegan, 2009; Fishbein & Ajzen, 2011; Oladepo & Fayemi, 2011; Plummer, 2012) but not as entity. In this study, sexual self-concept, sexual self-efficacy, sexual self-esteem and sexual self-determination were used as components of self to enhance sexual abstinence among in-school adolescents. It is likely that greater experience of empowerment in any and all of these dimensions would significantly contribute to positive sexual experiences, and therefore promote sexual abstinence among the in-school adolescents.

There are several moderator variables including gender, age, ethnicity, race, home type (polygamy or monogamy) and sexual experience that might be considered in abstinence intervention research. However, the moderating variables for this study were gender and peer influence. The sex of participants is of great relevance. Many cultures in Nigeria show preference for the male child and accord him certain privileges often to the exclusion of the

female child. This leaves the female with little or no education and at a low socio-economic stratum with sex as the only bargaining tool. The male adolescents, likewise, are not left alone in their struggle with sex. Their secondary sexual growth, changes in hormonal secretion, emotional, cognitive and psychosocial development result in sexual curiosity and experimentation, often in situations of little reproductive health information or services.

Major predictors of sexual abstinence were being female, and not having a boyfriend/girlfriend. Adolescent female as compared with adolescent male are consistently older at initiation of sexual intercourse, often hold stronger normative beliefs supporting abstinence and are more vulnerable to direct negative sexual consequences, including pregnancy and sexually transmitted infections (Oladepo & Fayemi, 2011). Accordingly, it would be important to know whether abstinence interventions are more effective with adolescent females than with adolescent males, as well as the mediators of any differential intervention effect across gender. If abstinence programmes were known to be effective with both males and females, this lack of information would not be problematic. However, since efforts to delay and decrease sexual intercourse among adolescents have been mostly unsuccessful, it may be that there is the need to better understand how these gender differences relate to abstinence messages.

On the other hand, literature revealed that peer pressure influence sexual initiation and subsequent sexual behaviours, and adolescents who perceive their friends are engaged in sexual practices are more likely to adopt those same behaviours (Oladepo & Fayemi, 2011). Bhardwaj, Ramsay, Bain and Prakasam (2007) revealed that susceptibility of adolescents to negative peer influence is linked with greater tendency to copy the risky sexual behaviour of their friends. Egbochukwu and Ekanem (2008) found exposure to peer pressure at 61.2% as potent factor exerting a large measure of influence on the attitude of adolescents towards sexual practice.

For adolescents without sexual experience (virgins) and the sexually active adolescents (non-virgins), gender and peer influence were found to be significant predictors of intention to delay sexual intercourse (Oladepo & Fayemi, 2011; Rijsdijk**,** Bos**,** Lie**,** Ruiter**,** Leerlooijer & Kok, 2012). Understanding the interwoven and interconnected factors that influence sexual behaviours of adolescents is vital in designing and implementing sexual abstinence interventions. Hence the moderating variables (gender and peer influence) for this study.

Sexual abstinence is no doubt an identified viable option for preventing both pregnancy and sexually transmitted infections, including HIV/AIDS. However, sexual abstinence has been defined or examined based on sentiments (belief and background) of authors in the literature observed. Further, there is no consensus about whether sexual abstinence is a health protective behaviour or something more inclusive. Contextual and developmental issues influencing abstinence are poorly understood. In the classroom, the prevailing mentality often condones teen sexual activity as long as youths use contraceptives. Abstinence is usually mentioned only in passing, if at all. Sadly, many adolescents who need to learn about the benefits of abstaining from sexual activity during the teenage years never hear them, and many students who choose to abstain fail to receive adequate support for their decisions. Therefore, research needs to more clearly define and examine sexual abstinence, as well as those factors that may promote or discourage early sexual activities. Identifying the factors associated with sexual abstinence among adolescents would have meaningful implications in a generalized HIV epidemic country such as Nigeria in Africa.

Statement of the Problem

The Nigerian society today has to grapple with many widely publicized behavioural problems of its youth, which include heterosexual activities variously named as sex abuse, sex offences, sexual misconduct, sexual immorality, promiscuity and sexual maladjustment. The consequences of early sexual experimentation by young people are enormous. For example, the increased sexually transmitted infections (STIs) are attributed to sexual involvement by adolescents who do not know how to protect themselves. Global statistics show that out of the 36.9 million people currently living with HIV/AIDS, young people are predominant, with sub-Saharan Africa accounting for almost 70% of the new HIV infections (WHO, 2015).

In addition, there is likelihood that a young female who become pregnant in school will not want to give birth to a bastard; as such, may resort to abortion. According to WHO (2015), people who died of abortion complications are adolescents. Besides, adolescents who become pregnant will have low self-esteem, depressed, and possibly drop out of school due to poor academic achievements. Parents of pregnant teenagers face stigma in churches, mosques and in the community at large because people feel that they have failed in their parenting roles. The

consequences of premarital sex by young people are, therefore, grave for national development and life expectancy.

Prevalence of negative consequences of early sex initiation such as sexually transmitted infections and unintended pregnancies has prompted the study of adolescent sexual behaviour to the forefront of sexuality research. While an attempt at understanding why adolescents choose to engage in sexual activity at an early age has been made by researchers in this field, most specifically investigate adolescents' sexual behaviours. Examinations into the enhancement of sexual abstinence, however, have been less reported in Nigeria and have resulted in a significant gap in the literature surrounding this line of research.

The debate over what messages to give adolescents about the prevention of sexually transmitted infections (including HIV/AIDS) and pregnancy has proven to be confusing to youth and has proven conflictual and polarizing in many communities. Adolescent sexual activity is costly, not just for the adolescents, but also for the society. Adolescents who engage in sexual activity risk a host of negative outcomes including STIs, emotional and psychological harm, academic under-achievement, and out-of-wedlock childbearing. Genuine abstinence education is therefore crucial to the physical and psycho-emotional well-being of the nation's adolescents and youth. In addition to teaching the benefits of abstaining from sexual activity until marriage, the need for a psycho-educational group therapy and self-components training are germane to the enhancement of sexual abstinence among the adolescents with focus on developing character traits that prepare youths for future-oriented goals.

This study is predicated, therefore, on experimentally using psycho-educational group therapy and self-components training to enhance sexual abstinence among in-school adolescents with the intention of coming up with remediative measures that would be usable in planning adolescents' welfare in Nigeria vis-à-vis their sexuality.

Purpose of the Study

On the premise of the background to the study, the broad objective of this study was to examine the effectiveness of psycho-educational group therapy and self-components training in the enhancement of sexual abstinence among in-school adolescents in Ondo State, Nigeria. Specifically, the study was designed to:

- investigate the potency of psycho-educational group therapy and self-components training in promoting sexual abstinence among the participants; and
- determine the moderating effect of gender and peer influence on enhancing sexual abstinence among in-school adolescents in Ondo State, Nigeria.

Significance of the Study

It is expected that this study would provide a picture of possible contributions of psycho-educational group therapy and self-components training to enhancing sexual abstinence practice among adolescents in Nigeria. The outcome of the study would form a basis for practical techniques for counselling secondary school adolescents on HIV/AIDS prevention in a developing country, such as Nigeria. Such counselling intervention strategies could impact greatly on fostering positive attitudinal dispositions and response to sexual abstinence practices.

Specifically, the findings of this study would offer challenge to adolescents and youth counsellors to rise up to the occasion and proffer psychological remedy, which could be applied by adolescents in handling their sexuality, regardless of their background, disposition, beliefs, values, customs and culture.

Also, this study is expected to be significant to parents and teachers alike in assisting adolescents to handle negative peer influence and boost their self-efficacy in abstaining from premature sex. The adolescents themselves would benefit from the study by having clues to most of their unanswered questions regarding their sexuality. This would enable them navigate the adolescent stage with much ease.

This study would be significant as it is aimed at informing a major campaign promoting abstinence and delayed sexual debut among Nigerian adolescents. Since Nigeria is a very religious society and abstinence before marriage is in line with both Christian and Islamic beliefs (the two major religions practised in the country), the campaign that the findings will inform would likely garner a lot of goodwill and support from the Nigerian populace and especially gatekeepers. The findings from this study will also corroborate the "Zip Up!" campaign in Nigeria.

Besides, the findings from this study would serve as reference materials for future researchers to consult, and recommendations from the study could form the basis for choosing

research topics by researchers. In addition, policy makers would find the findings of the study helpful in formulating policies regarding adolescent sexuality.

Scope of the Study

This study focused on investigating the effects of psycho-educational group therapy and self-components training in enhancing sexual abstinence. The study was restricted to in-school adolescents in public co-educational (boys and girls) urban secondary schools in Ondo State, Nigeria with samples drawn from Junior Secondary (JS) 2 classes.

Operational Definition of Terms

For the purpose of this study, the following concepts were operationalised:

In-school adolescent: individual between the ages of 10 and 18 years, who is a student in a public co-educational secondary school used for the study.

Psycho-educational Group Therapy (PGT): is a treatment package that makes use of both psychotherapy and education to help the adolescent cope and properly adjust regarding sexual abstinence and sexual matters.

Self-components Training (SCT): is a treatment package that makes the adolescent to have a grasp of sexual self-concept (the sum total of adolescent's personality regarding sexual abstinence and sexual matters of which he/she is aware and can consciously call his/hers), sexual self-determination (the adolescent's resolution and commitment to practise sexual abstinence), sexual self-efficacy (confidence in the adolescent's ability to choose sexual abstinence and make appropriate decisions to remain abstinent) and sexual self-esteem (the adolescent's overall evaluation or appraisal of his or her own worth regarding sexual abstinence and sexual matters).

Sexual Abstinence: refers to the voluntary state of the adolescents in delaying or not engaging in sexual intercourse.

Sexually Experienced: refers to the state of the adolescent used for the study having had sex i.e. already initiated sex (non-virgin)

Sexually Inexperienced: refers to the state of the adolescent used for the study who has not initiated sex (virgin).

CHAPTER TWO

REVIEW OF LITERATURE

This chapter dealt with the theoretical and empirical review of relevant literature. The first part of this review focused on the philosophical definitions and explanations of concepts under the study followed by the empirically reported findings of each variable in various studies.

Theoretical Review

Sexual Abstinence

Sexual abstinence, according to encyclopedia, is the practice of refraining from some or all aspects of sexual activity for medical, psychological, legal, social or religious reasons. The word, abstinence, according to the Oxford Advanced Learner's Dictionary, is described as the practice of not allowing oneself something, especially food, alcoholic drinks or sex, for moral, religious or health reasons. The British Broadcasting Corporation English Dictionary emphasized it as the practice of not having something you enjoy; such as alcoholic drinks. Meanwhile, Awareness International Nigeria (2006) put sexual abstinence as keeping away from sexual activity, not engaging in sexual activity as a means of prevention of sexually transmitted infections (STIs) and unwanted pregnancy.

Sexual abstinence is defined differently by different people. For faith-based groups, abstinence means refraining from sexual intercourse until marriage. For others, abstinence means delaying sex until a later time, for example, when entering a regular relationship or before marriage. Hammed and Adenegan (2007) opined that sexual abstinence is a deliberate, conscious practice to refrain from or delay sex until marriage. This is related to the categorization of abstinence by programmers into primary and secondary. For the purposes of this study, primary abstinence is the commitment to delay sex till marriage for those who have never had sex (virgins or sexually inexperienced adolescents) while secondary abstinence refers to those who have initiated or experienced sex at one time (non-virgins) but decide to refrain from sex until marriage. Most campaigns often take it for granted that young persons particularly teenagers, know of and have a common agreement of what abstinence means.

Therefore, a common definition of abstinence is voluntarily refraining from vaginal, oral and anal intercourse till marriage. Some programmes defined it as refraining from any genital contact, even if there is no penetration. In general, abstinence until-marriage approach presents

abstinence as the only option for protection against unplanned pregnancy, HIV and STIs. It proposes that young people should postpone sexual intercourse until they are married. It does not discuss contraceptive options.

Santelli, Ott, and Lyon (2006) found varying definitions of abstinence, which ranged from postponing sex, never having had vaginal sex and secondary abstinence – refraining from further sexual intercourse, if sexually experienced (i.e. ever had sexual intercourse). This study refers to all the three forms of sexual abstinence. These findings suggest that youth do not consider abstinence and sexual activity opposing constructs. If they did, a stronger negative correlation would have been seen between abstinence cognitions and sex cognitions. These findings align with previous qualitative and quantitative findings on adolescents' conceptualizations of abstinence (Paradise, 2001; Michels, 2005; O'Sullivan & Brooks-Gunn, 2005; Ott, Pfeiffer & Fortenberry, 2006), demonstrating that teenagers consider abstinence and sex to be linked in complex ways, and view abstinence as not simply the "opposite of sex." Youth may view abstinence as a developmentally appropriate stage, which precedes the equally appropriate stage of becoming sexually active when they are "ready," as Ott, Pfeiffer and Fortenberry (2006) reported. Teenagers, especially females, may see endorsing abstinence as socially desirable, while their feelings about sexual activity may be far more complex, including elements of both desire and coercion (Tolman, 2002).

Historical Views on Abstinence

Historically, there has been a swing from the sexually free end of the Industrial Revolution to the chaste values of the early Victorian period (1837 – 1901) in the British history. This was then followed by a new Puritanism from the late Victorian era to the mid-1900s. This important transformation often colours discussion of sexual behaviour in the later 20th century. World War I began a return to sexual freedom and indulgence, but more often than not, the appearance of conforming to the earlier moral values of abstinence before marriage was retained. With the conclusion of World War II, the societal importance of abstinence declined swiftly. The advent of the first oral contraceptive pill and widely available antibiotics suppressed many consequences of wide and free sexual behaviour, while social morals were also changing. By the 1970s, abandonment of premarital chastity was no longer taboo in the majority of western societies; perhaps even the reverse; members of both sexes would have experienced a number of sexual

partners before marriage was considered normal. Some cultural groups continued to place a value on the moral purity of an abstainer, but abstinence was caught up in a wider reevaluation of moral values.

Throughout history, and especially prior to the 20th century, there have been those who have held that sexual abstinence confers numerous health benefits. For males, lack of abstinence was thought to cause a reduction of vitality. In modern times, the argument has been phrased in biological terms, claiming that loss of semen through ejaculation results in a depletion of vital nutrients such as lecithin and phosphorus, which are also found at high levels in the brain (GPR, 2006). Conservation of the semen allegedly allows it to be reabsorbed back into the bloodstream and aid in the healthy development of the body. During the early 20th century, prominent feminist and birth control advocate Margaret Sanger argued that abstinence from sexual activity led to greater endurance and strength, and was a sign of the best of the species (Wikipedia, 2009).

Along these lines, the noted German philosopher Friedrich Nietzsche in Wikipedia (2009) spoke of the positive physiological effects of abstinence: "The re-absorption of semen by the blood ... perhaps prompts the stimulus of power, the unrest of all forces towards the overcoming of resistances ... The feeling of power has so far mounted highest in abstinent priests and hermits". Before the "sexual revolution" of the 1960s, it was commonly believed by members of the medical profession that numerous mental and physical diseases in men were caused primarily by loss of nutrients through seminal discharge, and that the deliberate conservation of this substance would lead to increased health, vitality, and intellectual prowess. This also applied to masturbation, which was also thought to lead to bedwetting and hairy palms.

Some advantages in favor of sexual abstinence were also claimed that there is an important internal physiological relation between the secretions of the sex glands and the central nervous system, that the loss of these secretions, voluntarily or involuntarily, exercises a detrimental effect on the nutrition and vitality of the nerves and brain, while, on the other hand, the conservation of these secretions has a vitalizing effect on the nervous system, a regenerating effect on the endocrine glands and a rejuvenating effect on the organism as a whole.

In most cultural, ethical, and religious contexts, coitus within marriage is not considered to be opposed to chastity. Some religious systems try to prohibit sexual activities between a person

and anyone other than a spouse of that person, as have, in the past, legal systems and societal norms. In such contexts, sexual abstinence was prescribed for unmarried individuals for the purpose of chastity. Chastity has been used as a synonym for sexual abstinence, but they are similar but different behaviour and restrictions.

Some religions regard chastity as a virtue expected of faithful adherents. This usually includes abstinence from sex for the unmarried, and fidelity to a marriage partner. In some religions, some groups of people are expected to remain unmarried and to abstain from sex completely. These groups include monks, nuns, and priests in various sects of Hinduism, Buddhism and Christianity. Chastity is required of the respective sacerdotal orders. The Shakers, on the other hand, impose chastity in the form of celibacy for all members, even forgoing procreation. While there have been cultures which achieved total sexual abstinence, such as castration cults, it is unlikely that any of them survived for a substantial period of time, due to their lack of reproduction.

Many Christians teach that sexual intercourse is meant to take place within the context of marriage, and that sexual abstinence is the norm outside of that. But for married couples, Paul of Tarsus wrote that they should not deprive each other, except for a short time for devotion to prayer (1 Corinthians 7:3-5). Catholicism defines chastity as the virtue that moderates the sexual appetite. Unmarried Catholics express chastity through sexual abstinence. Sexual intercourse within marriage is considered chaste when it retains the twofold significance of union and procreation until marriage (Catholics Encyclopedia). But even then, in accordance with the teaching of the Apostle Paul, periods of abstinence are encouraged among married couples.

Regarding to abstinence in Judaism, Judaism forbids intercourse outside marriage (which is termed *zenuth* or promiscuity), but has no ideal of chastity. Within marriage abstinence is also required during and following a woman's menstruation. Islam forbids intercourse outside of marriage; however, maintaining celibacy as an act of piety is not mentioned, while marriage for all who are able is strongly encouraged. Sexual abstinence is practised during the time of a woman's menstruation. Abstinence from sexual intercourse is also practised from dawn to dusk during days where fasting is observed.

The Hindu tradition of Brahmacharya places great emphasis on abstinence as a way of harnessing the energy of body and mind towards the goal of spiritual realization. In males, the

semen is considered sacred, and its preservation (except when used for procreation) and conversion into higher life-energy is considered essential for the development of enhanced intellectual and spiritual capacities. In actual practice, there is a strong societal taboo against pre-marital sex for both males and females, which still exists today in Hindu societies.

Buddhism defines what is right and what is wrong in absolute terms for lay followers. By the third principle in Pancha Sheela, Buddhists pledge to refrain from unlawful sexual relationships. Buddhist monks and nuns of most traditions are expected to refrain from all sexual activities (Japanese Buddhism being a notable exception). The second of the Four Noble Truths states that the ultimate cause of all suffering is attachment and unquenchable desire (tanha), and the third states that the way to eliminate suffering is to eliminate attachment and desire. Sexual practices are characterized as both attachment (*kama-upadana*) and desire (*kama-tanha*).

Lifelong (or at least long-term) abstinence, often associated with religious asceticism, is distinguished from chastity before marriage. Abstinence is often viewed as an act of self-control over the natural desire to have sex. The display of the strength of character allows the abstainer to set an example for those not able to contain their "base urges." At other times, abstinence has been seen as a great social skill practised by those who refuse to engage with the material and physical world. Some groups that propose sexual abstinence consider it an essential means to reach a particular intellectual or spiritual condition, or that chastity allows one to achieve a required self-control or self-consciousness (Koenig, Zablotska, Lutalo, Nalugoda, Wagman & Gray, 2004; Kann, 2009).

On the other hand, there have been numerous studies (Aji et al, 2013) indicating that excessive repression of the sexual instinct leads to an increase in the overall level of aggression in a given society. Societies forbidding premarital sex are plagued by acts of rage and tend to have higher rates of crime and violence (Rector & Johnson, 2005). There may be a link between sexual repression and aggression, insensitivity, criminal behaviour, and a greater likelihood of killing and torturing enemies (Rector & Johnson, 2005).

Although many individuals abstain from sex for complex reasons such as religion or morality, for some individuals, sexual abstinence is simply a lifestyle choice. Those individuals who fall into this category may have a dislike of sex (anti-sexualism), or are simply not interested in it (asexuality). They may view sex as an unnecessary part of human life. As with

other lifestyle choices, this attitude toward sex and relationships can vary greatly. Some who choose such a lifestyle still accept sex for reproduction, some engage in romantic relationships, and some engage in masturbation.

Reasons and Motivations for Practising Sexual Abstinence

Sexual abstinence in teenagers decreases the risk of contracting STIs and having children outside marriage. According to Farnham (2003), compared to sexually abstinent teens, those who partake in sexual activity during high school years (e.g., at least until age 18) are: approximately half as likely to graduate from school; approximately half as likely to be accepted in of high school; almost twice as likely to drop out from college; on average, having approximately 15 percent lower incomes.

Sexual abstinence diminishes the risk of contracting sexually transmitted infections. On the other hand, it may necessitate relinquishment of potential health benefits of sex. A study (Farnham, 2003) tracked the mortality of about 1,000 middle-aged men over the course of a decade and found that men who reported the highest frequency of orgasm enjoyed a death rate half that of the laggards. The report also cited other studies to show that having sex even a few times a week may be associated with the following: improved sense of smell; reduced risk of heart disease; weight loss and overall fitness; reduced depression (in women); the relief or lessening of pain; less frequent colds and flu; better bladder control; better teeth; and improved prostate function. The report cited a study published by the British Journal of Urology International which indicated that men in their 20s can reduce by a third their chance of getting prostate cancer by ejaculating more than five times a week (Farnham, 2003).

The holistic view of Farnham (2003) about sex is commendable. It is clear that everything in life has its advantages and disadvantages. Indeed having sex at an early age or premarital sexual behaviour could harm adolescents' overall health in general and their sexual health in particular (Vesely, Wyatt, Oman, Aspy, Kegler, Rodine, Marshall, & McLeroy, 2004). The association between premarital sexual activities and the risk of acquiring sexually transmitted infections or increased risk of unprotected sexual behaviours are well documented (Wong, 2012; Ghebremichael & Finkelman, 2013). In addition there is evidence that adolescents who engage in premarital sexual activities may not experience the same quality marital relationship and stability as the married people who abstained from premarital sexual activities

(Ogunsola, 2012). Thus to prevent young adolescents from adverse outcomes of premarital sexual behaviours, sexual abstinence has been recommended (Kirby, Laris & Rolleri, 2007; Kohler, Manhart & Lafferty, 2008).

Common reasons for practising sexual abstinence include: poor health - medical celibacy; material reasons (to prevent conception – undesired pregnancy – or sexually transmitted infection or transmission); psycho-sociological reasons (e.g., clinical depression, social anxiety disorder, increasing testosterone in males, or negative past experiences); legal injunctions requiring conformity; circumstantial reasons such as incarceration or geographical isolation; to focus on other matters – sublimation; inability to find a suitable sexual partner – involuntary celibacy; religious or philosophical reasons; and physically or emotionally unprepared.

With reference to the posted blog of The Abstainers (2014), the following were identified as inherent benefits of abstinence: more self respect and more respect for each other; security that you're not being pursued for sexual reasons; Greater chance of faithfulness in marriage, and trust in your partner's ability to control him/herself with other people; chance to develop more depth in relationships; Less worries regarding pregnancy, birth control, STI's, emotional betrayal, etc.; peace of mind and joy in the knowledge that you are obedient to God in this area of your life; and better sex when you are married. Although premarital abstinence doesn't guarantee a great sex life, it certainly can start things off without baggage from past relationships. People who have had sex with multiple partners have numbed themselves to the connection it gives to the partner. This is relative based on the number of partners and the emotional bond of the relationship at the time. Many people need to work on reconnecting their sex life to their emotions once they are in a marriage relationship because it has been damaged by past promiscuity.

Others, as listed by The Abstainers (2014) included stronger marriage. Statistically it has been proven that marriages between people who have practised sexual abstinence have a lower divorce rate. Although sex is not the foundation of the marriage, it is a very essential part of the bond between husband and wife. Avoid choosing your mate based on their sexual performance over other characteristics such as shared values, goals and companionship; and freedom from memories of past sexual partners. All of the forgiveness in God's kingdom doesn't erase memories. Suppose you are sexually active, and do find the love of your life, and they are your

soulmate, but they are not the best sex you've ever had. If you had nothing to compare them to, they would be the best sex you've ever had because they would be the only sex you've ever had. Many people can work on sexual techniques and improve their sex life over years of marriage. Premarital abstinence will also spare your spouse of insecurities based on wondering if you are really satisfied with them sexually. These insecurities over time can erode a marriage. Also, a partner who finds him/herself frequently remembering past partners who may have been better in bed can cause guilt or conflicting emotions which will erode a marriage.

There are so many other personal, social and economical reasons why abstinence is a great idea. But ultimately, it all comes down to personal choice. Abstinence is a great choice for so many reasons. Here is a list of the most important reasons to practise abstinence, and why sexual abstinence is a 'big deal' as opined by YLC (2013):

1. Sexual abstinence is the only 100% guarantee that you won't become a mummy or a daddy until you're ready. (No stretch marks, no crying babies, no poopy diapers – until you're ready!)
2. Sexual abstinence is the only 100% guarantee that you won't get an STI. (While latex condoms can help prevent some STIs, they are not nearly 100% effective. Condoms don't prevent against gonorrhoea, or genital herpes among many other STIs)
3. Having sex with an individual has psychological repercussions. If there is a breakup, increased chances of depression and unstable mental health are higher.
4. Practising sexual abstinence is a great way to get to know your boundaries and develop a stronger relationship emotionally and spiritually with the person you are dating.
5. You won't need to hide anything from your parents or your friends, which takes a lot of pressure off your back and helps strengthen your relationship with them.
6. Statistics show that teens who practise sexual abstinence are less likely to have depression, less likely to attempt suicide, less likely to live in poverty as adults.
7. Statistics show that teens who practise sexual abstinence are likely to do better in school. (Twice as likely to graduate from college than teens who do not practise abstinence).

Statistically it has been proven that marriages between people who have practised abstinence have a lower divorce rate (Rahi, 2012). Sex is not the foundation of the marriage although it is a very essential part of the bond between husband and wife. Avoid choosing your

mate based on their sexual performance over other characteristics such as shared values, goals and companionship, opined Rahi (2012).

Sex Education and Abstinence

Efforts to prevent negative sexual outcomes among teenagers have taken two principal approaches: comprehensive sex education and abstinence-only programmes (Fortenberry, 2005). Comprehensive sex education programmes provide youth with information on pregnancy and STIs; sexual relationships, orientation and values; decision making and negotiation; and contraception, condoms and safer sex. Their intent is to equip teenagers to have positive sexual outcomes and prevent negative ones. These programmes include information on abstinence as a valid sexual choice and often teach techniques for saying no to unwanted sex. In contrast, abstinence-only programmes instruct adolescents to abstain from sex until marriage or to become "secondary virgins" by ceasing sexual activity until marriage. Typically, such programmes limit the discussion of contraception and condoms to their failure rates (Santelli, Ott, & Lyon, 2006) and teach the "gains to be realized by abstaining from sexual activity" and that a "mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity" (Haskins & Bevan, 1997).

In light of the widespread provision and funding of abstinence-only programmes in the United States (Advocates for Youth, 2007; Bleakley, Hennessey & Fishbein, 2006), it would be helpful to better understand how teenagers think about abstinence and how it functions in their lives. However, little research has explored these questions. The most rigorous studies of abstinence-only programmes have evaluated intentions to be abstinent, rather than avoidance of sexual behaviour (Santelli, Ott, & Lyon, 2006). This is not an unusual approach, given that theoretical models propose that cognitive mechanisms like intentions influence behaviour; however, no studies, according to Masters, Beadnell, Morrison, Hoppe and Gillmore (2008) have demonstrated that abstinence intentions predict sexually abstinent behaviour. In contrast, associations have been found between sex cognitions, including intentions, and the likelihood of having sex. To investigate the relationship between abstinence intentions and actual behaviour, it is necessary to differentiate between abstinence cognitions and sex cognitions.

A central question is whether teenagers regard "having sex" and "being abstinent" as opposites, as is often assumed, or whether their understanding of these constructs is more

complex. One qualitative study found that adolescents considered abstinence to be not so much a health choice, or even a moral choice, as a stage of life that was naturally followed by a sexually active life stage, once the teenager was "ready" (Ott, Pfeiffer & Fortenberry, 2006). "Readiness" for sex also appeared to play a role in a survey that investigated young women's reasons for having or not having sexual intercourse; beliefs and values were cited as reasons for not only abstaining from sex, but also engaging in sexual activity (Paradise, 2001). Furthermore, in a prospective cohort study of 12–15-year-old females, changes in teenagers' sexual behaviour (including intercourse, manual sex and oral sex) over a one-year period did not differ by their abstinence attitudes (O'Sullivan & Brooks-Gunn, 2005). These findings demonstrated that there is much to learn regarding youths' cognitions about sex and abstinence, and raise questions about whether and how these cognitions interact to influence sexual behaviour.

Abstinence-only Sex Education and Criticisms

Dailard (2003) in his view about abstinence-only sexuality education, posited that the programme should: teach that abstinence is the expected standard for all unmarried individuals; teach that having children outside marriage leads to negative consequences for the individual, family, and community; teach young people how to avoid unwanted sexual advances and how alcohol and drug use can impair the healthy use of judgment; and focus on the importance of being self-sufficient before engaging in sexual activity.

Research has suggested that abstinence-only education can be helpful for children in elementary and early middle school by providing information on the benefits of abstaining from sexual activity as well as how to ward off pressure to engage in unwanted sexual activity. Abstinence-only education can also provide support for those teens who choose not to engage in sexual activity (McCave, 2007).

Saul (1998) reports that a Planned Parenthood affiliate in Michigan received Adolescent Family Life Act funding for an abstinence-only education programme that helped seventh graders postpone sexual activity and fend off unwanted sexual pressure. In an evaluation of Pennsylvania's abstinence-only education programmes, Smith, Dariotis and Potter (2003) found that four out of thirteen abstinence-only education programmes had a positive effect on postponing sexual activity among children in elementary and early middle school. They

indicated that after eighth grade, the programmes offered positive reinforcement and support for those adolescents who were choosing to be abstinent. Therefore, the efficacy of abstinence-only approaches has been of concern, especially for older adolescents. According to Smith, Dariotis and Potter (2003), Pennsylvania's abstinence-only programmes were ineffective in delaying the onset of sexual activity in older teens and did not establish values that would lead to abstinence.

The Sexuality Information and Education Council of the United States advocated comprehensive sexuality education rather than abstinence only education (Nadler, 1997). The council, in 1996, emphasized that comprehensive sexuality education should cover "sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles" (Elia, 2000). In another development, The American Academy of Paediatrics (2001) asserted that comprehensive sexuality education should be provided for children and youths in fifth grade through high school. They argued that effective comprehensive sexuality education combines necessary skills in communication and negotiation, information on STIs and pregnancy prevention, and referrals to reproductive health resources and programmes. They promoted abstinence as the best option, and contraceptives as the next best option.

Considering the statistics, it appears that contraceptive use is the next best choice after abstinence (McCave, 2007). According to research by the Alan Guttmacher Institute, increased use of contraceptives explains 75 percent of the decline in teenage pregnancy between 1988 and 1995, compared to abstinence, which explains the remaining 25 percent (Dailard, 2003).

Kirby's (2001) report on programmes targeting pregnancy prevention provided a summary of effective program structures. Such programmes: provide accurate basic information about the risks of sexual activity and ways to avoid intercourse or use methods of protection against pregnancy and STIs; use approaches that influence other health-related behaviours and target important sexual antecedents; include activities that address social pressures that influence sexual behaviour; allow participants to practise communication, negotiation, and refusal skills; involve participants by personalizing the information; use behavioural goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students; last a sufficient length of time; and use trained teachers or peer leaders who believe in the program.

Kirby's (2001) report indicated that effective teen pregnancy programmes provide comprehensive sexuality education rather than relying only on abstinence-only education. Some

refer to comprehensive sexuality education as abstinence-plus education. Huberman and Berne (1995) pointed out that students who enrolled in seven different abstinence-plus education programmes were more likely than controls to abstain from sex for one to two years. This outcome is one that the Division of Adolescent and School Health of the Centers for Disease Control and Prevention has included in its protocol for evaluating school-based sexuality curricula, along with rates of condom use and unprotected sex. All the programmes that were found to be successful when measured against their outcome standards were comprehensive in scope, not abstinence-only programmes (Huberman & Berne, 1995).

Comprehensive sexuality education programmes not only promote abstinence as the most effective method for preventing sexually transmitted infections (STIs) and pregnancy but also provide students with information about how to protect themselves from pregnancy and STIs if they choose to engage in sexual activity (Chenneville, 2008b). Comprehensive sexuality education programmes incorporate developmentally and culturally appropriate information on a range of sexual health topics (Kirby, Laris, & Rolleri, 2007; McKeon, 2006). Walsh and Chenneville (2013) suggest, as a general rule of thumb, that HIV education for young children (aged 5–7 year) focuses on providing accurate information about contagion aimed at reducing the fear of contracting HIV and the stigma around persons with HIV. For older children (aged 8–10 years), HIV education should focus on providing accurate information on transmission and preventions. For adolescents (aged 11 and older), HIV education should focus on a thorough review of preventions and the biological mechanisms that underlie transmission.

Review of effective sexuality education programmes have identified a number of critical components including teaching medically accurate information about anatomy; abstinence and contraception; helping students understand their personal, family and community values; and developing social skills such as communication, refusal and negotiation skills. In addition to these topics, effective comprehensive sexuality education involves active student engagement with instruction delivered by educators trained in best practice of sexuality education methods (Kirby et al., 2007; McKeon, 2006; Walcott, Meyers, & Landau, 2008). The components of effective programmes include a theoretical base, trained facilitators, both abstinence and methods for engaging in safer sex, access to condoms and contraception, skill building for

reducing sexually risky behaviours and peer pressure, active engagement among students and a structured curriculum (Walcott et al., 2008).

Research findings suggest that comprehensive sexuality education programmes result in a multitude of positive outcomes for youth. Specifically, findings indicate that the initiation of sexual intercourse is delayed, the frequency of sex and the number of sexual partners are reduced and condom use is increased among youth that participated in these comprehensive programmes (Manlove, et al., 2001; McKeon, 2006). Despite strong evidence supporting these programmes, the current political climate is quite polarized on this issue. Since the early 1980s, the federal government's focus on funding abstinence only education [e.g. Title V, Section 510 of the Social Security Act (welfare reform), Community-Based Abstinence Education (CBAE), under Title XI, Section 1110 of the Social Security Act and Adolescent Family Life Act, under Title XX of the Public Health Service Act] has restricted comprehensive sexuality education for youth in the United States at the state and local levels (United States Social Security Administration, 2012).

Furthermore, findings from a recent study suggest that there has been a decrease of HIV prevention topics taught in schools between 2008 and 2010 (Kann, Brenner, McManus, & Weschler, 2012). As such, federal, state and local policies should seek to promote comprehensive sexuality education programmes for all students while abstinence only programmes should be changed to include information on protections for those who choose to engage in sexual activity (Walsh & Chenneville, 2013).

Interventions for sexually active students might involve the following: (1) additional small group sexuality education training with sexual health precautions (e.g. HIV testing); (2) explicit skills training (e.g. instruction and practice in proper condom use) and (3) social skills training that helps students say no if they do not want to engage in sexual activity. Certainly, great variability exists in the quality and inclusiveness of sexuality education programmes, with programmes ranging from "abstinence only" models to more thorough comprehensive sexuality education models. However, the widespread focus on restriction of sexuality present in many sexuality education programmes contributes to the taboo surrounding human sexuality, particularly when it comes to adolescents and young adults (Wernersbach, 2013). The effectiveness of abstinence programmes and movements remains debated amongst many levels.

Adolescent Sexuality

It has been suggested that socio-cultural factors determine how adolescent sexuality is expressed through the cultural context which pervades the adolescent's daily life (Moore & Rosenthal, 2007). Social institutions such as family and religion exert influence in three ways: they provide the norms for acceptable sexual behaviour; individuals in powerful roles in these institutions use norms as the basis for informal controls; and finally, there are often formal rules which constrain sexual behaviour through fear of institutional sanctions.

Adolescence has been considered from a variety of viewpoints. In the main, these viewpoints have approached the subject from a consideration of physiological and hormonal development, social influences, economic determination, or emotional development. Often it is considered from a combination of approaches, usually including physiological and hormonal maturation. One knows, for example, that the age of puberty, the time when the young person is capable of reproducing his kind, usually occurs sometime between the tenth and fifteenth year of the individual's life. For some, this has been considered the onset of adolescence, as it is more certainly a part of adolescent development.

According to Adams (1976), adolescence can be defined as a holding period in which education, maturation, and waiting are the major tasks to be faced. Steinberg (1996) defined adolescence as a period of transitions: biological, psychological, social, economic. It is an exciting time of life. Individuals become interested in sex and become biologically capable of having children. They become wiser, more sophisticated, and better able to make their own decisions. Adolescence is defined, roughly speaking, as the second decade of lifespan (Steinberg, 1996).

UNICEF (2003) defined adolescence as a period of transition between childhood and adulthood. It begins with physical changes during puberty. It ends when a person takes on adult roles and responsibilities. Adolescent period is a time when major lifestyle decisions have to be made. The period of adolescence is a very delicate phase of life from biological, psychological and social perspectives. This special age group ranges between 12 and 19 years.

Adolescence is characterized psychologically with the onset of secondary sexual characteristics, the growth spurt, final development of central nervous system as well as hormonal neurotransmitter and bio-chemical changes. It is also the time they integrate sexual

impulse into self-concept. There is high sexual awareness, sexual activity and interest in the opposite sex. According to Akinboye in Asuzu, Nwagwu, Ohaeri and Asuzu (2003) the sudden changes in adolescents may result in behavioural, social, peer and developmental problem.

A study of individuals' conceptions of adolescence asked a sample of adolescents to designate the most important factors that they thought differentiated adolescence from adulthood (Sieving, Eisenberg, Pettingell & Skay, 2006). According to this group of respondents, psychological factors, such as "taking responsibility for my actions" or "making my own decisions" were generally seen as more important boundaries between adolescence and adulthood than were the more event-related transitions that we traditionally use to define the shift in status, such as getting married, completing school, or establishing one's own residence. The one event-related transition that was seen as a relatively important factor by the adolescents surveyed, interestingly, was having a job.

Steinberg (1996) posits that rather than argue about which boundaries are the correct ones, it probably makes more sense to think of development during adolescence as involving a series of passages from immaturity into maturity. Some of these passages are long, and some are short, some are smooth, and others are rough. And not all of them occur at the same time. Consequently, it is quite possible and perhaps even likely – that an individual will mature in some respects before he or she matures in others. The various aspects of adolescence have different beginnings and different endings for every individual. Every young person is a child in some ways, an adolescent in other ways, and an adult in still others.

One problem that students of adolescence encounter early is a fundamental one; deciding when adolescence begins and ends, or what the boundaries of the period are. Different theorists have proposed various markers, but there is little agreement on this issue. Here are some examples of the ways in which adolescence has been distinguished from childhood as itemized by Steinberg (1996).

	When Adolescence Begins	When Adolescence Ends
Biological	Onset of puberty	Becoming capable of sexual reproduction
Emotional	Beginning of detachment from parents.	Attainment of separate sense of identity.
Cognitive	Emergence of more advanced reasoning abilities.	Consolidation of advanced reasoning abilities.
Interpersonal	Beginning of a shift in interest from parental to peer relations	Development of capacity for intimacy with peers.
Social	Beginning of training for adult work, family, and citizen roles.	Full attainment of adult status and privileges.
Educational	Entrance into junior high school	Completion of formal schooling.
Legal	Attainment of juvenile status	Attainment of majority status
Chronological	Attainment of designated age of adolescence (e.g. 13 years)	Attainment of designated age of adulthood (e.g. 20 years)
Cultural	Entrance into period of training for a ceremonial rite of passage	Completion of ceremonial rite of passage.

Source: Steinberg (1996).

This special age group ranges between 12 and 19 years. There are those who mature early, who from ages 10 and 11 have featured the puberty signs and characteristics of adolescence. These young minds between the ages 10 and 15 are grouped as early adolescence. Adolescence is characterized psychologically with the onset of secondary sexual characteristics, the growth spurt, final development of central nervous system as well as hormonal neurotransmitter and bio-chemical changes. It is also the time they integrate sexual impulse into self-concept. There is high sexual awareness, sexual activity and interest in the opposite sex. According to Asuzu, Nwagwu, Ohaeri and Asuzu (2003), the sudden changes in adolescents may result in behavioural, social, peer and developmental problem.

What, if anything, is distinctive about adolescence as a period in the life cycle? According to Hill (1983), there are three features of adolescent development that give the period

its special flavour and significance: the onset of puberty, the emergence of more advanced thinking abilities and the transition into new roles in the society. These three set of changes – biological, cognitive, and social are referred to as the fundamental changes of adolescence. They are changes that occur universally; virtually without exception, all adolescents in every society go through them.

Steinberg (1996) asserted that in modern societies, four main contexts affect the development and behaviour of young people: families, peer groups, schools, and work and leisure settings. The nature and structure of these contexts dramatically affect the way in which the fundamental changes are experienced. To the extent that one adolescent's world differs from another's, the two young people will have very different experiences during the adolescent years.

Five sets of developmental issues are paramount during adolescence: identity, autonomy, intimacy, sexuality, and achievement (Steinberg, 1996). These five sets of developmental issues are termed psychosocial issues (aspects of development that are both psychological and social in nature) by theorists. Sexuality, for instance, is a psycho-social issue because it involves psychological change (that is changes in the individual's emotions, motivations, and behaviour) as well as changes in the individual's social relations with others.

Sexuality as an Adolescent Issue

Sexuality is a term used to describe the feelings and activities connected with a person's sexual desires and development. It refers to one's sexual identity and sexual feelings. Sexuality is a more complex phenomenon, which is difficult to define but perhaps easy to understand (WHO, 1994). Sexuality refers to the total sexual make up of an individual. It includes sex, sexual behaviour and sexual intercourse. It is not confined to sexual intercourse but includes touching, talking, embracing, fantasizing, kissing, caressing or just holding hands. In addition to covering the physical aspects, sexuality also encompasses feelings, attitudes, values and preferences. It involves a lot of caring and sharing.

Asuzu (1994) defined human sexuality as the totality of all that is characteristic of the human sexes (male and female) especially those that distinguish them most from each other. Human sexuality spans the totality of our beings. It can be grouped in the areas of the genetic, the anatomical, the physical, the physiological, the psychological, the social, the cultural, the mental, the spiritual and the religious spheres of our being.

Functionally, however, human sexuality may be divided into two aspects: genital and non-genital sexuality. Genital sexuality has to do with the genital or sex organs- including the breasts especially in female i.e. all the basic things necessary in order to have coitus (intercourse) and to physically reproduce the human species. Non-genital sexuality consists of all the rest of human sexuality – i.e. all the things it takes to make life beautiful and complementary between and from the sexes, and to bring human beings (procreate them) to their full nature as *Homo sapiens*. Genital sexuality is quite a small portion of the total human sexuality, perhaps no more than 10-15% of it (Asuzu, 1994).

Human sexuality is not merely a biological phenomenon, but one that pervades the total person. A complex interrelationship exists among biological, psychological, and sociocultural aspects of our sexuality posited Phipps, Long, and Wood in Adejumo (2004). It is a somewhat complex phenomenon, which makes it a little difficult to have a precise definition of sexuality. Sexuality in the view of Smeltzer and Bare (1996) includes perception of self as a man or a woman, quality of sexual relationships, and concerns of sexuality related to sexual functioning. The Oxford Advanced Learner's Dictionary however defines sexuality as the feelings and activities connected with a person's sexual desires.

Manlove (2001) drew an interesting and valid distinction between sex (by which they mean an aspect of physiology) and sexuality (which involves the whole complex of personality factors and social relationships having their origin in the reproductive drive). Sex is innate in the human being, sexuality must be learned. As far as is known, the learning of sexuality follows the same principles of learning as does the learning of other attitudes and habits. Learning theory, as well as common sense, suggests that a pleasurable reaction once given is more readily given in a subsequent, similar situation. Thus it is an unusually safe prediction that the more a boy or girl has taken part in sexual intimacies, the less likely he or she is to refrain from similar actions when another opportunity or temptation occurs (Hammed & Adenegan, 2009).

Sexuality is one of the most fundamental aspects of who we are as human beings. It is directly related both to an individual's physical as well as psychosocial well-being. It also is multidimensional in nature, referring not only to sexual behaviours but also to attractions, fantasies, affiliations, sexual orientation, and gender identity. Issues related to sexuality, particularly adolescent sexuality, are often controversial. In our pluralistic society, attitudes

about adolescent sexuality differ not only by ethnicity, socioeconomic status, religion, and geographic region, but also can vary widely within individual families and communities. It is always a "hot topic" and one that health care providers will be required to address in their daily practice with adolescents and their families (Bidwell, 2003).

Human sexuality begins in infancy and continues through old age. However, with the beginning of puberty, there clearly is a quantitative change in the experience of sexuality by the developing child. The process has been described as a "sexual unfolding", that is the evolving expression of sexual feelings and experiences whose strongest roots are established in early infancy and childhood. This sexual "unfolding" is influenced by hormonal and physical changes, as well as psychosocial changes shaped by individual experiences and societal influences. Sexual development includes an adolescent's increasingly better understanding of who he/she is as a sexual being. This is accomplished in part through the acceleration of sexual exploration both with self and others. In general, pediatrics in the Western world feels that such experimentation is a normal and healthy part of adolescent development. However, there still remains some controversy, even within pediatrics, around what specific feelings and behaviours are developmentally appropriate.

Sexual development is intimately connected to the stages of adolescent development. In early adolescence (approximately 10 to13 years old) there is a significant increase in sexual feelings and preoccupations. These may be directed toward the same or opposite sex. There is often an increase in sexual self-exploration, including masturbation, which is considered a normal sexual behaviour. Nocturnal emissions ("wet-dreams") occur in males and menarche in females, signifying the onset of reproductive capacity. Some adolescents may engage in same or opposite-sex exploration. These do not necessarily reflect eventual sexual orientation. These sexual experiences are usually more experimental and self-focused than those of older adolescents.

Middle adolescence (approximately 14-16 years old) is often the hallmark of adolescent sexuality. Pubertal changes are nearly complete and there is significant increase in both same and opposite sex preoccupation and activity. With an increased understanding of their sexual selves, middle adolescents are more able to establish longer-term relationships and understand that intimacy involves more than simply sexual activity.

In late adolescence (approximately 17 to 19 years old), preoccupation with sexuality and the percentage of teenagers who are sexually active continue to increase but the older adolescent is, in general, able to bring a greater commitment and mutuality to his/her relationships. The late adolescent is also more future-oriented and often begins to consider what sorts of qualities, sexual and otherwise, he/she considers desirable in a potential spouse or life-partner. The "sexual unfolding" outlined above is a lifelong process and does not, of course, end at age 19. It is, in fact, a lifelong process.

While all adolescents address issues of sexual development, more than half abstain from sexual intercourse until age 17. However, research has demonstrated that some of these "abstinent" teenagers may engage in a variety of potentially risky sexual behaviours with others. These include mutual masturbation, fellatio, cunnilingus and anal intercourse. The Centers for Disease Control and Prevention's (CDC) 2002 Youth Risk Behaviour Survey, an anonymous survey of 9th to 12th graders in all 50 states, indicates that within this grade range, 46 percent acknowledge sexual intercourse, 14 percent have had four or more sexual partners, and 33 percent have had intercourse during the three months prior to the survey. Among those students who reported sexual intercourse, 33% had not used a condom and 82% of females had not used birth control pills during their most recent sexual intercourse. Despite this evidence of significant adolescent sexual activity, positive trends have appeared in the CDC data over the past decade. For example, the percentage of students reporting sexual intercourse has dropped from 54% to 46% between 1991 and 2001. The percentage reporting four or more partners has decreased from 19% to 14% and the use of condoms at most recent intercourse has increased from 46% to 58% during that ten-year period.

One of the reasons that health professionals are concerned about the high percentage of adolescents engaged in sexual behaviours is that these behaviours often entail significant risks to physical and psychosocial health. Early pregnancy and sexually transmitted infections are two of the primary risks inherent in adolescent sexual activity. Pregnancy occurs at a rate of 80 per 1,000 females aged 15 to 19. For the same age range, the birth rate is 50 per 1,000 and the abortion rate (intentional termination of pregnancy only) is 28 per 1,000 females. Adolescent pregnancy and birth rates have remained stable over the past decade. The rate of chlamydia infection is 1,132 per 100,000 adolescents aged 15 to 19. For the same age group, the rates for

gonorrhea and syphilis infections are, respectively, 572 and 6 per 100,000 persons. The fact that these rates are far greater than those of Western European countries with similar rates of adolescent sexual activity most likely reflects U.S. adolescents' lower use of condoms and contraceptives. This may be due, in part, to cultural factors as well as health and educational policies at the federal and local levels that limit adolescents' access to information and services related to sexual and reproductive health.

Adolescent sexual decision-making is a very complex phenomenon. Research has demonstrated that the early onset of sexual activity with others is usually accompanied by other risk behaviours, such as substance use, school problems, and parent-teen conflict. It is also highly associated with a history of physical and sexual abuse, both inside and outside the family. In short, biological, social, familial, and experiential factors all play a part in each adolescent's decision to be sexually abstinent or become sexually active. If an adolescent does become sexually active, these factors also influence the ability to engage in "safer sex" practices. In general, the earlier the age of sexual initiation the more likely there are associated risk factors and a history of significant childhood abuse. The initiation of sexual activity during later adolescence is more likely to represent a normative process with fewer associated risks. The multitude of factors influencing an adolescent's decision to be abstinent or sexually active, likely is one of the reasons that "abstinence-only" sexuality curricula have been less effective in preventing adolescent sexual risk-taking than "comprehensive" sexuality curricula. The latter interventions encourage abstinence as the safest choice but recognize that some adolescents will choose to be sexually active and should be provided the information and skills they need to make that activity as safe as possible.

One of the most neglected areas related to adolescent sexuality has been that of sexual orientation. During puberty, approximately 3 to 10 percent of adolescents begin to recognize their lesbian or gay (homosexual) sexual orientation. An even greater percentage may be bisexual while a small minority is transgender, feeling as if they are one gender trapped in the body of the other gender. Sexual orientation and gender identity are not a choice and appear to be established by early childhood. They likely are shaped by both biological and environmental influences. Pediatrics now regards homosexuality and bisexuality as normal and healthy developmental outcomes. Transgenderism continues to be listed in the Diagnostic and Statistical

Manual, 4th edition (DSM-IV) under the designation "Gender Identity Disorder," although the appropriateness of this continues to be debated. It is important to recognize that there are significant risks to growing up lesbian, gay, bisexual or transgender (LGBT) in American society. Certain segments of society regard a minority sexual orientation or transgender identity as pathologic or sinful. Many LGBT youth experience violence at school and in their own homes. Growing up with a stigmatized identity, or forced to hide one of the most important part of who they are, LGBT adolescents often encounter problems at home, at school, and in their communities. A small percentage run away from home, drop out of school, and turn to drugs, street-life, prostitution, or suicide as a means of escape. A larger percentage choose to postpone their sexual development or lead secret sexual lives that distort their sexual development and place them at high risk for depression, exploitation, violence, HIV/AIDS, and other sexually transmitted infections. Health providers have a special responsibility to these disenfranchised youths to make sure that they have access to accurate information, appropriate health care, and supportive community services so they may develop into healthy and productive adults. It is important to note that the American Academy of Pediatrics has taken a strong stand against "reparative therapies' and "transformational ministries" that seek to change sexual orientation from homosexual to heterosexual. These interventions are regarded as harmful and unethical.

A health provider has multiple roles in addressing issues of sexuality with adolescent patients, including those of screener, educator, counselor, and advocate. Research indicates, however, that many providers feel uncomfortable and unskilled in discussing sexuality with their adolescent patients. Therefore, providers must first examine their own comfort and attitudes about sexuality, particularly as these relate to adolescents, and reflect on how these attitudes affect their work with teenagers.

In their role as screeners, health providers should monitor their patients' sexual development by routinely asking questions related to sexual feelings and behaviours, preferably well before the onset of sexual activity. As educators, providers are in an excellent position to provide accurate information and anticipatory guidance to teenagers and their families, not only about pubertal development but also about normative sexual development during the adolescent years. It is especially important that they inform teenagers and their families about pediatrics' position on such controversial issues as contraception, masturbation and sexual orientation. As

counselor, the provider should encourage postponement of sexual activity with others until the adolescent has the physical, emotional and cognitive maturity to enter into relationships that are consensual and non-exploitative. The provider should counsel adolescent patients that healthy sexual relationships should be both honest and pleasurable, and that steps should be taken to prevent sexually transmitted infections and unintended pregnancy. At a community level, health providers are in an excellent position to participate in the development and delivery of comprehensive sexuality curricula in the schools and other community forums. They also can be strong advocates for the development of confidential, accessible and affordable reproductive services for teenagers and for policies that nurture and support the healthy sexual development of all adolescents (Bidwell, 2003).

The evolution of our sexuality illustrates the complexity and interrelationship of aspects of our sexuality. From the moment of conception a variety of factors come into play to influence our sexuality, not only as children but also as adults. In early embryonic life theory chromosome from the paternal sperm sets in motion a process analogous to a relay race; that is each component has control of the process for a time, eventually yielding control to another (Money & Ehrhadt, 1972). The chromosomes tag the undifferentiated foetal gonads as male or female, thus setting a motion another process by which hormonal secretions in turn affect not only the appearance of the genital but also the pathways of the brain. The appearance of the infant's genitals at birth initiates another series of events, those primarily dependent on socialization of the child. The behaviour of other persons during infancy and early childhood and the appearance of the child's external genitals are instrumental in the evolution of childhood gender identity and role. In fact, gender identity seems to be well established by the time the person is 18 months of age. At puberty, biological influences again come to the force as hormones influence the morphology of the genitals and eroticism.

Thus, from conception we are all sexual beings, subject to multiple influences throughout life. Thus from conception we are all sexual beings, subject to multiple influences throughout life. In the opinion of Phipps, Long and Woods (1980), if the aforementioned processes proceed without interference, the person's biological sex (female or male) or congruent with gender identity (individual's perception as male or female and gender role (outward manifestation of masculinity or femininity).

This complex set of biological and psychological variables begun at conception has a pervasive influence on the remainder of our lives. The biological component of sexuality, sexual function or expression, constantly interacts with the psychological components of gender identity, cognition, and affect as well as with social factors such as sanctioned roles and mores and folkways regulating sexual expression. Such complexity mandates a holistic approach to conceptualizing a person's sexual problems and concerns (Phipps, Long & Woods, 1980).

The simplest, most elemental, and universal manifestation of sexual differentiation is the mating urge. In humans, sexual desire, while it has its origin in bodily chemistry (as it does in the lower animals), arises and becomes intensified not primarily as a result of biological conditions but of psychological factors. These factors, according to Staton (2006) are principally attitudinal and emotional. For instance, a brother typically is not stimulated sexually by his sisters under circumstances that would produce arousal if another girl were involved. A physician typically is not sexually excited by seeing or touching a female patient whom he is examining or treating. If the reaction were fundamentally biological and chemical, sexual arousal of the males in the foregoing illustrations would be universal.

The fact that the mating urge, manifested as sexual desire, is primarily psychological rather than precipitated by biological conditions is vital to any intelligent treatment of the subject of human sexual affairs (Staton, 2006). In educating adolescents to adhere to desired patterns of sexual behaviour, it means that attention must be given in that direction in terms of their mental and emotional lives; of the experiences that will have one or another effect on their emotions at a given time; of their desires, aspirations, and fantasies; and of the invisible but terrific force of peer group opinion and behaviour. There is the need to consider, and lead adolescents to understand how their imaginations can trigger their endocrine systems to action under certain conditions. All these factors are more important than the objective conditions of the situation in which the adolescent is involved.

Sexual behaviour depends principally on the attitudes held by the individual involved (Adenegan, 2006). As pointed out by McKinney (1960), the biological sex urge is seldom so powerful that it seizes control of the adolescent and dominates his behaviour without its first being stimulated by psychological factors and or deliberate physical manipulation. When fanned to a fever heat by prolonged petting, sex-oriented conversation, infatuation on the part of the girl,

or wish fulfillment fantasies on the part of the boy, the sex urge can, indeed, become temporarily overwhelming. But it was built to this pitch of influence by the minds and emotions of the people involved. It did not become so as an inevitable biological process.

Like other aspects of psychosocial development, sexuality is not an entirely new issue that surfaces for the first time during adolescence. Young children are curious about their sex organs and at a very early age derive pleasure (if not what adults would label orgasm) from genital stimulation – as both Sigmund Freud and the famous sex researcher Alfred Kinsey pointed out long ago (Kinsey, Pomeroy & Martin, 1948). And, of course, sexual activity and sexual development continue long after adolescence. Although sexual development may be more dramatic and more obvious before adulthood, it by no means ceases at the end of adolescence. Studies in reproductive health (Ezimokhai, Ajabor, Jackson & Izilien, 1981; Orosanye & Odaise, 1983; Nichols, Ladipo, Paxman & Otolorin, 1986) have paid considerable attention to initiation of sexual activities among adolescents.

Adolescence is a fundamentally important time – if not the most important time in the life cycle – for the development of sexuality. There are several reasons for this. Perhaps most obvious is the link between adolescent sexuality and puberty. There is an increase in the sex drive in early adolescence as a result of hormonal changes (Udry, 1987). Moreover, it is not until puberty that individuals become capable of sexual reproduction. Before puberty, children are certainly capable of kissing, petting, masturbating, or even having sexual intercourse. But it is not until puberty that males can ejaculate semen or females begin to ovulate, and the fact that pregnancy is a possible outcome of sexual activity changes the nature and meaning of sexual behaviour markedly – for the adolescent and for others. What had previously been innocuous sex play becomes serious business when pregnancy is a genuine possibility. Not until puberty do individuals develop the secondary sex characteristics that serve as a basis for sexual attraction and as dramatic indicators that the young person is no longer physically a child.

But the increased importance of sexuality at adolescence is not solely a result of puberty. The cognitive changes of adolescence play a part in the changed nature of sexuality as well. One obvious difference between the sexual play of children and the sexual activity of adolescent, according to Steinberg (1996), is that children are not especially introspective or reflective about sexual behaviour. One of the chief tasks of adolescence is to figure out how to deal with sexual

desires and how to incorporate sex successfully and appropriately into social relationships. Much of this task is cognitive in nature, and much of it is made possible by the expansion of intellectual abilities that takes place during the period. In addition to how the physical changes of puberty and the growth of sophisticated thinking capabilities influence sexuality during adolescence, the new social meaning given to sexual and dating behaviour at this time in the life cycle makes sexuality an especially important psychosocial concern.

According to Brooks–Gunn and Paikoff (1993), there are four distinct developmental changes concerning sexuality in adolescence. First, the adolescent needs to come to feel comfortable with his or her maturing body – its shape, size and attractiveness. Second, the individual should accept having feelings of sexual arousal as normal and appropriate. Third, healthy sexual development in adolescence involves feeling comfortable about choosing to engage in – or choosing not to engage in various sexual activities, that is, healthy sexual development involves understanding that sex is a voluntary activity for oneself and for one's partner. Finally, healthy sexual development, at least for those who are sexually active includes understanding and practising safe sex- sex that avoids pregnancy and sexually transmitted diseases.

Sexual Behaviour within the Perspective of the Society

The Nigerian society today has to wrestle with many widely publicized behavioural problems of its youth, which include heterosexual activities variously named in the literature as sex abuse, sex offences, sexual misconduct, sexual immorality, sexual promiscuity and sexual maladjustment (Odoemelam, 1996; Adedipe, 2000; Ndu, 2000; Nnachi, 2003). There are a number of very normal biological needs that are part of every human being. Most of these needs are satisfied in an unprohibited manner; e.g. no one objects to human breathing, drinking water, eating or eliminating waste products. However, in the area of sex, meeting such need is not so simple. It is the only biological need for which society claims a restrictive right. Although, sexual feelings are natural, expressing them is rarely simple. It is something that society feels a strong need to shape and to regulate. Public attitudes toward sex have repeatedly swung back and forth between valuing freedom in sexual choices and valuing restrictions on sexual expression.

The adolescent's sexual needs cannot be ignored. Sex, like many other human experiences, is a learning experience observed Adams (1976) and Adenegan (2010). The learning process in the society has been hastened with the emphasis placed on heterosexual contacts at an early age. Insisting that children learn to dance together in the elementary school, one should not be surprised when they sleep together during their secondary school years. If the youths are to be prepared for meaningful lasting sexual relationships upon graduation from high school, the learning experiences provided should be admirable. As it is, most youths must put off marriage, and the responsibilities that should accompany sexual relationships for a prolonged period of time.

Even more unfortunate is the fact that many youths are unable to tolerate the waiting period. They desperately need the human closeness that the sexual experience can provide. Toffler in Adenegan (2007a) lamented that the speed with which industrialized society has developed has removed many of the possibilities for human involvement and companionship that were available to many of us as we were growing to maturity. It is scarcely surprising that adolescents turn to their peers of the opposite sex for their emotional and physiological needs. In many respects it may not be desirable, but in every respect it should be understandable. If premarital sex and sexual debut are expected to decrease, the society that produces the situations which cause the need for the sexual involvement must first be looked into for change. In addition, the youth should be given both intellectual and emotional understanding of the implications of the sexual relationship.

In recent decades, especially in the mid 90s, there came a shift towards less restrictive attitudes, which Nass and Fisher (1984) called "sexual revolution". Holding a restrictive view about sex does not necessarily mean being anti-sex. Christianity for instance value sex within marriage. Statistics indicate that despite the restrictive value placed on keeping sex within marriage, sex outside marriage is increasingly common. Young adults' cohabitation is also increasing. Young adults are marrying later, if at all, making it more likely that their sexual relationships will not be marital.

An adolescent's perception of self as a male or a female i.e. gender identity as well as the sets of cultural expectations that define the ways in which the members of each sex should behave, i.e. gender roles influences sexual behaviour. Added to this, the biological viewpoint

posits that sex role identification and specifically gender behaviour are influenced by a linkage between hormonal conditions, brain functions, and behaviour (Money & Ehrhadt, 1972). Endocrine glands in males secrete testosterone, and in females, progesterone and oestrogen. Each sex has some male and some female hormones which largely influence many aspects of sexuality. The fact that hormonal factors sometimes contribute to behavioural differences between men and women does not mean that environmental factors are unimportant (VanderZanden, 1981).

In other words, adolescent sexuality and sexual behaviour could be related to the above theoretical underpinnings. As a result, gender behaviours in adolescence are becoming more diffuse, less rigid and more responsive to a combination of bio-psychosocial predictors. There are no longer strict male or female sexual role behaviours, especially in the areas of dressing, initiation into sexual activities, etc. For example, boys now wear shorts (knickers) outdoor. Young males and females both wear "very revealing" clothes. Whether or not they are considered beautiful, revealing sex-related body parts such as the breast or genitals often carry strong stimulus value (Nass & Fisher, 1984; Hammed & Adenegan, 2009).

In some societies women deliberately reveal their genitals to turn on potential sex partners, others may do it to attract attention. Contemporary males who wear tight underwear beneath tight-fitting trousers with casual tops revealing their musculature, as well as females whose nipples are revealed by extreme body-hugs give off sexual appeal and invitation (Nass & Fisher, 1984). Same also goes for ladies who wear extremely revealing short skirts. Partial concealment of sex-related parts is often more arousing than full and continuing nudity. Imagination is one of the greatest sexual stimulants in the view of Adenegan (2007a).

Ideas about male-female virginity are also changing. Our society traditionally valued "saving oneself for marriage", but over half of all Americans (and also in many African societies), now find it acceptable for a man and a woman to have sexual relations before marriage. As far back as 1985, a study revealed that only 21 percent of women in the United States were virgins when they married (Shearer, 1985). Many young people experience real or imaginative pressure from their peers to be more sexually active. This pressure has been more particularly strong in males.

For females, the idea that males do not want 'used goods' as wives was a traditional deterrent to singles' intercourse. Brides in some cultures were expected to produce physical evidence of their virginity on their wedding night to bleed in order to prove that their hymen was being ruptured by first intercourse. Emphasis on the hymen is now diminishing, as there are other activities other than intercourse and also total lack of hymen that may not encourage an absolute insistence on bleeding hymen at first sexual contact as the yardstick for measuring chastity.

The debate over what messages to give adolescents about the prevention of sexually transmitted diseases (including HIV/AIDS) and pregnancy has proven to be confusing to youth and has proven conflictual and polarizing in many communities. The diverse messages that the contemporary adolescents receive can be summarized as: a) remain abstinent until marriage, b) remain abstinent until emotionally and developmentally ready to become sexually active, c) remain abstinent but, if not able to, have accurate information about birth control and protection, and d) have accurate and factual information on how to use birth control and protection effectively because abstinence is not a realistic expectation. While many adults feel strongly about promoting one of the above positions with youth, it is not well understood how adolescents understand and incorporate these disparate admonitions into personal behaviour patterns.

The Transition of Adolescent to First Sexual Intercourse

The initiation of sexual activity is important in the transition from adolescence to adulthood (Upchruch, Aneshensel, Sucoff & Levy-Storms, 1999). Early initiation of intercourse, however, increases the risk of premarital and sexually transmitted disease (STI) among teenagers. To reduce the risk of these outcomes, school sexuality education and public health programmes have attempted to delay the transition to intercourse among adolescents and to promote contraceptive use and responsible behaviour among those who are sexually active (Forste & Haas, 2002). Although such efforts have resulted in some declines in risky sexual practices among adolescents, males continue to initiate intercourse at younger ages and engage in more risky sexual behaviours, such as having multiple partners, than do females (Santelli, Brener, Lowry, Bhatt & Zabin, 1988). Thus, the health consequences of adolescent sexual behaviour particularly high-risk behaviours among adolescent males continue to be of public concern.

An understanding of the various social, psychological and behavioural factors that influence adolescent sexual activity will aid in the planning of prevention and intervention programmes. These factors include parental and family background, association with institution such as schools and churches, attitudes and participation in risky behaviour. Demographic factors, such as race and ethnicity, can also influence the age at first intercourse. For example, black youth initiate sexual activity before puberty more commonly than white youth (Moore, 1995; Newcomer & Baldwin, 1992).

Family structure and socio-economic background are associated with teenage sexual activity. Youth living with one parent have higher rates of first sex than those living with both biological parents (Upchruch, Aneshensel, Sucoff & Levy-Storms, 1999; Newcomer & Baldwin, 1992), and young people in low-income house holds (Newcomer & Baldwin, 1992). In addition maternal education and employment levels are predictive of age at sexual initiation. The lower the mother's educational level or the more hours she works, the younger a teenager is likely to when he or she initiates intercourse (Kowaleski-Jones & Mott, 1998; Buhi, Goodson, Neilands & Blunt, 2011).

Involvement in activities outside the family, such as church and school attendance, can also influence adolescent sexual behaviour. For example, young men who attend religious services regularly are less likely than those who do not attend to engage in premarital intercourse (Thronton & Camburn, 1989; Hammed & Adenegan, 2009); and the lower a teenager's school grades, the more likely he or she is to be sexually experienced (Hogan & Kitagawa, 1985; Koffi & Kawahara, 2008).

A number of psychological factors could affect youths' sexual behaviour. Teenagers with low self-esteem are more likely than those with high self-esteem to engage in sexual activity (Kowaleski-Jones & Mott, 1998), and youth have an increased likelihood of early transition to first intercourse if they lack a sense of being in control of their lives (Day, 1992) or are accepting of premarital sex (Hanson, Morrison and Ginsburg, 1989). Furthermore, traditional attitudes toward gender roles among adolescent males predict high-rate sexual behaviour (Pleck, Sonenstein & Ku, 1993; Buhi, Goodson, Neilands & Blunt, 2011).

Substance use can impede a youth's decision-making ability, thereby making sexual activity more likely. Graves and Leigh (1995) found that males aged 18-30 who smoked

cigarettes or marijuana and those who drank alcohol excessively were more likely than males who did not use these substances to be sexually active. By the same token, sexual activity can predict delinquent behaviour. Sexually active 15-27 year olds are more likely than their sexually inexperienced peers to have been suspended from school (Ketterlinus, 1992).

A limitation of past research about teenage sexual experience is that studies have generally examined the transition to first intercourse as a dichotomous outcome. Whitaker, Miller and Clark (2000), however, argue for a broadening of this narrow definition to expand our understanding of adolescent sexual behaviour, so that prevention and intervention programmes can become more effective. Inspired by the earlier typology of Miller, Norton, Curtis, Hill, Schvaneveldt, and Young (1997), they separate sexually inexperienced teenagers into two groups: delayers, who have not had sex and do not expect to do so in the next year, and anticipators, who have not had sex but anticipate doing so in the next year.

Delaying Sexual Initiation

Early sexual intercourse is commonly associated with a higher number of lifetime sexual partners (Santelli, Brener, Lowry, Bhatt, & Zabin, 1998) and, consequently a higher risk of contracting sexually transmitted diseases (STIs). From the perspective of sexually transmitted infection, sexual encounters include not only present partners but also past partners and all of their partners' partners. Thus voluntarily delaying sexual debut is of key importance in the prevention of sexually transmitted infections and the promotion of long term health. The ABC approach to changing sexual behaviour described by Shelto and Colleagues (Genuis and Genuis, 2004) can be used as a primary strategy for tackling all sexually transmitted infections.

Since the World Health Organization estimates that two thirds of sexually transmitted infections worldwide (including HIV) occurs in teenagers and young adults (Dehne & Riedner, 2001), prevention programmes must target this population. Given the apparent relation between early sexual intercourse and an increased number of sexual partners, adolescents would benefit from a health-oriented approach that includes all components of the ABC approach but specifically recommends abstinence in the form of delayed sexual debut. Some proactive interventions are able to change attitudes to sexuality and appreciably increase the number of adolescents delaying sexual debut or abstaining. In association with the ABC programme, for

example, sexual activity among 13 to 16 year olds in one district of Uganda declined from nearly 60% in 1994 to less than 5% by 2001 (Hogle, Green, Nantulya, Stoneburner & Stover, 2002).

In addition, because early sexual involvement is a common expression of non-sexual need, physicians and public health officials can promote delayed intercourse through educational interventions for parents and teenagers (Kay, 1995). The importance of health education that covers early sexual behaviour is highlighted by the Centers for Disease Control and Prevention: one of the national health objectives for 2010 is "to increase … the proportion of adolescents in grades 9-12 who have never had sexual intercourse" (Centers for Disease Control and Prevention, 2002). With sexual lifestyles that often include early onset of sexual intercourse and subsequent serial monogamy, young people are placing themselves at considerable risk of acquiring a sexually transmitted infection. Although partner reduction is a critical and often overlooked component in the ABC strategy, it is believed that delayed sexual debut for young people should be the first step in programmes to prevent sexually transmitted infection.

Staton (2006) opines that separation of the sexes for instruction in sexual matters serves as an example in giving boys and girls a comprehension of the relationship between sexually-oriented conversations or discussion of sexual topics and sexual arousal and desire. Kinsey (1953) found that adolescent boys, and many adolescent girls, have experienced the arousal of sexual excitement, if not passion as a result of reading accounts of sexual activity or participating in discussion of sexual topics. With such sexually arousal mutually experienced, there is greater difficulty in a girl controlling her own behaviour as well as the advance of her companion. Experienced boys and men often employ suggestive and subsequently more directly sexually oriented conversation as a means of arousing sexual interest in a girl and gradually lessening her inhibitions. A girl, who engages in sexually-oriented conversation to show her emancipation, or for a thrill, is encouraging the development of urges and passion in both herself and her companion that almost inevitably leads the boy to attempt physical intimacy. The adolescent girl should know that unless she wants to lead the boy into sexual intimacies on the physical level, she had better not engage in suggestive or sexually-oriented conversation with him. Words may be as effective as sights, or even physical contact, in arousing and intensifying erotic urges.

In this connection, it may be noted that Ehrmann's (1952) depth interviews with girls on the psychodynamics of petting revealed that the crucial point at which limiting further physical

intimacies became most difficult was when the girl permitted caresses beyond a simple embrace. Psychologists had theorized that probably the degree of intimacy that made it most difficult for a girl to call a halt to the progression of erotic activities was after she had permitted the boy's hand to caress her insider her clothing. From interviews with adolescent and late-adolescent girls, Ehrmann found that the girl's permitting the boy's hands to caress her below the shoulder level, even caressing her breasts outside her clothing, triggered the erotic forces in each party that were most likely to constitute the point of no return. Failure to comprehend this can result in a girl's letting her relationship with her companion get out of her control before she realizes she has entered the danger zone of sex play.

When a boy and girl find themselves in a situation of privacy for a considerable period of time, and most especially if it follows an experience encouraging feelings of romance in the girl or erotic arousal in the boy (such as a dance, a party, a romantic movie, or any emotion-arousing activity), the temptation to follow the urgings of psychological and biological nature is strong. Robert in Staton (2006) summarized the ingredient of a situation leading to sexual indiscretions as "a well-loved lad, convenience snug, and a treacherous inclination".

It seems wise for parents to require that dating adolescents come home within a short time after leaving a scheduled activity or group function, and prohibit against late dating hours or extended periods of privacy for a couple in the home. Extended time in considerable privacy is conducive to the development of intimacies. This is true even though the couple has not deliberately sought and planned these intimacies. Without the prolonged erotic and romantic play, final intimacy would not have taken place. Except in the case of the boy and girl who have become habituated to sexual intimacies from long practice with each other, boy-girl sexual behaviour almost invariably follows a well-defined and time-consuming course from kissing to necking to petting to intercourse, with considerable time spent in each activity.

The time a boy and girl spend in intimacies has a cumulative effect. That is to say, they carry over from one date to the next. This is one of the dangerous (although probably not the chief one) of adolescents' "going steady." A boy and girl who think enough of each other to be together repeatedly, especially to the exclusion of dating other people, become increasingly familiar with each other's bodies as well as personalities. Increasingly intimate physical contact comes to be taken for granted. For them, the starting point for romantic or erotic activities

becomes petting of greater and greater intimacy, with little or no time being spent in the preliminary conversation and kissing by which a boy and girl not thoroughly familiar with each other gradually achieve greater physical intimacy.

Factors Influencing Adolescent Sexual Behaviour

Many factors influence adolescents' decision to have sex or remain abstinent. Schalet (2011) posited that a host of economic, political, and cultural factors contribute to the differences in adolescent sexual behaviour. While comparing the low teenage fertility and abortion rates in Netherland with America, he exemplified some of these factors from his observations that the Dutch youth are less likely than their American counterparts to grow up in the poverty that fosters early childbearing, to lack formal education on contraception, and to encounter financial or emotional barriers to obtaining contraceptive and abortion services. Adult acceptance of adolescent sexuality makes it easier for teens to recognize that they are sexual beings, plan sexual acts, negotiate sexual interactions, and ask for assistance when they need it (Schalet, 2011).

Odimegwu, Solanke & Adedokun (2002) reported that adolescents with low parental income were more sexually active than those who reported high or medium parental income. This is consistent with arguments and reports that economic hardship encourages girls to become sexually active at an early age for economic reasons (Anochie & Ikpeme, 2001). The perceived or real rewards, both financial and material, are also major enticements to engage in early sex (Ankomah, Mamman-Daura, Omoregie & Anyanti, 2011).

Male adolescents more often than females identify peer pressure as one of the reasons for having sex (Izugbara, 2001; Etuk, Ihejiamaizu & Etuk, 2004; Okonta, 2007). Pressure to conform was mentioned by nearly all participants in Ankomah, Mamman-Daura, Omoregie and Anyanti's (2011) study – the pressure could range from subtle name calling to physical harassment. Many cultures in Nigeria show preference for the male child and accord him certain privileges often to the exclusion of the female child. This leaves the female with little or no education and at a low socio-economic stratum with sex as the only bargaining tool (Okonta, 2007). Female genital mutilation is another factor. The practice is done mainly for cultural reasons in the belief that it will reduce promiscuity in the female (Alubo, 2001). However, researchers have documented that the reduced sexual pleasure associated with female genital

mutilation could lead them into having multiple sex partners with the hope that sexual satisfaction will be achieved with one of them (Okonofua, Larsen, Oronsaye, Snow & Slanger, 2002).

Evidence from the Focused Group Discussions in Ankomah et al's (2011) study suggested that participants felt that parents could have either negative or positive influence on the sexual activity of their children. On one hand, children of "good" parents have good home training and would grow up to be youth who abstain until marriage, while on the other hand, children (especially females) of "bad" parents stand a higher chance of being pushed consciously or unconsciously by their mothers into early sexual initiation. Slap, Lot, Huang, Daniyam, Zink and Succop (2003) found in their study that Nigerian secondary school students from a polygamous family structure are more likely to engage in sexual activity than students from a monogamous family structure. Students' sense of connectedness to their parents, regardless of family structure decreases the likelihood of sexual behaviour (Slap et al, 2003). Odeyemi, Onajole and Ogunowo (2009) also reported parents' marital status as a factor in early sexual activity.

Religious influence was observed to be a restraining factor towards sex. Both Muslim and Christian youths mentioned that their religion forbids pre- and extramarital sex. This was the primary reason religious participants gave for abstinence (Ankomah et al, 2011). Media also plays a role in this. Exposure to television has been found in quantitative studies as a key correlate to onset of early sex (Fatusi & Blum, 2008). Locally produced movies as well as foreign films have been identified, particularly in Lagos, as a key catalyst for engagement in first sex, particularly for males (Ankomah et al, 2011).

Consequences of Adolescent Sexual Activity

Sexual activity can have both positive and negative outcomes for people of any age. Young people are at heightened risk for some negative sexual outcomes, such as unplanned pregnancy and STIs, including HIV/AIDS. There is evidence that most of the adolescents seen in STI clinics had previous history of vaginal intercourse (Aji et al, 2013). In Cross River State, 13.1% of the sexually active female adolescents have had genital tract infection (Etuk, Ihejiamaizu & Etuk, 2004). In Abia State, 19.3% boys and 9.5% girls claimed they had been

infected with gonorrhea and syphilis (Izugbara, 2001). Data from Niger State show that 15.4% of sexually active adolescents had contacted STIs (Odimegwu, Solanke & Adedokun, 2002).

In Rivers State, 27% of the sexually active girls claimed to have been pregnant at least once (Anochie & Ikpeme, 2001). In Abia State, 4.9% of the sexually active girls admitted to have been pregnant, while 2.5% of their male counterparts admitted getting a girl pregnant. Pregnant adolescent girls who do not succeed in procuring an abortion go on to have a delivery and are exposed to the risks associated with teenage pregnancy, labour and delivery (Alubo, 2001).

In Nigeria, the law restricts abortion – thus, most abortions are done illegally under septic conditions (Okonofua, Shittu, Oronsaye, Ogunshakin, Ogbomwan & Zayyan, 2005). In Rivers State, 24.8% (34) of sexually active girls have had at least one abortion, out of which 7.3% (10) had had more than three (Anochie & Ikpeme, 2001). Pregnant women aged less than 15 years were 4-8 times more likely to die during pregnancy and childbirth than pregnant women aged more than 19 years (Anochie & Ikpeme, 2001). In Nigeria, abortion complications are responsible for 72% of all deaths among teenagers aged under 19 years (National Population Commission, 2003). Anochie and Ikpeme (2001) noted infant mortality to be 30% higher for infants born to women aged 15-19 years than for those born to women 20 years and above.

Peer Influence and Pressure

Peer pressure is pressure from one's peers to behave in a manner similar or acceptable to them. During adolescence, peers play a large part in a young person's life even while the family continues to be significant. In general, peer friendships offer youth with many positive opportunities despite the negative connotations that peer relationships have. Peer relationships are important for healthy development and essential for youth to develop into healthy adults. Nonetheless, peer relationships also have the potential to encourage problem behaviours as an individual adolescent is likely to act similarly to his or her peers. For example, heavy-drinking individuals tend to have heavy-drinking peers, whereas light-drinking individuals tend to have light-drinking peers (Dike, 2011). Based on social influence theory, peers influence the behaviour of an individual adolescent (e.g., getting him or her to drink heavily) through peer pressure, modeling, or other mechanisms, thus transforming the individual adolescent to resemble the group. On the other hand based on selection, an individual adolescent who already

engaged in problem behaviours finds a like-minded network of peers and flow along with them. Studies support parent's perceptions that the influence of friends can have a positive effect on academic motivation and performance. Conversely, experimentation with drugs, drinking, vandalism, and stealing can also increase by interaction with the peer group. Although the negative influence of peers is often over-emphasized, one of the implications for this study is that peers can help each other to utilise counselling and health services.

Attitudes and Intentions

Although sexual intercourse among adolescents has been characterized as unplanned and impulsive (Moore, 1995), some research suggested an underlying cognitive decision-making process. Attitudes and intentions are two cognitive constructs commonly found to be antecedents of sexual behaviour (Masters, Beadnell, Morrison, Hoppe & Gillmore, 2008). These constructs, attitudes and intentions are guided by the theory of reasoned action (Fishbein & Ajzen, 2005) and the theory of planned behaviour (Ajzen, 2002; Madden, Ellen & Ajzen, 1992). According to these models, engaging in a behaviour (e.g., being abstinent or having sex) can be predicted by an individual's intention to perform the behaviour. Intention, in turn, is a function of two factors: the individual's attitude toward the behaviour (how desirable or undesirable the behaviour is) and the individual's perception of social norms regarding the behaviour (what others think is desirable or undesirable).

Evidence suggests that attitudes and norms predict adolescents' intentions to have sex, and that intentions predict behaviour (Fisher, Fisher & Rye, 1995; Gillmore, 2002). Although these studies focused on engaging in sex, there is reason to believe that these cognitions may also be predictive of abstaining from sex: Attitudes and intentions are fairly robust predictors of different aspects of adolescent sexual behaviour, such as use of condoms (Basen-Engquist & Parcel, 1992; Gillmore, 1994; Morrison, Baker & Gillmore, 1998; Masters, Beadnell, Morrison, Hoppe & Gillmore, 2008) and other contraceptives (Adler in Masters, Beadnell, Morrison, Hoppe & Gillmore, 2008), as well as frequency of sex and number of partners (Jorgensen & Sonstegard, 1984; Basen-Engquist & Parcel, 1992). Furthermore, two meta-analyses have found that attitudes and intentions predict health behaviour, including condom use and other safer-sex strategies (Sheeran, Abraham & Orbell, 1999; Albarracin, 2005).

Concept of Psycho-educational Group Therapy

A definition of Psycho-education seems especially important since many rather diverse definitions now exist. The definition promulgated by Guerney, Stollak, and Guerney (1971), who were among the founders of the Psycho-education movement, appears most fitting. They suggest the following: The practising psychologist following an educational model is one whose work would derive directly or indirectly from a concern not with "curing" neurosis and not with eliminating symptoms (or complaints) and not with intellectual growth per se but rather with the teaching of personal and interpersonal attitudes and skills which the individual applies to solve present and future psychological problems and to enhance his satisfaction with life.

The Psycho-education model, therefore, views the role of the psychological practitioner not in terms of abnormality (or illness) diagnosis prescription therapy cure; but rather in terms of client dissatisfaction (or ambition) goal-setting skill-teaching satisfaction (or goal achievement). Likewise, the client is viewed as a pupil rather than a patient. The roots of the Psycho-education movement have been delineated elsewhere (Authier, Gustaf-son, Guerney & Kasdorf, 1976). Suffice it to say that counselling and psychotherapy have been construed as educational processes for many years, but only within the last decade has a concentrated effort been made to bring the counsellor's role in line with its educational base. Early proponents of psychotherapy as education (Shoben, 1949; Dollard & Miller, 1950; Murray, 1954; Mower, 1950; Rotter, 1954) appeared more content to theorize than to put their theories into practise. In fact, several years elapsed before theoretical principles were applied to clincial problems (e.g. Wolpe, 1958, 1965, 1969; Lazarus, 1960, 1961, 1963; Krasner, 1962a; Krasner 1962b; Ullman & Krasner, 1965).

In contrast to the earlier theoretical era, psychotherapy as an educational process during the clinical application era was characterized by a series of techniques, such as counter-conditioning, adversive-conditioning, operant-conditioning, behavioural control, stimulus control, etc., all of which were designed to remove patient symptomatology. This long awaited practical application of learning principles to clincial problems served as the first force of the Psycho-education movement, but because of its narrow emphasis on the "patient","symptom alleviation", "cure", and, in essence, adherence to a medical model, this behaviour modification era for the most part seemed to avoid consideration of the cognitive, emotional and interpersonal domains of the client. Indeed, an adherence to the medical model prevented the behaviour

modifiers from conceptualizing their roles as teachers with ability to educate their "patients" in these latter domains.

However, despite their failure to speak of themselves as teachers, it is readily apparent that the teaching function of behaviour modifiers ranges in complexity from explaining the rationale and application of a procedure to serving as a consultant or program coordinator to the client via directly instructing him/her in self-control techniques. Of course, the latter approach epitomizes the therapist as a teacher in that it embodies learning how to learn, the final goal of most educational processes. Behaviour modification thus simultaneously highlighted therapy as an educational process and the deficiency of a medical model for such an endeavor.

Indeed, the inadequacy of the medical model, especially in the area of preventive mental health, was obvious and perhaps comprised the second force leading to the adoption of a Psycho-education model. Although behaviour modification raised the issue indirectly, Szasz (1961a, 1961b, 1966) was among the first to directly question the appropriateness of a medical model for treating the "mentally ill". In essence, he noted that the medical model was used to instill societal and cultural values, and in so doing, he made helping professionals aware of the danger of foisting their own value systems on others in the guise of making them mentally healthy. An educational orientation, which includes the student's right to choose what he/she will learn can only benefit from this increased awareness.

Psycho-educational groups are designed to educate clients about substance abuse, and related behaviours and consequences. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures. Frequently, an experienced group leader will facilitate discussions of the material. Psycho-educational groups provide information designed to have a direct application to clients' lives – to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf, such as entering a treatment programme. While Psycho-educational groups may inform clients about psychological issues, they do not aim at intrapsychic change, though such individual changes in thinking and feeling often do occur.

The major purpose of Psycho-educational groups is expansion of awareness about the behavioural, medical, and psychological consequences of substance abuse. Another prime goal is

to motivate the client to enter the recovery-ready stage. Psycho-educational groups are provided to help clients incorporate information that will help them establish and maintain abstinence and guide them to more productive choices in their lives.

These groups also can be used to counteract clients' denial about their substance abuse, increase their sense of commitment to continued treatment, effect changes in maladaptive behaviours (such as associating with people who actively use drugs), and supporting behaviours conducive to recovery. Additionally, they are useful in helping families understand substance abuse, its treatment, and resources available for the recovery process of family members. Some of the contexts in which Psycho-educational groups may be most useful are

- Helping clients in the precontemplative or contemplative level of change to reframe the impact of drug use on their lives, develop an internal need to seek help, and discover avenues for change.
- Helping clients in early recovery learn more about their disorders, recognize roadblocks to recovery, and deepen understanding of the path they will follow toward recovery.
- Helping families understand the behaviour of a person with substance use disorder in a way that allows them to support the individual in recovery and learn about their own needs for change.
- Helping clients learn about other resources that can be helpful in recovery, such as meditation, relaxation training, anger management, spiritual development, and nutrition.

Psycho-educational groups generally teach clients that they need to learn to identify, avoid, and eventually master the specific internal states and external circumstances associated with substance abuse. The coping skills (such as anger management or the use of "I" statements) normally taught in a skills development group often accompany this learning. Psycho-educational groups are considered a useful and necessary, but not sufficient, component of most treatment programmes. For instance, Psycho-education might move clients in a precontemplative or perhaps contemplative stage to commit to treatment, including other forms of group therapy. For clients who enter treatment through a Psycho-educational group, programmes should have clear guidelines about when members of the group are ready for other types of group treatment. Often, a Psycho-educational group integrates skills development into its programme. As part of a larger programme, Psycho-educational groups have been used to help clients reflect on their own

behaviour, learn new ways to confront problems, and increase their self-esteem (Galanter, 2008). Psycho-educational groups should work actively to engage participants in the group discussion and prompt them to relate what they are learning to their own substance abuse. To ignore group process issues will reduce the effectiveness of the Psycho-educational component.

Psycho-educational groups are highly structured and often follow a manual or a preplanned curriculum. Group sessions generally are limited to set times, but need not be strictly limited. The instructor usually takes a very active role when leading the discussion. Even though Psycho-educational groups have a format different from that of many of the other types of groups, they nevertheless should meet in a quiet and private place and take into account the same structural issues (for instance, seating arrangements) that matter in other groups. As with any type of group, accommodations may need to be made for certain populations. Clients with cognitive disabilities, for example, may need special considerations. Psycho-educational groups also have been shown to be effective with clients with co-occurring mental disorders, including clients with schizophrenia (Galanter, 2008).

Leaders in Psycho-educational groups primarily assume the roles of educator and facilitator. Still, they need to have the same core characteristics as other group therapy leaders: caring, warmth, genuineness, and positive regard for others. Leaders also should possess knowledge and skills in three primary areas. First, they should understand basic group process – how people interact within a group. Subsets of this knowledge include how groups form and develop, how group dynamics influence an individual's behaviour in group, and how a leader affects group functioning. Second, leaders should understand interpersonal relationship dynamics, including how people relate to one another in group settings, how one individual can influence the behaviour of others in group and some basic understanding of how to handle problematic behaviours in group (such as being withdrawn). Finally, Psycho-educational group leaders need to have basic teaching skills. Such skills include organizing the content to be taught, planning for participant involvement in the learning process, and delivering information in a culturally relevant and meaningful way.

To help clients get the most out of Psycho-educational sessions, leaders need basic counselling skills (such as active listening, clarifying, supporting, reflecting, attending) and a few advanced ones (such as confronting and terminating). It also helps to have leadership skills, such

as helping the group get started in a session, managing (though not necessarily eliminating) conflict between group members, encouraging withdrawn group members to be more active, and making sure that all group members have a chance to participate. As the group unfolds, it is important that group leaders are non-dogmatic in their dealings with group members. Finally, the group leader should have a firm grasp of material being communicated in the Psycho-educational group.

During a session, the group leader should be mindful both of the group's need and the specific needs of each member. The group leader will need to understand group member roles and how to manage problem clients. Except in unusual circumstances, efforts should be made to increase members' comfort and to reduce anxiety in the group. Leaders will use a variety of resources to impart knowledge to the group, so each session also requires preparation and familiarization with the content to be delivered. Group leaders should have ongoing training and formal supervision. Supervision benefits all group leaders of all levels of skill and training, as it helps to assure them that people in positions of authority are interested in their development and in their work. If direct supervision is not possible (as may be the case in remote, rural areas), then Internet discussions or regular telephone contact should be used.

Techniques to conduct Psycho-educational groups are concerned with how information is presented, and how to assist clients to incorporate learning so that it leads to productive behaviour, improved thinking, and emotional change. Adults in the midst of crises in their lives are much more likely to learn through interaction and active exploration than they are through passive listening. As a result, it is the responsibility of the group leader to design learning experiences that actively engage the participants in the learning process. Four elements of active learning can help.

First, the leader should foster an environment that supports active participation in the group and discourages passive note taking. Accordingly, leader lecturing should be limited in duration and extent. The leader should concentrate instead on facilitating group discussion, especially among clients who are withdrawn and have little to say. They need support and understanding of the content before expressing their views. Techniques such as role playing, group problem-solving exercises and structured experiences all foster active learning.

Second, the leader should encourage group participants to take responsibility for their learning rather than passing on that responsibility to the group leader. From the outset of the group, the leader can emphasize group self-ownership by allowing members to participate in setting agreements and other group boundaries. The leader can emphasize member responsibility for honest, respectful interaction among all members and can de-emphasize the leader role in determining group life. Third, because many people have pronounced preferences for learning through a particular sense (hearing, sight, touch/movement), it is essential to use a variety of learning methods that call for different kinds of sensory experience.

Most people, at one time or another, have had unpleasant experiences in traditional, formal classroom environments. The resulting shame, rejection, and self-deprecation strongly motivate people to avoid situations where these experiences might be brought back into awareness. Therefore it is critically important for the group leader to be sensitive to the anxiety that can be aroused if the client is placed in an environment that replicates a disturbing scene from the past. To allay some of these concerns, leaders can acknowledge the anxieties of participants, prevent all group participants from mocking others' comments or ideas, and show sensitivity to the meaning of a participant's withdrawal in the group. Overall, leaders should create an environment where participants who are having difficulty with the Psycho-educational group process can express their concerns and receive support.

Fourth, people with alcoholism and other addictive disorders are known to have subtle, neuropsychological impairments in the early stage of abstinence. Verbal skills learned long ago (that is, crystallized intelligence) are not affected, but fluid intelligence, needed to learn some kinds of new information, is impaired. As a result, clients may seem more able to learn than they actually are. Therapists who are teaching new skills should be mindful of this difficulty.

Sexual education in American schools is now almost universal, and both parents and adolescents support the programmes even at elementary and junior high school. Typically, such programmes are short (e.g., 5-10 hours or less), and they focus on the basics of anatomy, human reproduction, and physical and psychological changes during puberty. Some programmes are part of a broader curriculum of family life education that includes material on the rules and responsibilities of family members, family problems (e.g., abuse, divorce, substance abuse), relationships with parents, information on marriage and child bearing, and

career and financial planning. Evaluations of such programmes support the following conclusions:

- Providing young people with education about sexuality and even about contraception does not increase the likelihood that they will initiate or increase the frequency of sexual activity. No evidence exists, despite common belief, that educational programmes will promote, rather than prevent, sexual activity.
- Sexual and family life education increase knowledge of sexual functioning and other topics covered in such courses. In short, sexual education is successful at educating young people about sexuality.

In the context of UNFPA's programmes (UNFPA, 2002a; 2002b), education refers to the teaching and learning process involved in developing attitudes, values and skills that shape individual and social life in the areas of population and development, reproductive health, adolescent reproductive health, HIV/AIDS and gender. UNFPA supports the integration of population/family life/sexual health education in school-based and out-of-school education programmes and activities. This is to ensure that all adolescents receive the information they need to develop attitudes, values and skills that will enable them to make responsible choices regarding their sexual and reproductive health and to exercise their right to gender equality and equity. UNFPA also promotes youth participation in education activities. It views education as a key factor in linking adolescents to sexual and reproductive health services, including counselling.

Smith, Steen, Schwendiger, Spaulding-Given, and Brooks, 2005 reported on a study conducted to assess the effect of gender on pre- and post intervention attitudes about sexual abstinence after an abstinence education intervention. Gender had a statistically significant effect on the pre-test response for each item. Gender had a statistically significant effect on the post-test response for most of the items. Gender had no effect on items related to the negative impact on future endeavours of having sex and having children. Overall, boys entered the program with stronger attitudes against abstinence than did girls but demonstrated more change toward pro-abstinence beliefs after the intervention. In conclusion, the authors suggest the creation of gender-specific health promotion modules and further research on the efficacy of these (Smith, Steen, Schwendiger, Spaulding-Given, & Brooks, 2005)

Psycho-education is among the most effective of the evidence-based practices that have emerged in both clinical trials and community settings. Because of the flexibility of the model, which incorporates both illness-specific information and tools for managing related circumstances, Psycho-education has broad potential for many forms of illnesses and varied life challenges. Psycho-education is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions. Many forms of psychosocial intervention are based on traditional medical models designed to treat pathology, illness, liability, and dysfunction.

In contrast, Psycho-education reflects a paradigm shift to a more holistic and competence-based approach, stressing health, collaboration, coping, and empowerment (Dixon, 1999; Marsh, 1992). It is based on strengths and focused on the present. The patient/client and/or family are considered partners with the provider in treatment, on the premise that the more knowledgeable the care recipients and informal caregivers are, the more positive health-related outcomes will be for all. To prepare participants for this partnership, Psycho-educational techniques are used to help remove barriers to comprehending and digesting complex and emotionally loaded information and to develop strategies to use the information in a proactive fashion. The assumption is that when people confront major life challenges or illnesses, their functioning and focus is naturally disrupted (Mechanic, 1995).

Psycho-education embraces several complementary theories and models of clinical practice. These include ecological systems theory, cognitive-behavioural theory, learning theory, group practice models, stress and coping models, social support models, and narrative approaches (Anderson, Reiss, & Hogarty, 1986; Lukens, Thorning,& Herman, 1999; McFarlane, Dixon, Lukens, & Lucksted, 2003). Ecological systems theory provides the framework for assessing and helping people understand their illness or experience in relation to other systems in their lives (i.e., partners, family, school, health care provider, and policymakers). Under this umbrella, Psycho-education can be adapted for individuals, families, groups, or multiple family groups. Although Psycho-education can be practised one-on-one, group practice models set the stage for within-group dialogue, social learning, expansion of support and cooperation, the potential for group reinforcement of positive change, and network building (Penninx, van Tilburg, Kriegsman, Boeke, Deeg & van Eijk, 1999). They reduce isolation and serve as a forum

for both recognizing and normalizing experience and response patterns among participants, as well as holding professionals accountable for high standards of service.

Cognitive-behavioural techniques such as problem solving and role-play enhance the presentation of didactic material by allowing people to rehearse and review new information and skills in a safe setting. These can be amplified through specific attention to the development of stress management and other coping techniques (Anderson et al., 1986; McFarlane, 2002). Narrative models, in which people are encouraged to recount their stories as related to the circumstances at hand, are used to help them recognize personal strengths and resources and generate possibilities for action and growth (White, 1989).

Self-components Training

Schalet (2011) proposed ABC-D approach, as a new paradigm to enhance healthy sexuality among the adolescents. The new paradigm includes sexual *autonomy*, *building* good romantic relationships, *connectedness* with parents and other caregivers, and recognizing *diversities* and removing *disparities* in access to vital socioeconomic resources. Creating the conditions for more positive sexual experiences and outcomes among adolescents requires both political will and cultural innovation. Offered here is an alternative model for adolescent sexual health: this ABC-and-D directs attention to the fundamental skills, relationships, and resources that youth need to develop as healthy sexual and emotional beings. The A in this conceptual model refers to autonomy of the sexual self. It is known that adolescents acquire new skills for autonomy, but this premise is rarely applied to sexuality. Gaining sexual autonomy involves knowing about sexual desire and pleasure, recognizing and articulating sexual wishes and boundaries, and learning to anticipate and prepare for sexual acts. When youth have sexual autonomy, they can recognize their sexual feelings as separate from the desires and pressures of others, own their feelings, and exercise control over their sexual decision making (Tolman, 2002).

Acquiring such autonomy is easier when youth move slowly in sex, assessing their desires and comfort levels at every step before moving to the next. A sense of sexual autonomy helps youth to navigate sexual interactions: Teens who have a greater sense of control in sexual situations are more likely to refrain from intercourse and use condoms when they have sex (Pearson, 2006). When girls report more sexual subjectivity body esteem, entitlement to

pleasure, and sexual self-reflection they experience greater self-efficacy in condom use (Horne & Zimmer-Gembeck, 2006). And girls who report more sexual self-efficacy ability to act on their sexual needs are more likely to have used condoms at first intercourse (Impett, Schooler, & Tolman, 2006).

Self-esteem and self-efficacy are significant factors in discussing sexual health. Self-esteem or self-worth is integral to sexual health because people must have some level of self-respect in order to develop the confidence to make independent, healthy decisions about the actions and behaviours in which they elect to engage (Tayside Region Education Department, 1993). Individuals with higher levels of self-esteem experience more ease in self-control and reduced anxiety and guilt about not living up to self- or other-imposed standards of behaviour (e.g., total abstinence from sexual behaviour; Chilman, 1990). While self-esteem is often examined at a global level, more specific levels within the construct often demonstrate greater predictive value than the global construct (Coopersmith, 1967; Dutton & Brown, 1997; Oattes & Offman, 2007; Rosenfeld, 2004; Zeanah & Schwarz, 1996). Sexual self-esteem is defined as "affective reactions to subjective appraisals of sexual thoughts, feelings, and behaviours" (Zeanah & Schwarz, 1996) and is considered a contributing factor to global self-esteem.

Sexual self-esteem has been positively linked to sexual communication including partnered discussions of STIs and sexual history while global self-esteem appears to be too broad a construct to relate (Oattes & Offman, 2007; Rosenfeld, 2004). Self-efficacy, including perceived behavioural control and motivation, is also important: individuals need to have a sense of capability as well as knowledge (Meaney, Rye, Wood & Solovieva, 2009). Higher levels of sexual self-efficacy are predictive of positive attitudes regarding contraception and engagement in safe sex (Weiser & Miller, 2010). Sexually self-efficacious individuals also experience a greater sense of control in sexual experiences, including advocacy for one's sexual interests, lower levels of sexual anxiety, and higher levels of sexual self-awareness and sexual-subjectivity (Horne & Zimmer-Gembeck, 2005). Sexual subjectivity has been defined as the ability to feel confident in and in control of one's body and sexuality (Thompson, 1990) and may be contrasted with the concept of sexual objectification—that is, experiencing one's body exclusively as an object for the pleasure of others. For young women, internalized conventional ideas about femininity and self-objectification appear to reduce feelings of sexual self-efficacy (Tolman,

Impett, Tracy & Michael, 2006). Those without adequate knowledge and self-acceptance may have difficulty discerning choice from coercion (Thompson, 1990).

Sexual self-efficacy may also be tied to sexual empowerment. Psychological empowerment has been defined as a feeling of control over one's life (Rissel, 1994), and has been divided into three subcomponents, each of which may be used to understand the concept of sexual empowerment (Zimmerman, 1995). Intrapersonal components include perceived control, competence, and mastery (e.g., feelings of sexual self-efficacy, desire, and pleasure; Peterson, 2010). Interactional components include awareness of options, resources, and problem-solving and decision-making skills (e.g., knowledge of pleasure, clear desires, and communication with a sexual partner; Peterson, 2010). Behavioural components include taking actions to directly influence outcomes (e.g., asking for what one wants, refusing unwanted experiences, and general sexual exploration, alone or with a partner; Peterson, 2010). It is likely that greater experience of empowerment in any and all of these dimensions would significantly contribute to positive sexual experiences, and therefore improved sexual health.

Theoretical Framework

Self-Efficacy Theory

Bandura (1977) defined self-efficacy as one's belief in one's ability to succeed in specific situations. Self-efficacy values are not about individual's skills objectively; they are really about the persons' decisions of the things they can accomplish with those skills. Self-efficacy is a term used in psychology, roughly corresponding to a person's belief in their own competence. It has been defined as the belief that one is capable of performing in a certain manner to attain certain goals (Luszczynska & Schwarzer, 2005). One's sense of self-efficacy can play a major role in how one approaches goals, tasks, and challenges. It is believed that our personalized ideas of self-efficacy affect our social interactions in almost every way. Understanding how to foster the development of self-efficacy is a vitally important goal for positive psychology because it can lead to living a more productive and happy life.

Bandura (1997) proposed that self-efficacy beliefs have an effect on psychosocial conduct. These beliefs have an effect on thought patterns, emotional reactions and thought patterns in various situations. For instance, individuals will avoid situations they believe they're not capable of handling; their level of self-efficacy also will influence their amount of effort and determine

the amount they persist when confronted with failure. Those with high self-efficacy can focus more effort on the task at hand and persevere more than individuals with low self-efficacy (Pajares & Urdan, 2009).

Bandura (1997) showed that self-efficacy beliefs are formed due to advanced thoughts of self-appraisal and self-persuasion from distinct efficacy resources; he listed these sources of information as past performance successes, vicarious experiences, verbal persuasion and physiological states. Past performance achievements have shown to be the most influential supply of efficacy information since they're based on a person's own experiences of success or failure (Bandura, 1997). People that view past performance as positive results are going to have increased self-efficacy beliefs; however, if these experiences are deemed as failures, then self-efficacy beliefs will probably decrease (Luszczynska, Schwarzer, Lippke & Mazurkiewicz, 2011).

Vicarious experiences have an impact on self-efficacy as information can be derived through persons paying attention to and looking at themselves to others (Luszczynska, Schwarzer, Lippke, & Mazurkiewicz, 2011). Bandura (1997) suggests that this process involves watching the performance of others, coding the result which has been observed, noting the result of the performance and then finally using that information to make decisions about your own amount of mastery. Vicarious influences likewise incorporate social judgements, including, considering other individuals in terms of their physique might have an impact on self-efficacy (Lippke, Wiedemann, Ziegelmann, Reuter, & Schwarzer, 2009). Vicarious sources of efficacy information are generally regarded as weaker than past performance accomplishments (Luszczynska, Schwarzer, Lippke, & Mazurkiewicz, 2011).

Verbal persuasion information affects self-efficacy through elements which includes evaluative feedback, anticipation by others, self-talk, imagery together with other cognitive strategies; self efficacy beliefs determined by these sources are additionally considered to be weaker compared to those of performance accomplishments (Schwarzer, 2008). Physiological information impacts self-efficacy as persons cognitively evaluate their physiological condition and state to make decisions about their efficacy (Luszczynska, Schwarzer, Lippke & Mazurkiewicz, 2011). Physiological facts are produced from factors such as fitness, levels of fatigue and pain; as well as psycho-physiological factors just like arousal, fear, a lack of self-

confidence and ones ability to get psyched up and ready for performance (Schwarzer, 2008). Physiological information has been shown to be considered a more important supply of info affecting self-efficacy in physical exercise tasks compared to nonphysical tasks (Schwarzer, Richert, Kreausukon, Remme, Wiedemann, & Reuter, 2010).

Studies suggested that the partnership between self efficacy and behaviour is really a reciprocal one in nature (Weinberg & Gould in Luszczynska, Schwarzer, Lippke & Mazurkiewicz, 2011). In a very sports circumstance, an athlete or coach with previous high levels of performance are going to have higher self efficacy, these feelings of high self efficacy thus have a favourable effect on performance.

The concept of self-efficacy lies at the center of Bandura's social cognitive theory, which emphasizes the role of observational learning and social experience in the development of personality. The main concept in social cognitive theory is that an individual's actions and reactions in almost every situation are influenced by the actions which that individual has observed in others. People observe others acting within an environment whether natural or social. These observations are remembered by an individual and help shape social behaviours and cognitive processes. This theoretical approach proposes the idea that by changing how an individual learns their behaviours in the early stages of mental development could have a large impact on their mental processes in later stages of development. Since Self-efficacy is developed from external experiences and self-perception and is influential in determining the outcome of many events, it is an important aspect of social cognitive theory. Self-efficacy represents the personal perception of external social factors (Bandura, 1988; Mischel & Shoda, 1995; Ormrod, 1999; Bandura, 2005; Pajares, & Urdan, 2009). According to Bandura's theory, people with high self-efficacy—that is, those who believe they can perform well—are more likely to view difficult tasks as something to be mastered rather than something to be avoided.

Specifically, this theory is relevant to adolescents' sexual abstinence practice. According to Hulton (2010), self-efficacy for sexual abstinence represents the subjects' level of confidence that they can resist having sexual intercourse across a number of tempting situations. Thus, self-efficacy for sexual abstinence is conceptualized in two ways: confidence in ability to change risk behaviours, and ability to continue these behaviours despite temptation. Bandura's (1977) pioneering self-efficacy theory has important implications for understanding the relationship

between adolescents' use of cognitive resources in pursuit of ongoing recovery from sexual initiation or for delaying sex. Self-efficacy is a crucial element toward prevention and coping with the sexual urges to enhance sexual abstinence.

Erikson's Psychosocial Theory

Erickson (1902-1994) was a psychologist who like Piaget proposed a stage theory of human development (Erickson, 1950; 1968). But unlike Piaget, his theory focuses on more than cognitive development. Erickson's theory is based on his observations of a wide range of people of various ages. His views were influenced more by Freud than by Piaget. Unlike Freud, however, he chose to focus on the social environment, which is why his theory is called psychosocial.

As a stage theory, Erickson implies that we naturally go through the resolution of each conflict or crisis in order and that facing anyone type of crisis usually occurs at about the same age for all of us. At adolescence, the fifth stage, which is the stage of identity formation, is described as the stage of optimal sense of identity experienced merely as a sense of psychosocial well-being. A feeling of being at home in one's body, a sense of knowing where one is going and an inner assuredness of anticipated recognition from those who count.

For many adolescents, resolving one's identity crisis a relatively simple and straightforward process. In such cases, adolescence brings very little confusion in terms of attitudes, beliefs or values. So many adolescents are able and willing to accept the values and sense of self theory began to develop in childhood.

Although for many, the conflict of identity formation is real. They feel like giving up the values of parents and teachers in favour of their own new ones. These values include physical growth, physiological changes, increased sexuality and perception of social pressures which they give up to decide what they want to be when they 'grow up'. Sometimes, this may lead to confusion. That is, their desire for independence, to be one's own self, does not fit in with the values of the past of childhood. Hence, the adolescent experiments with various possibilities in an attempt to see what works out best (including initiation of sex), to the dissatisfaction of the bewildered parents and the adolescent confusion and problems.

Behaviour Contagion Theory

This theory states that behaviour is contagious if one person is more likely to exhibit it when a significant and relevant person has already done so. This theory, proposed by Jones and Jones in Oyeyemi (2004), is commonly thought to contribute to many social problems such as sexual promiscuity among teenagers.

It explains behavioural contagion from parents to children as confirmed by some polygamists who claim their fathers had many wives as basis for their polygamous life. Peers may also influence their group members by contaminating them through pressurizing them to engage in the behaviour excesses leading them into problem behaviour like early sexual debut.

Social Control Model

Theories of social control, like primary socialization theory, hold that prosocial family processes – rules, monitoring, and attachment have a significant impact on the peers with whom an adolescent chooses to associate. Social control operates through four processes: direct control (such as parental monitoring and supervision); indirect control (the interaction of a child's/adolescent's beliefs and attachment for example, not wanting to disappoint parents or jeopardize the relationship); satisfaction of needs (if the child/adolescent is emotionally satisfied within the family, he or she will not have to seek intimacy and support from peers); and internalized control.

One important implication of this and other models is the timing of family management practices and how these affect later peer choices. The authors maintain that poor attachment, monitoring, and supervision in the preadolescent phase will surface later in an adolescent's choice of peers (Oxford & Harachi, 2001).

As its name suggests, the social development model suggests that all children move through similar developmental stages and processes. At each one, they develop either prosocial or antisocial behaviours, depending on the influences of their family, personal characteristics, and environment (Catalano & Hawkins 1999). The model holds that both types of behaviour prosocial and antisocial are learned from the same agents of socialization: the family, school, religious or other community institutions, and peers.

How does this learning occur? In each type of interaction, children learn social behaviour patterns by interacting with others, having opportunities for involvement, the degree to which

they are involved, the skills they have to make their involvement meaningful, and the reinforcement they receive. Even though they experience both prosocial and antisocial models, one or the other will dominate. Therefore, the model suggests, children and adolescent who were primarily exposed to pro-social influences will demonstrate prosocial behaviours as adults, and vice versa.

Theories of Reasoned Action and Planned Behaviour

The theory of reasoned action (Ajzen & Fishbein, 1980) was first introduced in 1967 by Fishbein in an effort to understand the relationship between attitude and behaviour. It attempts to explain the relationship between *beliefs, attitudes, intentions* and *behaviour*. According to the theory of reasoned action, the most accurate determinant of behaviour is *behavioural intention*. The direct determinants of people's behavioural intentions are their *attitudes* towards performing the behaviour and the *subjective norms* associated with the behaviour. Attitude is determined by a person's beliefs about the outcomes or attributes of performing a specific behaviour (that is, behavioural beliefs), weighted by evaluations of those outcomes or attributes. The subjective norm of a person is determined by whether important referents (that is, people who are important to the person) approve or disapprove of the performance of a behaviour (that is, normative beliefs), weighted by the person's *motivation to comply* with those referents (Ajzen & Fishbein, 1980; Montano & Kasprzyk, 2002).

According to Montano and Kasprzyk (2002), the theory of reasoned action is successful in explaining behaviour when volitional control is high. In conditions where volitional control is low, the theory of planned behaviour (Ajzen, 1991) is more appropriate to explaining behaviour. Ajzen (1991) proposed the theory of planned behaviour by adding *perceived behavioural control (PBC)* to the theory of reasoned action, in an effort to account for factors outside a person's volitional control that may affect her/his intentions and behaviour. This extension was based on the idea that behavioural performance is determined by motivation (intention) and ability (behavioural control). According to Montano and Kasprzyk (2002), perceived behavioural control is similar to Bandura's concept of self-efficacy, which refers to an individual's belief in his/her ability to perform a particular behaviour under various conditions. The two theories are applicable in adolescents' practice of sexual abstinence.

According to the theory of planned behaviour, perceived behavioural control is determined by control beliefs concerning the presence or absence of facilitators and barriers to behavioural performance, weighted by the perceived power or input of each factor to facilitate or inhibit behaviour. Thus, a person who holds strong control beliefs about factors that facilitate behaviour will have high perceived control, which translates into an increased intention to perform the behaviour (Ajzen, 1991; Montano & Kasprzyk, 2002).

Theory of Reasoned Action posits that individual behaviour is driven by behavioural intentions where behavioural intentions are a function of an individual's attitude toward the behaviour and subjective norms surrounding the performance of the behaviour. Attitude toward the behaviour is defined as the individual's positive or negative feelings about performing a behaviour. It is determined through an assessment of one's beliefs regarding the consequences arising from a behaviour and an evaluation of the desirability of these consequences. Formally, overall attitude can be assessed as the sum of the individual consequence and desirability assessments for all expected consequences of the behaviour.

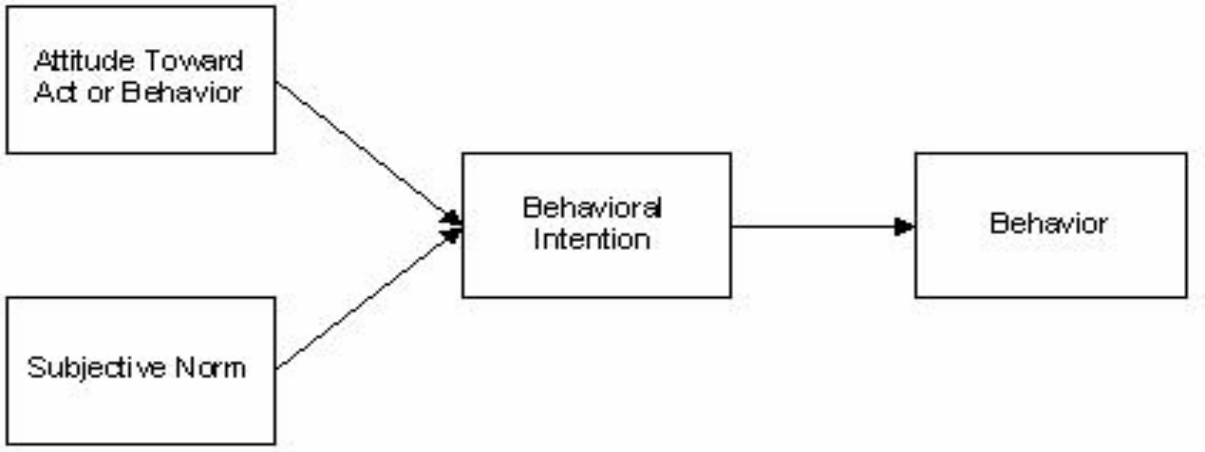
Subjective norm is defined as an individual's perception of whether people important to the individual think the behaviour should be performed. The contribution of the opinion of any given referent is weighted by the motivation that an individual has to comply with the wishes of that referent. Hence, overall subjective norm can be expressed as the sum of the individual perception and motivation assessments for all relevant referents.

Theory of Reasoned Action suggests that a person's behaviour is determined by his/her intention to perform the behaviour and that this intention is, in turn, a function of his/her attitude toward the behaviour and his/her subjective norm. The best predictor of behaviour is intention. Intention is the cognitive representation of a person's readiness to perform a given behaviour, and it is considered to be the immediate antecedent of behaviour. This intention is determined by three things: their attitude toward the specific behaviour, their subjective norms and their perceived behavioural control. This theory is relevant as the components are considered in Self-components training, which is the second therapy for this study.

The theory of planned behaviour holds that only specific attitudes toward the behaviour in question can be expected to predict that behaviour. In addition to measuring attitudes toward the behaviour, we also need to measure people’s subjective norms – their beliefs about how

people they care about will view the behaviour in question. To predict someone's intentions, knowing these beliefs can be as important as knowing the person's attitudes.

Notably, perceived behavioural control influences intentions. Perceived behavioural control refers to people's perceptions of their ability to perform a given behaviour. These predictors lead to intention. A general rule, the more favourable the attitude and the subjective norm, and the greater the perceived control the stronger should the person's intention to perform the behaviour in question. This theory can be summarized by what is represented in Figure 2.1



Source: Fishbein, M., & Ajzen, I. (1975).

Figure 2.1: Summary of the Theories of Reasoned Action and Planned Behaviour

The theory of reasoned action and the theory of planned behaviour were chosen for this study as they are the theories most cited in sex-related researches, and have been found to be better predictors of sexual health behaviour than other models (Fishbein, 1993; Terry, Gallois & McCamish, 1993; Warwick, Terry & Gallois, 1993). It is the result of a decision-making process that involves an individual processing the information available to him/her, and then deciding on a course of action after reflecting on the consequences of performing the behaviour and his/her beliefs about what other people expect him/her to do.

The Nigerian populace has been exposed to sufficient information on the consequences of adolescent sexuality. There is a need to move towards behaviour change. As attitudes and beliefs have been shown to be significant in people's choice of action, the theories of reasoned action and planned behaviour are relevant to behaviour change. This study is specifically anchored on

the theories of reasoned action and planned behaviour. The model that is applied in this study is based on the assumption that if adolescents' attitudes towards sexual abstinence behaviours are *shaped* in particular directions and their beliefs about the expectations of their significant others are reinforced; it will then be possible to change behaviour.

The theories of reasoned action and planned behaviour fall within the realm of cognitive theories. These two theories are based on the assumption that humans are endowed with the ability to reason, and that reason is the primary psychological process involved in decision-making (Leviton, 1989). It follows that a major criticism of the theory of reasoned action, according to Dutta-Bergman (2005), is that its strong cognitive orientation tends to preclude the affective nature of humans, which also plays a role in decision-making processes.

Using sexual behaviour change as an example, the theory of reasoned action suggests that for behaviour change to occur, the individual must systematically identify and weigh the outcomes of his/her sexual behaviour to form attitudes towards the specific behaviour that must be learned. This assumes that behaviour change can be induced by adding a new belief, increasing or decreasing the favourability or unfavourability of an existing belief, and increasing or decreasing the belief strength associated with the intended behaviour. The persuasive process involved in behaviour change would be primarily information-based, thus providing the individual with the necessary pieces of information required to create a desirable attitude towards the intended behaviour. While the individual may satisfy the requirements for behaviour change in this paradigm, they may not be able to enact the behaviour in a situation where they initiate sexual intercourse on the spur of the moment.

Empirical Review

Adolescents and Sexual Abstinence

Wellings, Wadsworth, Johnson, Field, Whitaker and Field (1995) remarked from their findings that the age at which people become sexually active has fallen sharply. Similarly, Oladapo (1997) reported from a survey of secondary school students in Akure (the capital of Ondo State, from where the researcher drew sample for this study); 30% were sexually active. The mean age at first intercourse was 13.5 years and 15.2 years for males and females

respectively across all types of schools. In co-educational (mixed) schools, 40% were found to be experienced sexually. In single-sex schools, it was 19% for boys only and 8% for girls only.

In a comparative study of the sexual behaviours of female students in tertiary institutions in Anambra State, Nigeria, it was found out that 82% of the students were sexually experienced, and that study has a tempering effect upon adolescent sexuality (Adinma, Agbai & Okeke, 1998). This was further buttressed by Koenig, Zablotska, Lutalo, Alalugoda, Wagman and Gray (2004). In their study population of sexually experienced young women, 13% said that they had first had sex before the age of 14, 46% at age 14 or 15, and 41% at age 16 or older. All these featured barely at the close of the last century. A declining age at puberty, in this dispensation, puts young girls and boys at risk of early premarital exposure to sexual activities. Hence, there are girls as young as 9 years being sexually experienced. Oloko and Omoboye (2006) found mean age of first intercourse to be 10 years among their sampled adolescents. This was further confirmed when Akinyele and Onifade (2009) found that girls of ages 9 and 10 years were already sexually experienced.

Abiodun (2006) also found high incidence of "misuse of sexuality," that is, obliging sex for material and or financial gains, especially among females. He noted that some, among the females sampled, started at a very tender age. He further claimed that 68.3% of his samples had boy and girl friends with 58.8% of them having had coital experiences and 29.2% admitting they had done abortion. Similarly, Hammed and Adenegan (2009) reported that 51% of the adolescents sampled had engaged in sexual intercourse. The mean age at first intercourse was 11.7 years for males and 14.5 years for females.

This trend is not different from what is observed globally. In Cote d'Ivoire, among the 3,041 never-married youth (ages 15 – 24 years) sampled, 67% had had sex (Koffi & Kawahara, 2008). In Rwanda, the median age of first sexual intercourse among the adolescents was found to be 15.8 years and 16.6 years for male and female respectively (Babalola, Awasum & Quenum-Renaud, 2002). In America, teen sexual activity remains a widespread problem confronting the nation. Each year, some 2.6 million teenagers become sexually active; a rate of 7,000 teens per day. Among high school students, nearly half report having engaged in sexual activity and one-third reported currently active (Kim & Rector, 2010).

In a study in Niger State, majority of the respondents (73%) favoured remaining a virgin until marriage (Sunmola, Dipeolu, Babalola & Adebayo, 2003). In another study in Ogun State, more than 76.2% of adolescents agreed that youths should remain virgins until marriage. Irrespective of their previous sexual experience, 62.7% of the respondents intended to abstain until they marry, 30.7% were undecided while 6.6% would not (Iyaniwura, Daniel & Adelowo, 2007). Iyaniwura, Daniel and Adelowo (2007) also reported various misconceptions about abstinence among adolescents in Ogun State.

The reasons given for premarital sex in Anambra from the study of Duru, Ubajaka, Nnebue, Ifeadike and Okoro (2010) were peer group pressure (50%), monetary gain (27.5%), personal satisfaction (16.7%), curiosity (4.2%), and lack of home guidance from parents and relatives (1.7%). In Niger State the case was different; pleasure contributed 58% of the reasons, 22% to test fertility and 7% to enhance sexual proficiency (Sunmola, Dipeolu, Babalola & Adebayo, 2003). In Abia State, the context for sexual intercourse was worrisome. The study revealed that 5.4% of the girls were drugged; 4.1% raped; 7.4% coerced and 14.2% deceived. 23.0% of the girls did it out of curiosity and 4.1% due to biological urge, other reasons accounted for the rest (Izugbara, 2001).

The sex partners of adolescents have been found to vary. In Bida, Niger State, 56.4% of the sexually active adolescents engaged in sex with their boyfriend/girlfriend; 7.4% did with their fiancé/fiancée; 3.6% with a sugar daddy/mummy; 1.3 % had sex with any man/woman and 31.3% gave no response (Odimegwu, Solanke & Adedokun, 2002). In Abia State, among sexually active adolescents, the findings were different: 35.8% with classmate/playmate; 25.9% with boyfriend/girlfriend; 10% (boys) with prostitute; 9.3% with sugar daddy/mummy; 4.9% with proposed spouse; 1.2% with strangers and 12.4% with others (Izugbara, 2001).

In a study conducted among out of school female adolescents in Mushin, Lagos State, the main reason for sexual initiation was curiosity (Odeyemi, Onajole & Ogunowo, 2009). This was supported by evidence from Abia State, where twenty-three percent of the sexually active girls made their debut out of curiosity (Izugbara, 2001). There is evidence that in some instances first sex was the result of sexual violence including rape and other forms of coercion (Ankomah et al, 2011). This is supported by data from Abia State, where 31.1% of the adolescent girls made their sexual debut through various coercive factors (Izugbara, 2001). Other factors include person

adolescents reside with and watching of pornography, uncontrolled natural urge, as well as alcohol and drugs dependence (Odeyemi, Onajole & Ogunowo, 2009).

Abstinence-only programmes are taught in approximately one-third of U.S. schools, reaching about 8 million students (Frank, 2005). However, rates of sexual activity increase rapidly during the adolescent years and many teens engage in sexual behaviour that places them at risk for unintended pregnancy and STIs, including HIV. According to the report of Centers for Disease Control and Prevention (2002) in the United States, 46.8% of high school students reported that they had had sexual intercourse, with 14.3% reporting intercourse with four or more sexual partners. Moreover, 37.2% of sexually active high school students had not used a condom when they last had sex.

Gender and Sexual Abstinence

Empirical findings abound indicating the level of differences between the sexual abstinence practice between adolescent boys and girls. FHI/IMPACT (2000) found that 29% of unmarried boys aged 15 – 19 years and 12% of their female counterparts were sexually active. Babalola, Awasum and Quenum-Renaud (2002) reported from their findings that boys (34.4%) are more likely than girls (19.4%) to have ever had sex, with the median age at first sex lower for boys (15.8 years) than for girls (16.6 years). They observed age variable having considerable effects on the practice of sexual abstinence of both genders; the older the youth the less likely it is that he will be practising abstinence. An increase of one year in age reduces the odds of reporting primary sexual abstinence by 21%.

Girls indicated more often than boys that they did not have any sexual experience (i.e. vaginal or anal intercourse): 58.4% of the girls against 36.6% of the boys (Rijsdijk, Bos, Lie, Ruiter, Leerlooijer & Kok, 2012). This study also found that 72.4% of boys reported having ever had sex whereas 27.6% of girls were sexually experienced. Under a quarter (24.5%) was currently sexually active. Over 70% of learners reported never having had sex. Sexual initiation started significantly earlier among boys (mean age 13.9 years) than girls (mean age 15.6 years). A study in KwaZulu-Natal, South Africa, found that many young girls expressed positive attitudes towards abstinence, citing protection from pregnancy and sexually transmitted infections (STIs) as reasons (Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo &

Jinabhai, 2009). In the study, younger girls perceived having sex at their age as inappropriate. Among older sexually experienced girls, a minority supported secondary abstinence.

Girls held more positive attitudes in favour of abstinence. Abstaining girls had more positive attitudes than abstaining boys that abstinence would help them to reduce the risk of pregnancy, and assist them to mature emotionally, and also did not mean that they did not love their partner. The difference in the belief that abstinence may reduce HIV risk was stronger in girls of the non-abstaining group than in abstaining girls but girls always reported stronger beliefs than boys. Abstaining girls reported more social support to abstain than abstaining boys and encountered more positive norms towards abstinence from friends. They also reported that more of their parents abstained when they were at their age (Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo & Jinabhai, 2009).

Studies among learners attending KwaZulu-Natal public high schools indicated that many youth become sexually active before they reach high school (Varga, 1997; UNAIDS, 1998a; 1998b; Taylor, Dlamini & Kagoro, 2003b). This early age of sexual initiation has also been reported in the United States, where boys reported their age of sexual initiation to be younger (12.1 years) than that of girls (14.6 years) (Kirby, Waszak & Ziegler in Dlamini et al, 2009). Interventions to encourage adolescents to remain sexually abstinent are therefore required early before the age of sexual initiation (Varga, 1997; Taylor, Dlamini & Kagoro, 2003b), and then need to continue through their adolescent years, until they are able to critically make informed decisions about sexual activity.

On a global basis, gender roles and responsibilities and inequalities affect both men's and women's sexual health and access to health services and treatment. Gender constructs result in differential knowledge and awareness of sexual health issues, ideologies, expectations, and norms for sexual behaviours, different motivations for sexual activity and relationships, and differential socio-cultural and economic power to negotiate sex and safer sex. Overall, 18.8% (79/421) male and 9.6% (43/450) female respondents reported ever engaging in sexual touching, and 6.4% (27/421) male respondents and 1.3% (6/451) female respondents reported ever engaging in vaginal sex. Nearly 8% (33/421) males compared to 1.5% (7/450) females reported intention to have sex in the next three months (Gupta, 2000; Pham, Nguyen, Tho, TanMinh, Lerdboon, Riel, Green, & Kaljee, 2012).

Mean attitude and intention scores at six months differed significantly between males and females, and the effect sizes show that these differences were also practically significant to a moderate degree – that is, they were detectable in the real world, declared Masters, Beadnell, Morrison, Hoppe and Gillmore (2008). Participants of both genders reported positive attitudes about abstinence, although males somewhat less so than females (means, 3.6 vs. 4.0; on the five-point attitude scales, on which a score of 3 was neutral); males had positive attitudes about having sex, whereas females had more neutral attitudes (3.5 vs. 2.8). Males reported relatively neutral intentions about abstaining and about having sex (2.7 and 2.1, respectively, on the four-point intention scales, on which a score of 2.5 was neutral), while females reported positive intentions about abstaining and negative intentions about having sex (3.3 and 1.5 respectively), reported Masters, Beadnell, Morrison, Hoppe and Gillmore (2008).

Egbochukwu and Ekanem (2008) found significant difference in the attitude of male and female adolescents towards sexual practices. The male adolescents were identified with more permissive attitude towards sexual practices than their female counterparts. On the basis of class, there was no significant difference in the attitude of adolescents towards sexual practices while on the basis of age there was found to be significant difference in the attitude of adolescents of different age ranges toward sexual practices. Moore and Rosenthal (2007) found low rate of sexual abstinence among boys, with the Greek-Australian girls reporting high level of chastity and fidelity while placing premium on virginity as a virtue to be embraced.

Age and gender had also been identified as important correlates of sexual abstinence behaviour. Koffi and Kawahara (2008) revealed that older youth were significantly less likely than their younger counterparts to report sexual abstinence practice. Chio (2007) found that abstinence was higher among female youths. Overall, about 26% of the youth interviewed reported that they had ever had sex. Boys (34.4%) are more likely than girls (19.4%) to have ever had sex Babalola, Awasum and Quenum-Renaud (2002)

A study of 1551 high school students in four midwestern states showed that more girls than boys reported "some" or "a lot" of encouragement to abstain from having sex. More boys than girls reported societal pressure to become sexually active. The sources of encouragement for abstinence were mother, father, and teacher. The largest difference reported between boys and girls was for friends; more than twice as many girls as boys reported that friends encouraged

abstinence. Virgin versus non-virgin comparisons showed similar results, with mother and father chosen most frequently, but non-virgins chose guest speaker instead of teacher for third place. Regarding important decision-making factors, both boys and girls selected own feelings, health, future, boy- or girlfriend, and parents' feelings. Girls considered parents' feelings more while boys rated boy- or girlfriends' feelings higher (Jensen, De Gaston & Weed, 1994).

From Plummer's (2013) findings, male pupils seemed to understand better the knowledge of the risks and benefits of sexual abstinence than the girls. This reflected on how the boys were typically favoured and encouraged more in their learning. However, unlike the male data, living under the same roof as the father tends to shield girls from premarital sexual experimentation (Babalola, Awasum & Quenum-Renaud, 2002). One variable with considerable effects on the practice of sexual abstinence is age: the older the youth the less likely it is that he will be practising abstinence. An increase of one year in age reduces the odds of reporting primary sexual abstinence by 21% found Babalola, Awasum and Quenum-Renaud (2002).

For adolescents without sexual experience (virgins) and the sexually active adolescents (non-virgins), self-efficacy was found by Rijsdijk, Bos, Lie, Ruiter, Leerlooijer and Kok (2012) to be a significant predictor of intention to delay sexual intercourse. From her qualitative study, Plummer (2012) found that self-efficacy intervention significantly had impact on adolescent who had never had sex (the virgins). She noted that the abstinence and sexual refusal skills may have reinforced their sense of control and helped delay sexual debut more than the sexually active adolescents, who rarely believed they had sufficient self-control and efficacy to become abstinent again. Only few girls were found to perceive abstinence as a feasible option once had sex, while in the case of boys, they could go through abstinent period for weeks and months until they again had opportunity to have sex.

When comparing abstainers with non-abstainers, only one belief held for both boys and girls in that abstainers were more convinced that abstinence would help them to mature emotionally, found Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo and Jinabhai (2009). Abstaining girls perceived more advantages than non-abstaining girls because they encountered more positive social norms to abstain from friends and parents and knew more friends who abstain. Within the male population, abstaining boys reported a stronger norm not to have a sexual relationship than non-abstaining boys. A trend was found in that abstaining girls

felt more confident than non-abstaining girls to abstain from sex when pressured by their partner. Abstaining boys reported stronger intentions to abstain in the future (Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo & Jinabhai, 2009).

Peer Influence and Sexual Abstinence

In terms of the net effects of the individual ideational variables in the study of Babalola, Awasum and Quenum-Renaud (2002), the most significant was the perceived sexual behaviour of peers. The perception that most friends are having sex decreases the odds of sexual abstinence. Egbochukwu and Ekanem (2008) found Exposure to pornographic films and peer pressure at 65.1% and 61.2% respectively as factors exerting a large measure of influence on the attitude of adolescents towards sexual practice. Bhardwaj, Ramsay, Bain and Prakasam (2007) revealed that low parental monitoring is linked to the susceptibility of adolescents to negative peer influence and that they have greater tendency to copy the risk behaviour of their friends.

The relationship between perceived peer behaviour and sexual behaviour of youth has been widely documented. As pointed out by Jaccard (1999), perceived peer behaviour is not always synonymous with actual peer behaviour. This is because perceived peer behaviour is often biased by personal behaviour. Another reason for the disparity between perceived and actual peer behaviour is that youth often overestimate what their peers are doing (Steinberg, 1991). However, one study that investigated the influence of perceived peer behaviour versus actual peer behaviour on youth risk-taking found that perceived peer behaviour is a stronger determinant (Iannotti & Bush, 1992).

It is not clear whether the relationship between perceived peer behaviour and adolescent risk taking is due to selection (adolescents choosing their friends on the basis of their own behaviours) or socialization (adolescents adopting the traits of their risk-taking peers). Nonetheless, a strong relationship has been found between the two variables for a variety of health behaviours. For example, research findings on the correlates of substance use among adolescents have shown that what adolescents do is closely related to what they perceive their friends are doing (Stanton & Silva, 1992; Stacy, Newcomb & Bentler, 1993). Many studies have also documented the predictive role of perceived peer behaviour on early sexual experimentation

and risky sexual behaviours (Alexander & Hickner, 1997; Bearman & Bruckner, 1999; Miller & Benson, 2001). Findings by Uwakwe, Onwu and Mansaray (1993) revealed that the most common sources of information about sexual reproductive matters were friends, school mates and the media, while parents and guardians are the least common sources. In terms of the net effects of the individual ideational variables, the most significant is the perceived sexual behaviour of peers. The perception that most friends are having sex decreases the odds of sexual abstinence found Babalola, Awasum and Quenum-Renaud (2002).

Peer group influence is significant in adolescents' social development. Age mates play a great role in the everyday life of adolescent. Significantly, peer group interactions provide a basis for adolescent self-evaluation and critical information on what he or she is like, how he or she should behave and so on. These interactions help the adolescent to compare self with other age mates; an important exercise, which an adolescent does to evaluate his or her actions, attitude, feelings and values (Falaye, 2001). Compared with those who did not report that most of their friends are sexually active, the girls who perceived prevalent sexual activity among friends are 69% less likely to report sexual abstinence (Babalola, Awasum & Quenum-Renaud, 2002).

During their journey of self discovery, adolescent, especially girls, define themselves through their relationship with others. Living within the same household as the father tends to protect girls from early sexual experimentation but has no noticeable effect on boys. Moslems are considerably less likely than Christians to report primary sexual abstinence. The use of alcohol tends to be negatively associated with sexual abstinence. The ideational factors that are significant for primary sexual abstinence are perceptions about the sexual behaviours of peers, perceived self-efficacy to refuse sex with someone truly loved, perceived self-efficacy to refuse sex with someone known for more than three months, self-esteem and attitudes toward premarital sex (Babalola, Awasum & Quenum-Renaud, 2002).

Results from the study of Maguen and Armistead (2006) indicated that both parental sexual attitudes and parent-adolescent relationship quality predicted abstinence after accounting for the variance associated with peer variables. For the younger girls, perceived parental attitudes were the only significant predictor. Abstaining girls reported less pressure to engage in sexual relationships than abstaining boys. This was also reported by more non-abstaining girls in comparison with non-abstaining boys. Within the non-abstaining group, girls also reported more

positive norms from their parents and family (Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo & Jinabhai, 2009).

Psycho-educational Group Therapy and Sexual Abstinence

Psycho-educational Group Therapy which involved sexual and family life-education had been found effective among other programmes geared towards enhancing sexual abstinence among adolescents. With respect to short-term outcomes, Smith, McCall and Ingram (2014) reported that more programmes improved information/knowledge and attitudes/values than did not improve them or had negative effects, but programmes were not successful at raising self-esteem, improving behavioural intentions, acquiring skill in controlling one's behaviour, or improving family communications.

Smith, McCall and Ingram (2014) found that programmes that emphasize the educational, occupational, and psychological preparation for productive and self-sufficient lives for youth and impart a realistic hope that these goals can be obtained can motivate youth to refrain from sexual activity and prevent pregnancy. In terms of long-term outcomes, only 16 of the 52 programmes presented any results at all, and these programmes had no effect on delaying sexual activity, reducing sexual activity, reducing sexually transmitted diseases, or reducing pregnancy rates.

Sexual and family-life education in American schools is now almost universal, and both parents and adolescents support the programmes even at elementary and junior high school. Typically, such programmes are short (e.g., 5-10 hours or less), and they focus on the basics of anatomy, human reproduction, and physical and psychological changes during puberty. Some programmes are part of a broader curriculum of family life education that includes material on the rules and responsibilities of family members, family problems (e.g. abuse, divorce, substance abuse), relationships with parents, information on marriage and child bearing, and career and financial planning. Evaluations of such programmes support the following conclusions:

- Providing young people with education about sexuality and even about contraception does not increase the likelihood that they will initiate or increase the frequency of sexual activity. No evidence exists, despite common belief, that educational programmes will promote, rather than prevent, sexual activity.

- Sexual and family life education increase knowledge of sexual functioning and other topics covered in such courses. In short, sexual education is successful at educating young people about sexuality.

Generally, however, sexual education *alone* does not change attitudes about sexual behaviour, increase the use of family planning and contraceptive methods, or reduce pregnancy or birth rates. Simply providing knowledge alone, while useful in many respects, does not change sexual behaviour. The failure of sexual and family life education to reduce teenage pregnancies and change the sexual behaviour of adolescents may be due to several factors:

- **Providing education alone is not sufficient to change behaviour**. This is likely, because education on nutrition, safe driving, and the dangers of smoking and drug use is also not sufficient to change the behaviour of young people in these other domains.
- **Many sexuality and family life education courses are not explicitly directed at the goal of preventing teenage pregnancy**. While most school districts agree that a major goal of sex education is to promote rational and informed decision making about sexuality and to increase students' knowledge of reproduction, only a fraction of the programmes (25% or less a decade ago) explicitly state that a goal is to reduce sexual activity or pregnancy rates.
- **Many courses are superficial and avoid confronting the crucial material directly**. Although abstinence pro- grams presumably are less objectionable than those that emphasize family planning and contraception, fear of public repercussions from teaching explicit material often reduces such courses to teaching sexual anatomy and reproduction without dealing directly with values, controlling one's behaviour, heterosexual relations, dealing with aggressive partners, etc.

Self-components Training and Sexual Abstinence

From her qualitative study, Plummer (2012) found that self-efficacy intervention significantly made impact among young people. Defined as the confidence a person feels about performing a behaviour, perceived self-efficacy can be considered an emotional construct. Perceived self-efficacy to implement a recommended response is recognised in many behaviour change models to be a strong determinant of behaviour. The key models used to explain health-related behaviours – the Health Belief Model (Becker, 1974; Montgomery, Joseph, Becker, Ostrow, Kessler & Kirscht, 1989; Rosenstock, Strecher & Becker, 1994), the Theory of Planned

Behaviour (Ajzen, 1991; Armitage & Conner, 2001) the Social Cognitive Theory (Bandura, 1977; 1982; 1991) and the Extended Parallel Process Model (Witte, 1992; 1998; Roberto, Meyer, Johnson & Atkin, 2000) include self-efficacy as a key determinant of behaviour.

Empirical evidence also abounds in support of the predictive capacity of this construct with respect to the practice of health behaviour (for example Bandura, 1995; 1999; Schwarzer and Fuchs, 1996; Carvajal, Parcel, Basen-Enquist, Banspach, Coyle & Kirby, 1999). Babalola, Awasum and Quenum-Renaud (2002) found that perceived self-efficacy had significant effects on abstinence among boys. Eleven reports examined the empirical relationship between self-efficacy and sexual behaviour. Seven studies found protective effects of self-efficacy to negotiate safer sex (Sionéan, DiClemente & Wingood, 2002), resist peer pressure to have sex (DiIorio, Dudley & Kelly, 2001), delay initiation of sexual intercourse (Santelli, Kaiser & Hirsch, 2004), avoid sexual activity or risky sexual behaviour (Robinson, Price, Thompson & Schmalzried, 1998; Robinson, Telljohann & Price, 1999; Faryna & Morales, 2000), and to remain abstinent (Collazo, 2004). However, five reports revealed no effects of self-efficacy or perceived behavioural control on various sexual behaviour/intention outcomes such as sexual intercourse intention, engaging in risky sexual behaviour, ever having had sex, or refusing unwanted sex (Carvajal et al, 1999; Bachanas, Morris & Lewis-Gess, 2002; Sionéan, DiClemente & Wingood, 2002; DiIorio, Dudley, Soet & McCarty, 2004; Villarruel, Jemmott, Jemmott & Ronis, 2004).

As safe sex behaviour requires (individual) planning and forethought, socio-cognitive theories like the Theory of Planned Behaviour (TPB) (Ajzen, 1991; Ajzen, 2002), and, more recently, its successor the Reasoned Action Approach (RAA) (Fishbein & Ajzen, 2010), are often used to design interventions that promote safe sex behaviour. According to the RAA, the most important determinant of planned behaviour is the intention to perform the behaviour. This is supported by a meta-analysis of 47 experimental tests of intention-behaviour relations which showed that a medium to large sized change in intention leads to a small to medium sized change in behaviour (Webb & Sheeran, 2006). Behavioural intention, in turn, is the result of a combination of attitudes towards the behaviour, the perceived norm (e.g. descriptive and injunctive norms, social encouragement, pressure) and self-efficacy (Fishbein, 1998; Ajzen, 2002; Fishbein & Ajzen, 2010). Attitude is defined as a person's disposition to respond favourably or unfavourably towards certain behaviour. The perceived norm is a function of

beliefs that specific, important individuals or groups (e.g. friends, parents, one's girlfriend, one's husband) approve or disapprove of a certain behaviour as well as beliefs that these referents themselves perform or do not perform that specific behaviour. Self-efficacy, also termed perceived behavioural control, refers to "the extent to which people believe that they are capable of, or have control over, performing a given behaviour" (Fishbein & Ajzen, 2010).

The RAA has been supported by research, mainly conducted in the USA and Western Europe, on the adoption of many health-related behaviours (Godin & Kok, 1996; Armitage & Conner, 2001), including condom use (Bennet & Bozionelos, 2000; Aaro, Flisher, Kaaya, Onya, Fuglesang, Klepp & Schaalma, 2006; Gredig, Nideroest & Parpan-Blaser, 2006) and sexual intercourse delay (Ajzen, 1991; Carvajal, Parcel & Basen-Engquist, 1999). Although unsafe sexual behaviour is an important health risk among Sub-Saharan African adolescents (Kaaya, Flisher, Mbwambo, Schaalma, Aaro & Klepp, 2002), there have only been a few recent studies on the socio-cognitive determinants of (the intention of) delaying sexual intercourse and (the intention of) condom use in an African setting that meet international criteria concerning sample size and the use of multivariate statistical methods, according to Rijsdijk, Bos, Lie, Ruiter, Leerlooijer and Kok (2012).

Nonetheless, despite the paucity of research, the studies that have been conducted appear to support RAA; notably on correlates and determinants of condom use (Giles, Liddell & Bydawell, 2005; Bryan, Kagee & Broaddus, 2006; Heeren, Jemmott, Mandeya & Tyler, 2007; Schaalma, Aaro, Flisher, Mathews, Kaaya, Onya, Ragnarson & Klepp, 2009); on both primary abstinence and condom use (Babalola, Awasum & Quenum-Renaud, 2002) and on sexual activity and condom use intentions (Taffa, Klepp, Sundby & Bjune, 2002). To the best of the knowledge of Tumwesigye, Ingham and Holmes (2008), there is only one study on secondary abstinence and its determinants. Perceived self-efficacy to refuse sex with someone known for more than three months is the only self-efficacy variable that has significant effects on abstinence among boys found Babalola, Awasum and Quenum-Renaud (2002).

From her qualitative study, Plummer (2012) found that self-efficacy intervention significantly had impact on adolescent who had never had sex (the virgins). She noted that the abstinence and sexual refusal skills may have reinforced their sense of control and helped delay sexual debut more than the sexually active adolescents, who rarely believed they had sufficient

self-control and efficacy to become abstinent again. Only few girls were found to perceive abstinence as a feasible option once had sex, while in the case of boys, they could go through abstinent period for weeks and months until they again had opportunity to have sex.

With regard to confidence to abstain, abstaining girls were much more confident to abstain from sex, when in love, when pressured by their partner, when drunk and when they had known their partner for 6 months than abstaining boys. Non-abstaining girls reported higher self-efficacy levels than boys, but not when pressured by their partners. With regard to their intentions both for the abstaining and the non-abstaining group, a similar pattern was found showing that girls held stronger intentions to abstain than boys (Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo & Jinabhai, 2009).

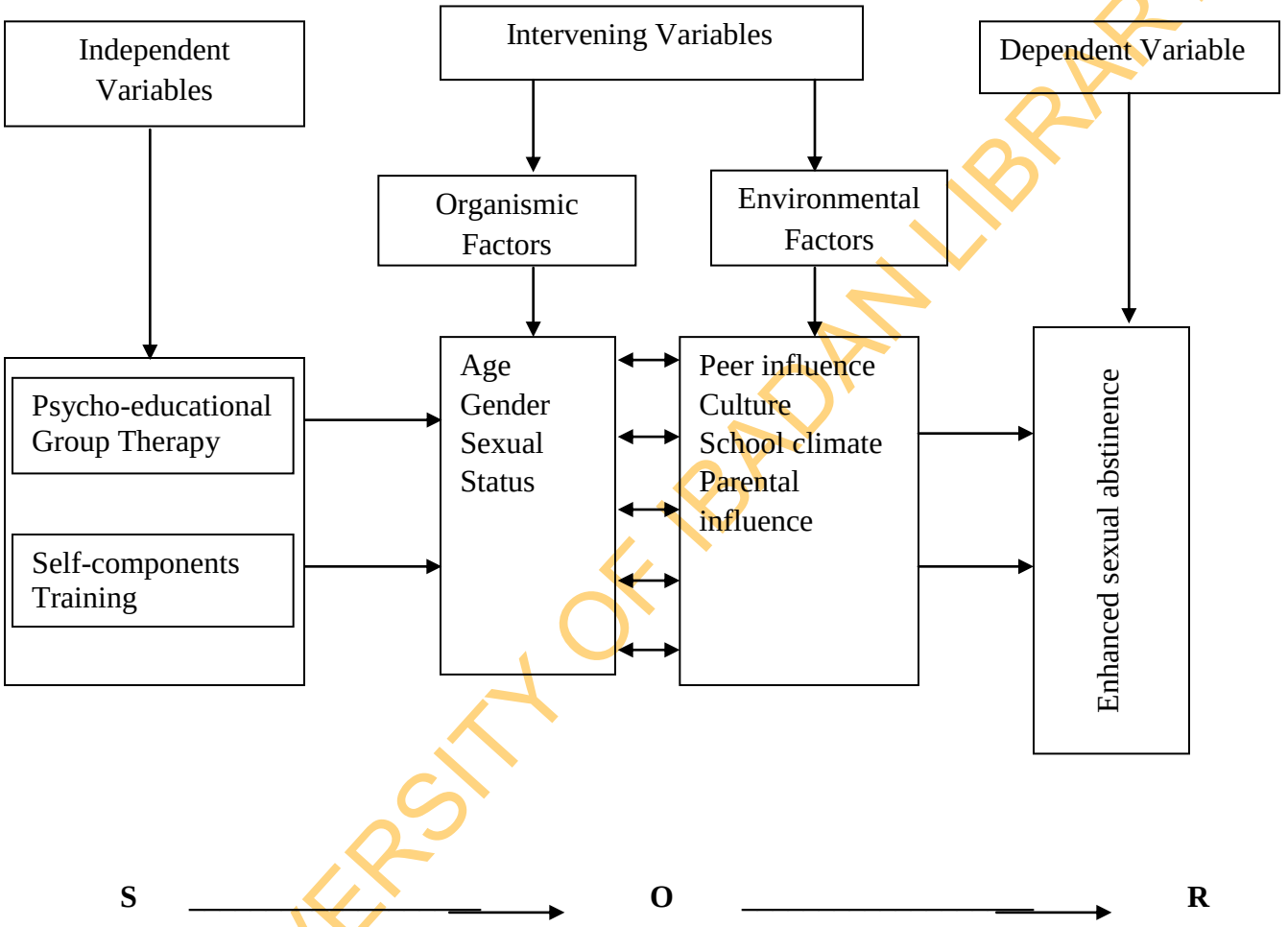
Self-esteem, a commonly used construct within psychology and in popular language, is included in the models predicting primary sexual abstinence and condom use. Rosenberg (1965) described self-esteem as a self-reflective attitude indicating the extent to which an individual likes or approves of himself. Evidence relating self-esteem to specific health behaviours abounds in public health and demographic literature although the findings have not been consistent. A number of studies have found that low self-esteem is associated with high-risk sexual and social behaviours (Young, 1989; Kissman, 1990; Smith & Pike, 1993; Morris, Young & Jones, 2000). On the other hand, a few studies have documented a negative relationship between self-esteem and health behaviours. For example, Cole and Slocumb (1995) and Abood and Conway (1992) found that youth with high self-esteem were more likely to practise risky sexual behaviours.

Evidence relating self-esteem to specific health behaviours abounds in public health and demographic literature although the findings have not been consistent. Morris, Young and Jones (2000) found that low self-esteem is associated with high-risk sexual and social behaviours. On the other hand, Abood and Conway in Babalola, Awasum and Quenum-Renaud (2002) found that youth with high self-esteem were more likely to practise risky sexual behaviours. Babalola, Awasum and Quenum-Renaud (2002) reported that a negative relationship between self-esteem and abstinence among their male participants.

Improving self-esteem has been shown to be an important way to improve reproductive health outcomes for adolescent in sub-Saharan Africa. For example, a successful health education programme in Namibia used a curriculum based on social cognitive theory to increase

young women's self-esteem and associated perceived control of their sexual relationships. These changes resulted in increased condom use and a delay in the timing of first intercourse (Stanton, Li, Black & Ricardo, 1996). Goal-setting (intention), self-efficacy, self-standard, and self-esteem are crucial to practising sexual abstinence (Buhi, Goodson, Neilands & Blunt, 2011).

Conceptual Model for the Study



S = Stimulus---------- **O** = Organismic Factor---------- **R** = Responses

(Independent variable) (Dependent variable)

Figure 2.2: Conceptual Model

From the model, psycho-educational group therapy and self-components training are the independent variables, which were the two treatment packages used in the study. These independent variables were manipulated by the researcher in order to examine their effects on the dependent variable, which is sexual abstinence. The intervening variables were of two kinds – the primary and the secondary intervening variables. The primary intervening variables are the organismic factors that were associated internally with the individual participants in the study. These included the particpants' age, gender and sexual status. The secondary intervening variables are environmental, external factors that included peer influence, culture, school climate and parental influence. The manipulation of the independent variables and the interactions with the intervening variables were expectant to produce a resultant effect which is enhanced sexual abstinence of participants. The behavioural equation S-O-R represents the total interaction of various variables in the study.

Hypotheses

In this study, the following non-directional null hypotheses were tested at 0.05 level of significance:

1. There is no significant main effect of treatment on sexual abstinence of participants.
2. There is no significant main effect of gender on sexual abstinence of participants.
3. There is no significant main effect of peer influence on sexual abstinence of participants.
4. There is no significant interaction effect of treatment and gender on sexual abstinence of participants.
5. There is no significant interaction effect of treatment and peer influence on sexual abstinence of participants.
6. There is no significant interaction effect of gender and peer influence on sexual abstinence of participants.
7. There is no significant three-way interaction effect of treatment, gender and peer influence on sexual abstinence of participants.

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology of the study and it covers the following areas: the research design; the description of the population, sample and the sampling techniques used in the study; the measures or instruments (including summaries of their psychometric data) administered to the participants together with the procedure for administration; and the methods used to analyse the collected data.

Research Design

The study employed a partial mixed research design with both qualitative and quantitative components. The qualitative component adopted a Focus Group Discussion (FGD) approach with average of ten in-school adolescents. Ten groups (comprising three groups of sexually experienced adolescents and seven groups of sexually inexperienced adolescents) were used. The quantitative component adopted the pre-test, post-test, control group experimental design with a 3x2x2 factorial matrix. The participants of the study were divided into three groups: two treatment groups (Psycho-education Group Therapy - A_1 and Self-components Training - A_2) and one control group - A_3. The two experimental groups and the control group made up the three rows; i.e., A_1, A_2, and A_3, while the Male and Female (gender) constituted into columns B_1 and B_2 respectively. The other moderating variable, peer influence (Positive and Negative) respectively constituted columns C_1 and C_2. The first and second groups were pre-tested and subjected to the therapeutic treatments (Psycho-education Group Therapy and Self-components Training). The control group was equally pre-tested. They were all post-tested by the end of the experimental sessions held with the two experimental groups.

In essence, the row consisting of the two interventions (Psycho-education Group Therapy and Self-components Training) and the control were crossed with the columns of gender and peer influence; each varied at two levels. This is represented in the matrix table 3.1

Table 3.1: A 3x2x2 Matrix for the Treatments to Enhance Sexual Abstinence among In-school Adolescents.

Treatment	Gender				Group Total
	Male (B_1)		Female (B_2)		
	Peer Influence				
	Positive (C_1)	Negative (C_2)	Positive (C_1)	Negative (C_2)	
A_1	$A_1B_1C_1 = 9$	$A_1B_1C_2 = 2$	$A_1B_2C_1 = 16$	$A_1B_2C_2 = 3$	30
A_2	$A_2B_1C_1 = 6$	$A_2B_1C_2 = 3$	$A_2B_2C_1 = 12$	$A_2B_2C_2 = 7$	28
A_3	$A_3B_1C_1 = 13$	$A_3B_1C_2 = 1$	$A_3B_2C_1 = 20$	$A_3B_2C_2 = 0$	34
Total	28	6	48	10	N= 92

Key: A_1 = Psycho-education Group Therapy A_2 = Self-components Training

A_3 = Control Group B_1 = Male B_2 = Female

C_1 = Positive C_2 = Negative

N = the sum total of all the values in each cell i.e. row wise and column wise

Population of the Study

The population for the study comprised the in-school adolescents who are in public co-educational secondary schools in Ondo State, Nigeria. Ondo State is one of the 36 states in Nigeria. It is in the South Western part of the country. Ondo State has three Senatorial districts with 18 local governments. The State, as at the period of the field work, has 300 public secondary schools, out of which 288 are co-educational (mixed) schools.

Sample and Sampling Technique

Multi-stage sampling technique was deployed in selecting the sample. Out of the three senatorial districts, the North Senatorial district (comprising of 6 local government areas) was randomly chosen for this study through ballot papers. Three local governments (Akure North, Akure South and Owo local government Areas) were further randomly chosen from the senatorial district. There were 31 public co-educational secondary schools in the Metropolises (urban-centred), out of which 3 schools were randomly chosen for the study through ballot papers. Junior Secondary (JS) 2 classes were purposively chosen for the study. The randomly selected schools had JS2 classes ranging from five to twelve arms. Hence, proportionate

stratified random sampling technique to eliminate gender bias and other demographic factors that could inadvertently moderate the study. The stratified random sampling technique allows for increase in precision of the estimate of population characteristics. It also allows for each sub-population to be treated as a population in its own right.

Fifty in-school adolescents were randomly chosen (from JS2 classes) from each of the three schools and then screened for sexual status (had sex/sexually experienced/non-virgin/non abstainers or not have had sex/sexually inexperienced /virgin/abstainers) using the Sexual Abstinence Test for Adolescents (SATA). Out of the 150 sampled, 29 (representing 19%) declared to have had sex at a mean of 10.1 years. Twenty-three were inconsistent in responding to the questionnaires provided. They were, therefore, not assigned to groups. Ninety-eight participants were then randomly selected into the experimental and control groups from the three public co-educational secondary schools. Ninety-two participants (94% out of the total assigned to groups) consistently commenced and completed the eight-week intervention programmes for the quantitative part of the study.

The qualitative component of the study made use of both the 29 sexually active in-school adolescents and the 92 sexually inactive in-school adolescents to make up the 121 samples. The 29 sexually active in-school adolescents were purposively used for the three FGD segments of those who had initiated sex (sexually experienced). The other seven FGD purposively comprised the ninety-two sexually inexperienced in-school adolescents.

The 121 participants from JS 2 classes had their ages ranging from 10 to 15 years with a mean age of 12.9 years and a standard deviation of 1.145 (12.9 years ± 1.145). The participants comprising 44 males and 77 females had 29 of them sexually experienced (that is 24% of the participants used: 10 males and 19 females sexually experienced adolescents) and 92 sexually inexperienced (34 males and 58 females sexually inexperienced adolescents).

Justification, Inclusion and Exclusion Criteria

Sexually experienced teenagers are a matter of serious concern. In the past decades, many school-based programmes have been designed for the sole purpose of delaying the initiation of sexual activity (Leger, 1999). There seems to be a growing consensus that schools can play an important role in providing youth with a knowledge base which may allow them to make informed decisions and help them shape a healthy lifestyle. The school is one of the major

institutions in regular contact with a sizable proportion of the teenage population, with virtually all youth attending it before they initiate sexual risk-taking behaviour. Hence, in-school adolescents were used for the study.

Only adolescents who were enrolled in public co-educational urban schools sampled from Akure North, Akure South and Owo local government Areas were included in the study. This was to have homogenous sample to prevent extraneous variable that may account for the sexual behaviours of adolescents in private, rural or single sex schools.

The sample was restricted to adolescents in JS2 classes. The study, as it aims to enhace and promote sexual abstinence among the in-school adolescents, is better done among the early adolescents. The age range of adolescents considered is densely populated in JS1 to JS3 classes. At this stage, the rate of the growth spurt of adolescents at this stage calls for attention. The JS1 and JS3 classes were, however, excluded. Adolescents in JS1 were excluded to avoid arousing their curiosity about sex, since they are just settling down from primary schools; while those in JS3 were preoccupied with their terminal certificate examinations.

Also, only in-school adolescents that had not initiated sex (virgins or sexually inexperienced) were used for the quantitative component of the study, while both categories (had sex/sexually experienced/non-virgin/non abstainers and not have had sex/sexually inexperienced /virgin/abstainers) were used for the qualitative study. There was screening of participants to separate the sexually inexperienced adolescents from their sexually experienced counterparts. This was made possible by randomly selecting more than required for the pre-test in relations to literature about the trend of sexual debut among adolescents. The reason for including the sexually active in-school adolescents in the study was to compare their consequential experiences at first sex with the consequences of first sex as perceived by the sexually inexperienced counterparts. This was to enable the researcher come up with remediating and persuasive campaign approach for abstinence.

The participants were gender-mixed for the qualitative component (Focus Group Discussions) of the study. Gender, however, was not proportionately balanced in the emerged result for sexual status when stratified by sampled schools. Thus, sexually experienced participants were purposively assigned to same group for discussion in their respective selected schools. Participants who were not willing to participate nor forth coming after being assigned

group were excluded from the study. Also, adolescents whose parents did not give their consent to the study were also excluded (a case of decline by a parent was reported).

Research Instruments

The data collected for this study made use of three instruments: Sexual Abstinence Scale (SAS) by Asuzu (2013) to measure the dependent variable (sexual abstinence); the Peer Pressure Inventory (PPI) by Brown and Clasen (1985) to measure one of the moderating variables, peer influence; and the Sexual Abstinence Test for Adolescents (SATA), self-developed by the researcher, to screen participants for sexual status. An FGD guide emerged from the afore-mentioned three research instruments to elicit qualitative responses from the participants.

Description of Instruments

- **Sexual Abstinence Scale (SAS)**

The Sexual Abstinence Scale (SAS) was designed by Asuzu (2013) to assess healthy sexual behaviour among adolescents as a way to reduce the incidence of HIV and other sexually transmitted infections. This scale was recently developed through a cross sectional study which took place in two phases. The first phase comprised of 1030 adolescents randomly selected from senior classes in secondary schools in three out of five local government areas within Ibadan municipality. The second phase had 250 participants also randomly selected from senior secondary classes. Items generated for the scale were obtained from an extensive literature review.

The Sexual Abstinence Scale is divided into two sections. The first section consists of items on respondents' socio-demographic variables like gender, age, parents' occupation, etc. The second section consists of six sub scales: knowledge of sexual abstinence, perceived risk of sexual abstinence, attitude towards sexual abstinence, perceived benefits of sexual abstinence, sexual abstinence self-efficacy, and sexual abstinence education. The content validity of the instrument was confirmed through peer reviews of experts in the field of adolescent sexuality. The internal consistencies for the six sub-scales were .8430 for knowledge of sexual abstinence sub-scale, .8170 for perceived risk of sexual abstinence sub-scale, .6310 for attitude towards sexual abstinence sub-scale, .9380 for perceived benefits of sexual abstinence sub-scale,.7910 for

sexual abstinence self-efficacy sub-scale, .8030 sexual abstinence education sub-scale and .8860 for the full scale.

Peer Pressure Inventory (PPI)

The Peer Pressure Inventory (PPI) is a well-validated measure of peer pressure developed and validated by Brown and Clasen (1985). The PPI was designed to assess the perception of peer pressure in a number of domains, including peer social activities, misconduct, conformity to peer norms etc. It originally contained 53 paired statements which were adapted to suit this study. Responses are made on a 4-point scale (+3 to -3 with 0 as the mid point between each paired statement). It has a Cronbach's alpha ranged from 0.69 to 0.91 for all measures. The inventory was recently used by Hammed, Odedare and Okoiye (2013) to measure peer influence in their study.

Sexual Abstinence Test for Adolescents (SATA)

The Sexual Abstinence Test for Adolescents (SATA) was self-designed by the researcher. The supervisors assisted in the content and face validity. A test-retest measure was carried out on some selected sample of adolescents (40 in-school adolescents) which yielded a reliability coefficient (alpha value) of 0.77. The instrument is divided into two parts. Part I seeks demographic attributes of the in-school adolescents. Part II seeks the sexual status of the in-school adolescents. Here, the sexual status of the participants was determined through questions which asked if the adolescents had ever had sex; age at first sex and if the respondents protected themselves at first sex or not. For the latter two questions, the first response option allowed them to say they had never had sex. This triangulation increased the accuracy of the sexual intercourse measure.

Focus Group Discussion Guide

The focus group discussion guide, which emerged from the reviewed literature and research instruments, was put together by the researcher. The FGD guide captured issues relating to abstinence (which formed the basis for thematic consideration for analysis) in the following perspectives: adolescents' perception about abstinence and virginity; knowledge about abstinence; advantages of practising sexual abstinence; self-efficacy to abstain; alternatives to

sex; experiences of first sex; peer pressure involvement; societal support for abstinence, and misconceptions about abstinence.

Procedure for Research

The study was carried out in four phases: pre-sessional activities (screening/recruitment stage), pre-test, treatment and post-test (post treatment stage). At the pre-session, activities included the screening, recruitment and assignment of participants to focus groups for discussion and the two experimental and control groups. Sequel to the letter of introduction received from the Department of Counselling and Human Development Studies, University of Ibadan, permission was obtained from the Ondo State Ministry of Education and principals of each of the schools selected for the study, and arrangement was made for appropriate places where the treatments were administered. The researcher sought approval for one day in a week (at least one hour each day) from the selected schools when therapeutic sessions could hold for the period of eight weeks for each of two treatment groups.

Preliminary visits were made to the selected schools to familiarise self with the participants and solicit their willingness and parental consent to participate in the study. The researcher was given permission by the school principals to address all the JS2 students, from which the screened participants emerged. Six research assistants (one male and five females) were trained to support the researcher. The seemingly gender imbalance of the research assistants was due to the fact that the available school guidance and counsellors were predominantly females.

At the screening stage, the questionnaire, primarily the Sexual Abstinence Test for Adolescents scale was administered to the participants. Following the screening, participants were assigned to focus groups and the groups for quantitative study. The researcher in this process was extra careful not to allow the participants to know the basis for the grouping in respect of sexual status to avoid stigmatization among themselves. Even those that were not formally assigned to any group for the purpose of research were still organised into two different sessions of contacts before they were dismissed. Those informal groups across the three sampled schools were given general talk. This was done to allay their curiosity about the participants eventually used, and to avoid stigmatization of the selected sample for either being promiscuous or sexually naive.

The Focus Group Discussions took place in conducive atmosphere where the participants could freely express their views without being prejudiced. The Focus Group Discussions featured thrice, in three successive weeks, with minimum of eight and maximum of twelve participants in a group. Each group selected a secretary to document the proceedings alongside the research assistants. The sessions were recorded and subsequently processed for qualitative analysis.

Regarding the quantitative component of the study, participants were assigned to groups and subjected to pre-test using the other two research instruments (Sexual Abstinence Scale and Peer Pressure Inventory). The first experimental group (A_1) was treated using Psycho-educational Group Therapy (PGT), the second experimental group (A_2) was subjected to Self-components Training (SCT). These groups were exposed to eight weeks training and treatment started a week after the pre-treatment measures. Participants in the two experimental groups only were exposed to eight weeks (eight sessions) of treatment (Psycho-educational Group Therapy and Self-components Training). Each session spanned for an average of 60 minutes. During this period the researcher and the participants interacted. Though the control group was not treated, the participants were given talk on goal setting towards academic excellence. The post-test was administered following the conclusion of the programmes.

Considering the attention span of the participants, the researcher deployed several stimulating and attractive packages to arouse and sustain their interest. Teaching aids were adopted for use. Gifts were intermittently given to attentive, cooperating and responsive participants. Light refreshment was also made available for the participants.

Summary of the Sessions of Focus Group Discussions

Session I: General Orientation about Sexual Abstinence

Session II: Advantages of Practising Sexual Abstinence

Session III: Sexual Abstinence and Challenges

Summary of the Treatment Packages

Experimental group A_1 - Psycho-educational Group Therapy (PGT)

The Psycho-educational Group Therapy is a humanistic approach to changing the behaviour patterns, values, interpretation of events, and life outlook of individuals who are not adjusting well to their environment(s) (e.g. home, school, workplace, and in this case sexual stimuli). Inappropriate behaviour is viewed as a person's maladaptive attempt to cope with the demands of that environment. Appropriate behaviours are developed by helping the individual to recognize the need for change, and then helping that person to display better behaviour choices. Psycho-educational interventions tend to be "packaged" plans that are implemented and modified to the needs of the adolescent to address surfaced crisis in the participants' sexual desires.

The Psycho-educational viewpoint seeks to understand the adolescent who is engaged in a struggle to adequately handle life situations. In doing so, it looks at both individual and social explanations for inappropriate, anti-social, and otherwise unacceptable sexual behaviour patterns. The eight sessions covered the following:

Summary of Sessions for Experimental Group 1

Session I: General orientation and administration of instrument to obtain pre-test scores

Session II: Relationship/Friendship

Session III: Values Clarification

Session IV: Learning to Negotiate

Session V: Assertive Communication

Session VI: Decision Making

Session VII: Behavioural Modification towards Sexual Abstinence

Session VIII: Revision of all activities in the previous sessions and administration of post-treatment measures.

The outline is as shown in the Appendix I.

Experimental group A_2 – Self-components Training (SCT)

Self-components Training attempts to address issues relating to adolescents' ability to understand self and hence strengthen their coping skills for sexual abstinence. The eight sessions covered the following:

Summary of Sessions for Experimental Group 2

Session I: General orientation and administration of instrument to obtain pre-test scores

Session II: Understanding Your Self; The Human Sexuality

Session III: Sexual Self-concept

Session IV: Sexual Self-esteem

Session V: Sexual Self-efficacy

Session VI: Sexual Self-determination

Session VII: Behavioural Modification towards Sexual Abstinence

Session VIII: Revision of all activities in the previous session and administration of post-treatment measures.

The Control Group

The control group (A_3) contained the participants selected for the training but this group was not treated for the eight weeks, but subjected to a non-therapeutic talk titled, "goal setting towards academic excellence".

Control of Extraneous Variables: This study was experimental in nature and involved the manipulation of independent variables by the researcher to determine their effect on the participants. The researcher was observant to control extraneous variables within and outside participants, environment, methodology and researcher. This was controlled with the use of experimental design, 3x2x2 factorial matrix which may prevent the possible variations that could occur within the participants. Randomisation (choice and assignment of participants to treatment and control groups without any bias) was conducted for effective control.

Data Analysis

The dependent variable is sexual abstinence on which pre-test scores were obtained. The independent variables are the treatments (Psycho-education Group Therapy and Self-components Training), while the moderating variables are gender and peer influence. The pre-test data for the three groups (Psycho-education Therapy group, Self-components Training group and the control group) were analyzed using mean and standard deviation to help establish the similarities and prove that the groups are similar in their level of sexual abstinence behaviours before the commencement of treatments while analysis of co-variance (ANCOVA) statistical technique was used to test all the seven null hypotheses raised to determine the effect of treatments on the experimental groups. The Scheffe Post-hoc analysis was also used in this study to determine the directions of differences and significance identified.

The qualitative data generated followed the statutory method of analysing focus group discussions, which included: recording, transcribing, labelling, thematic categorising and synthesizing. Responses to the FGD sessions were content-analysed.

CHAPTER FOUR
RESULTS

This chapter focuses on the presentation and highlights of results from quantitative and qualitative findings and statistical analysis. The statistical test of significance for each of the seven hypotheses tested, discussed and the statements of rejection or acceptance were made, followed by their interpretations.

Table 4.1: Descriptive Summary of Categorised Quantitative Data Used

Description		N	Total
Treatment	Psycho-educational Group Therapy	30	**92**
	Self-components Training	28	
	Control Group	34	
Gender	Female	58	**92**
	Male	34	
Peer Influence	Negative	16	**92**
	Positive	76	

Table 4.1 shows the summary of categorised data used for the quantitative component of the study. A total of 92 participants were used for the study. They were randomly assigned to the three groups (two of which were experimental and the third one, a control group). The three groups involved were: Psycho-educational Group Therapy, Self-components Training, and Control Group to which 30, 28 and 34 participants were respectively assigned. 58 of them were female while 34 were male, out of which 76 experience positive influence from peers while 16 participants reported negative influence from their peers.

Table 4.2: Descriptive Statistical Result of the 3x2x2 Factorial Matrix

Treatment	Gender	Peer Influence	Mean	Std. Deviation	N
Psycho-educational Group Therapy	Female	Negative	150.67	16.65	3
		Positive	158.88	15.71	16
		Total	157.59	15.68	19
	Male	Negative	189.00	2.83	2
		Positive	161.56	26.71	9
		Total	166.54	26.36	11
	Total	Negative	166.00	24.11	5
		Positive	159.84	19.84	25
		Total	160.87	20.29	**30**
Self-components Training	Female	Negative	148.14	6.84	7
		Positive	155.50	13.51	12
		Total	152.79	11.85	19
	Male	Negative	129.33	2.52	3
		Positive	147.83	21.41	6
		Total	141.67	19.33	9
	Total	Negative	142.50	10.73	10
		Positive	152.94	16.34	18
		Total	149.21	15.24	**28**
Control Group	Female	Negative	-	-	0
		Positive	125.55	30.91	20
		Total	125.55	30.91	20
	Male	Negative	190.00	.	1
		Positive	128.85	23.40	13
		Total	133.21	27.77	14
	Total	Negative	190.00	.	1
		Positive	126.85	27.84	33
		Total	128.79	29.47	**34**
Total	Female	Negative	148.90	9.71	10
		Positive	144.15	27.60	48
		Total	144.97	25.42	**58**
	Male	Negative	159.33	32.93	6
		Positive	143.43	27.48	28
		Total	146.24	28.64	**34**
	Total	Negative	152.81	21.10	16
		Positive	143.88	27.37	76
		Total	145.43	26.51	**92**

Going by the factorial matrix (Table 3.1) in Chapter Three, Table 4.2 reveals the emerged breakdown data from the field study. For instance, the $A_1B_1C_1$ = 9 participants as shown on Table 3.1 represents the subset or sub-division of sampled in-school adolescents who were assigned to Psycho-educational Therapy group (A_1), mainly male by gender (B_1) with positive peer influence (C_1) totalling 9 participants are displayed on Table 4.2 to have mean score of 166.56 (with standard deviation of 26.71) resulting from the treatment. Table 4.2 simplifies it for readers, at a glance, to be able to compare the outcome performance of each cell or sub-division of the sample in the factorial matrix.

Thus, the summary of the categorised data can be obtained from Table 4.2. The 30, 28 and 34 participants assigned to groups can be conspicuously seen on the table. The 58 females and 34 males sampled; and the number (76) who experienced positive influence from peers and 16 participants who reported negative influence from their peers can be obtained from the table. Specifically, Table 4.2 shows the mean scores for Psycho-educational Group Therapy, Self-components Training, and Control Group respectively as 160.87, 149.21 and 128.71; male and female respectively as 146.22 and 144.97; and positive peer influence and negative peer influence as 143.88 and 152.81 respectively. In other words, from the table the level of treatment influence can be ascertained on each sub group.

Table 4.3: Descriptive Statistics of Pretest Posttest * Treatment

Treatment		Pretest	Posttest
Psycho-educational Group Therapy	Mean	117.87	160.87
	N	30	30
	Std. Deviation	24.18	20.29
Self-components Training	Mean	127.46	149.21
	N	28	28
	Std. Deviation	16.31	15.24
Control Group	Mean	127.56	128.71
	N	34	34
	Std. Deviation	29.99	29.48
Total	Maximum	190.00	191.00
	Minimum	69.00	76.00
	Range	121	115
	Mean	124.37	145.43
	N	92	92
	Std. Deviation	24.74	26.51

Table 4.3 displays the descriptive statistical values of the pre and post treatment tests of the participants. Displayed on the table, for example: 30 participants were assigned to the Psycho-educational Group Therapeutic treatment. Their mean score significantly improved from 117.87 (pretest) to 160.87 (posttest). A decrease in the standard deviation from 24.18 (pretest) to 20.29 (posttest) implies a considerable effectiveness of the therapy, resulting from the individual scores not widely scattered from the mean. The table revealed that Psycho-educational Group Therapy impacted more on the participants than Self-components Training.

Remarkably, on the overall, the treatments had a contributory effect of mean increase from the pretest (124.40) to the posttest (145.43) on sexual abstinence. A maximum pretest score (190) compared to the maximum posttest score (191) is of importance. The pretest score, (190) was obtained from a participant in the control group. This score, however, influenced the range value of the control group and the overall range (121). This is further explained by the high value of control group's standard deviation (29.99), as reflected on Table 4.3. A slight increase in the control group's standard deviation for the posttest (29.48) portrays the effectiveness of treatments when compared with the control group.

Table 4.4: Hypothesis 1: There is no significant main effect of treatment on sexual abstinence of participants.

Source	Type III Sum of Squares	Df	Mean Square	F	Partial Eta Squared	Sig.
Corrected Model	60744.62[a]	11	5522.24	138.58	.953	.000
Intercept	3496.45	1	3496.45	87.74	.550	.000
Pretest	36086.65	1	36086.65	905.57	.926	.000
Main Effect						
Treatment	7703.48	2	3851.74	96.66	.710	.000
Gender	12.64	1	12.64	.32	.004	.575
Peer Influence	50.23	1	50.23	1.26	.017	.265
2-way Interactions						
Treatment * Gender	52.63	2	26.32	.66	.017	.519
Treatment * Peer Influence	49.39	2	24.69	.62	.017	.541
Gender* Peer Influence	.44	1	.44	.01	.000	.917
3-way Interactions						
Treatment * Gender * Peer Influence	3.12	1	3.12	.08	.001	.780
Error	3187.99	80	39.85			
Total	2009850.00	92				
Corrected Total	63932.61	91				

a. R squared = .950 (Adjusted R squared = .943)

Table 4.4 reveals that there is a significant main effect of treatments on sexual abstinence of in-school adolescents ($F_{(2,89)}$ = 96.66, P<.005, η^2 = .710). This implies that there is a significant difference between the groups test scores on sexual abstinence. The table also shows that the differences between the groups had large effect on their sexual abstinence test score. That is, the groups' differences account for 71.0% (Partial Eta Squared =.710) in the variation of their sexual abstinence test score. Hence the null hypothesis was rejected. To further understand where the differences lie the pairs-wise comparison of the adjusted Y-means was computed and the result is as shown in table 4.4.

Table 4.5: Scheffe Post-Hoc Pairwise Significant Differences among Various Treatment Groups

(I) Treatment	(J) Treatment	Mean Difference (I-J)	Std. Error	Sig.
Psycho-educational Group Therapy	Control Group	40.12*	2.85	.000
	Self-Components Training	22.17*	2.08	.000
Self-components Training	Control Group	17.94*	2.70	.000
	Psycho-educational Group Therapy	-22.17*	2.08	.000
Control Group	Psycho-educational Group Therapy	-40.11*	2.85	.000
	Self-components Training	-17.94*	2.70	.000

From the pairwise comparison of the adjusted Y-means of the main effect of treatment on Sexual Abstinence scores, Table 4.5 shows that after controlling for the effect of pre-sexual abstinence behaviour of the in-school adolescents, experimental group 1 (Psycho-educational Group Therapy; mean = 167.91) displayed higher sexual abstinence than experimental group 2 (Self-components Training; mean = 145.74) and control group 3 (mean = 127.79). This implies that Psycho-educational Group Therapy (mean difference = 40.12) had enhanced sexual abstinence better than Self-components Training (mean difference = 17.94). The coefficient of determination (Adjusted R Squared = .943) overall implies that the differences between the groups account for 94.3% in the variation of in-school adolescents' sexual abstinence.

Hypothesis 2: There is no significant main effect of gender on sexual abstinence of participants.

Table 4.4 indicates that there is no significant main effect of gender on sexual abstinence of in-school adolescents ($F_{(1,90)}$ = .317, P>.005, η^2 = .004). This implies that there is no significant difference between the test scores of male and female in-school adolescents on sexual abstinence. The table also shows that the differences between the groups had little or no effect on their sexual abstinence test score. That is, the groups' differences account for 0.4% (Partial Eta Squared = .004) in the variation of their sexual abstinence test scores. Hence the null hypothesis was accepted. To further understand the acceptance of the null hypothesis, the descriptive statistics of posttest pretest interaction with gender in Table 4.6 shows the insignificant difference.

Table 4.6: Descriptive Statistics of Pretest Posttest * Gender

Gender		Pretest	Posttest
Female	Mean	123.12	144.97
	N	58	58
	Std. Deviation	22.60	25.42
Male	Mean	126.50	146.24
	N	34	34
	Std. Deviation	28.25	28.64
Total	Mean	124.37	145.43
	N	92	92
	Std. Deviation	24.74	26.51
	Eta Squared	.004	.001

Table 4.6 reveals the posttest mean values for male and female as 146.24 and 144.97 respectively. The pretest and posttest Partial Eta Squared values (0.004 and 0.001) showed a contributory effect of less than one percent in the sexual abstinence behaviour of the participants, though the mean score of male is slightly higher than that of female. This implied that gender was not significant to influence sexual abstinence behaviour of the in-school adolescents. This explained the acceptance of the null hypothesis that there will be no significant main effect of gender on sexual abstinence of participants.

Hypotheses 3: There is no significant main effect of peer influence on sexual abstinence of participants.

Table 4.4 shows that there is no significant main effect of peer influence on sexual abstinence of in-school adolescents ($F_{(1,90)}$ = 1.26, P>.005, η^2 = .017). This implies that there is no significant difference between the test scores of positively and negatively influenced in-school adolescents on sexual abstinence. The table equally shows that the differences between the groups had little effect on their sexual abstinence test scores. That is, the groups' differences account for 1.7% (Partial Eta Squared = .017) in the variation of their sexual abstinence test scores. This denotes an insignificant main effect of peer influence on sexual abstinence since the table shows a contributing effect size of 1.7% in spite the slightly sharp difference, as displayed on Table 4.2, between the mean scores of negatively peer influenced adolescents (152.81) and the positively influenced participants (143.88). The null hypothesis was therefore accepted.

Hypothesis 4: There is no significant interaction effect of treatment and gender on sexual abstinence of participants.

Table 4.1 signifies that there is no significant interaction effect of treatment and gender on sexual abstinence of in-school adolescents ($F_{(2,89)}$ = .66, P>.005, η^2 = .017). This means that gender did not significantly moderate the effect of treatments on sexual abstinence of the in-school adolescents. The table also shows that the differences between the groups account for just 1.7% (Partial Eta Squared = .017) in the variation of the sexual abstinence test scores. Hence the null hypothesis was accepted.

Hypothesis 5: There is no significant interaction effect of treatment and peer influence on sexual abstinence of participants.

Table 4.1 denotes that there is no significant interaction effect of treatment and peer influence on sexual abstinence of in-school adolescents ($F_{(2,89)}$ = .62, P>.005, η^2 = .017). This means that peer influence did not significantly moderate the effect of treatments on sexual abstinence of the in-school adolescents. The table also shows that the differences between the groups account for just 1.7% (Partial Eta Squared = .017) in the variation of the sexual abstinence test scores. This implies an insignificant interactive effect of peer influence and

treatment on sexual abstinence since the table shows a contributing effect size of 1.7%. Therefore, the null hypothesis was accepted.

Hypothesis 6: There is no significant interaction effect of gender and peer influence on sexual abstinence of participants.

Table 4.1 depicts that there is no significant interaction effect of gender and peer influence on sexual abstinence of in-school adolescents ($F_{(1,90)}$ = .011, P>.005, η^2 = .000). This means that gender did not significantly moderate the effect of peer influence on sexual abstinence of the in-school adolescents. The table also shows a Partial Eta Squared of 0.000 which means that the differences between the groups had no percentage account (0%) in the variation of the sexual abstinence test scores. This symbolises an insignificant interaction effect of gender and peer influence on sexual abstinence more so the table shows a non contributing effect size of 0%. Hence, the null hypothesis was accepted.

Hypothesis 7: There is no significant three-way interaction effect of treatment, gender and peer influence on sexual abstinence of participants.

Table 4.1 signifies that there is no significant interaction effect of treatment, gender and peer influence on sexual abstinence of in-school adolescents ($F_{(1,90)}$ = .078, P>.005, η^2 = .001). This means that gender and peer influence did not significantly moderate the effect of treatments on sexual abstinence of the in-school adolescents. The table also shows that the differences between the groups account for just 1% (Partial Eta Squared = .001) in the variation of the sexual abstinence test scores. This implies an insignificant interaction effect of peer influence and treatment on sexual abstinence since the table shows a contributing effect size of 1%. Therefore, the null hypothesis was accepted.

Summary of the Findings

This study examined the effectiveness of psycho-educational group therapy and self-components training in enhancing sexual abstinence among in-school adolescents in Ondo State, Nigeria. The findings are summarised as follows:

1. There is significant main effect of treatment on sexual abstinence of in-school adolescents.
2. There is no significant main effect of gender on sexual abstinence of in-school adolescents.
3. There is no significant main effect of peer influence on sexual abstinence of in-school adolescents.
4. There is no significant interaction effect of treatment and gender on sexual abstinence of in-school adolescents.
5. There is no significant interaction effect of treatment and peer influence on sexual abstinence of in-school adolescents.
6. There is no significant interaction effect of gender and peer influence on sexual abstinence of in-school adolescents.
7. There is no significant three-way interaction effect of treatment, gender and peer influence on sexual abstinence of in-school adolescents.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter presents the discussion of results based on the seven hypotheses stated and tested in the study while juxtaposing them with the qualitative findings. This discussion entails interpreting the findings and relating them to previous empirical studies. Conclusion, implications and recommendations are made based on the findings.

Discussion

This study investigated the effects of psycho-educational group therapy and self-components training in enhancing sexual abstinence among in-school adolescents in Ondo State, Nigeria. The study embraced both qualitative and quantitative approaches. The qualitative data generated followed the statutory method of analysing focus group discussions, which included: recording, transcribing, labelling, thematic categorising and synthesizing. The filtered and analysed facts were juxtaposed with the quantitative findings of the study. The quantitative data collected were analysed using ANCOVA. The results are discussed as follows:

Preliminary and Qualitative Findings

One germane methodological finding was that gaining access to participants and bringing them together to discuss and have them fill questionnaire on sensitive sexual matters was not as difficult as primarily conceptualised. The parental consent obtained together with support of the school management (school principals and guidance counsellors) was encouraging. This outcome is in line with the view of Oladepo and Fayemi (2011) that many parents want schools to teach their youths to abstain from sexual activity until they are in a committed adult romantic relationship nearing marriage. The possible explanation to this is that parents and school authorities are willing to play into the hands of any individual or organization that can be of help to reduce the social menace of sex-related offences among their wards.

The in-school adolescents were quite enthusiastic about being chosen as participants as those who were not selected were curious to know what the exercise was all about for the selected sample. This phenomenon explained one of the psychosocial features of adolescence, which is curiosity as found by Akande and Akande (2007). Research has shown that adolescents want to constantly receive sexual information from their parents and teachers. This possibly

explains why researchers target the early stage of adolescence to give them the right and detailed information about their sexuality with emphasis on sexual abstinence.

Worthy of mention is the percentage of inconsistent responses to the questionnaire. Twenty-three (representing 15%) of the sample were not assigned to groups because of their inconsistent manner of filling the questionnaire; possibly sequel to their poor understanding of the questionnaire despite the researcher's attempts to localize the information for them. Some portions were left blank while double entries were made in some items. No doubt, this percentage is possibly a reflection of poor academic performance of some group of adolescents in school. They are very lazy and have apathy to learning. This group of adolescent is considered to require urgent attention because of their tendency to become dropouts, who could add to the social ills in the society as pointed by Nnachi (2003), and Adenegan and Ojo (2015).

The mean age of first experience of sex as found in this study is 10.1 years. This is alarming when compared with Obiekezie-Ali's (2003) stance that many Nigerian girls are known to start involvement in active sex at the early age of 13 years and Hammed and Adenegan's (2009) finding of mean age of initiating sexual intercourse (13.1 years for both boys and girls). This finding confirms the assertion of Egbochukwu and Ekanem (2008) that the age of initial sexual experience and involvement among adolescents thus becomes younger than 15 years. This finding is however not strange as Oloko and Omoboye (2006) found mean age of first intercourse to be 10 years among their sampled adolescents. This was further confirmed when Akinyele and Onifade (2009) found that girls of ages 9 and 10 years were already sexually experienced.

Plausible reason for this trend is that the early onset of puberty, among other environmental factors, makes it critical for the adolescents to avoid impulsive decision to initiate sex earlier than expected. Responses from the focus group discussions revealed a wide range of ages as being the right age for sexual debut. The age ranged from as young as 12 years to 25 years. "*once a girl matures with full female properties, she is okay to taste sex*", "*if a boy's penis is strong to enter a girl, he is fit to have sex*", "*no matter your age, the best time is after you have finished your study in the university and ready to marry*". These among others were the opinions of some participants. Despite giving some features and age ranges to be attained before first sex,

virtually all the participants (both sexually experienced and inexperienced adolescents) concurred that it is preferable to marry or at least have someone to marry before engaging in sex.

This study revealed that girls (19) were almost twice the boys (10) to have engaged in sex. This finding is in line with the assertion of Agha, Rossem and Ankomah (2006) that at any given age, women are more likely to have initiated sexual activity. This finding, however, opposes the report of Rijsdijk, Bos, Lie, Ruiter, Leerlooijer and Kok (2012) who found that girls indicated more often than boys that they did not have any sexual experience (i.e. vaginal or anal intercourse). This finding also contradicts several studies (Gupta, 2000; Babalola, Awasum & Quenum-Renaud, 2002; Pham, Nguyen, Tho, TanMinh, Lerdboon, Riel, Green & Kaljee, 2012), which revealed low rate of sexual abstinence among boys with the girls reporting high level of chastity and fidelity while placing premium on virginity as a virtue to be embraced. The possible explanation to this finding may be due to the high incidence of sexual abuse and rape reported among female adolescents compared to their male peers. This finding supports the report of The National Center for Victims of Crime (2012) and Child Molestation Research and Prevention Institute (2012), which estimated that at least two out of every ten girls and one out of every ten boys are sexually abused by the end of their 13th year.

Reasons reported for initiating sex early (prominent among the sexually active focus group discussion) included: rape by older men, abuse from house maids, curiosity and sexual exchange (financial gain). On the other hand, the sexually inactive focus groups submitted: "*when a girl likes a man, she will do anything he likes her to do*", "*boys are usually pressurised to do it by the influence of their friends*". Other reasons mentioned included illicit dressing that can arouse the passion of the opposite sex, watching '*blue*' films, and fear of offending the sexual partner or the person making the advances. Friends play a major role in the experiences of first sexual encounters especially among the boys. This supports the social influence theory, which is based on the assumption that people (especially the adolescents) engage in behaviours as a result of peer and other societal pressures.

The reasons given for premarital sex in this study were in agreement with the findings of Duru, Ubajaka, Nnebue, Ifeadike and Okoro (2010) who reported peer group pressure, monetary gain, personal satisfaction, curiosity, and lack of home guidance from parents and relatives as reasons for initiating sex. Also, this finding fairly compared with the outcome of Izugbara (2001)

and Sunmola, Dipeolu, Babalola and Adebayo's (2003) study, which revealed reasons such as pleasure, to test fertility, to enhance sexual proficiency, drug, rape, coercion, deception, curiosity and biological urge.

When asked about the consequences of first sex, virtually all the responses of participants tallied across the focus groups irrespective of sexual status. Shame, regret, fear of pregnancy, fear of contacting HIV/AIDS, "*fears of letting parents know what you did*", and drop out from school were prominent consequences given. These findings are in consonance with the findings of Ankomah, Mamman-Daura, Omoregie and Anyanti (2004, 2011).

Regarding the desired behavioural outcome of the study, sexual abstinence, many of the participants were naive about the concept of sexual abstinence. While some hold the view that sex with animals instead of human beings is partly abstinence, some consented that masturbation, oral and anal sex are part of the practice of chastity or sexual abstinence. "*So far the person doesn't do the main thing, which is to have sex with the opposite sex. He or she can go for the alternative*", a group from the sexually active adolescents posited. These responses they based on the fact that sexual self pleasuring is inherent in each individual.

Several other misconceptions about abstinence were held by a high degree number of the focus groups. Among such were "*abstinence can lead to mental breakdown*", "*abstinence can lead to late marriage*", and "*abstinence can cause some diseases due to having sex late in life*". Curious about these views of the participants bearing in mind their age bracket; how come they conceive those perceived risks about abstinence when they are just entering into adolescence? Findings revealed that many of those views were shared by older people in their hearings. This explains the contribution of behaviour contagion theory in adolescent sexuality, which states that behaviour is contagious if one person is more likely to exhibit it when a significant and relevant person has already done so.

Despite the perceived risks of sexual abstinence opined by some participants, abstinence was the preferred option by a very large number of them for moral, religious, pregnancy prevention and diseases reasons. "*I want to become a doctor in the future; I will not like anybody to impregnate me*", "*HIV/AIDS no dey show for face, I am scared to have unprepared sex*", "*My parents and pastor must not hear that I fornicate. So, I better abstain*". These, among others, were conspicuous reasons given by the adolescent participants. Whatever being the reason given,

it is obvious that a good number of youth is still practising abstinence. This finding is consistent with that of Sunmola, Dipeolu, Babalola and Adebayo (2003) together with Iyaniwura, Daniel and Adelowo (2007) who found out that majority of their study's respondents favoured remaining a virgin until marriage.

However, these same young adolescents expressed fear that abstinence is very difficult to practise (which was the popular view of the sexually active focus groups). This is not unconnected with discovery of sexual self pleasuring. This explains the reason why abstinence concept, exposed early to young minds and practised in its totality, enhances self-efficacy for sexual abstinence. Meanwhile, reports from the focus groups revealed that adolescents and youths noted or found practising abstinence are stigmatized and nicknamed "*Sister Mary*", "*Brother Joseph*", "*Mumu*", "*Suegbe*", "*SU*", among other derogatory names. Hence, many youths who have decided to wait for sex till later time in life or marriage are ashamed to disclose their sexual naivety to their peers for fear of jest or being ridiculed.

Notably observed among some of the participants (particularly among the control group) was high pre-test performance on sexual abstinence, very close to their post-test scores, similar to the post-test scores of those who have been significantly influenced by the treatments. Curious by this observation, the researcher found that the control group (school) had four very active guidance and counsellors, who from enquiries periodically carry out colloquiums on morals for the students. This, possibly, accounted for the good moral tendencies of the concerned participants. This justifies the submission of Santelli, Ott and Lyon (2006) and Advocates for Youth (2007) that counselling and moral promoting activities will help adolescents to abstain from sex until marriage or to become "secondary virgins" by ceasing sexual activity until marriage. This finding, nevertheless, did not downplay the effectiveness of the treatments administered to the participants.

Quantitative Findings

The quantitative findings with respect to the seven formulated and tested null hypotheses are discussed as follow:

Hypothesis One

There is no significant main effect of treatments on sexual abstinence of participants. This null hypothesis was rejected as the result on Table 4.4 shows that there was a significant main effect of treatments on sexual abstinence of in-school adolescents. This means that both psycho-educational group therapy and self-components training were both effective in enhancing sexual abstinence among in-school adolescents. This finding is in line with Smith, McCall and Ingram (2014), who found that programmes that emphasize the educational, occupational, and psychological preparation for productive and self-sufficient lives for youth and impart a realistic hope that these goals can be obtained can motivate youth to refrain from sexual activity and prevent pregnancy. Also aligning with this finding, Babalola, Awasum and Quenum-Renaud (2002); Santelli, Kaiser and Hirsch (2004); and Plummer (2012) found that self-component based treatment (self-efficacy intervention) significantly made impact among young people.

The possible explanation for this result could be that both psycho-educational group therapy and self-components training follow an educational model which is directly or indirectly concerned with the teaching of personal and interpersonal attitudes and skills which the adolescent applies to solve present and future psychological problems and to enhance his satisfaction with life. While psycho-educational groups generally teach clients that they need to learn to identify, avoid, and eventually master the specific internal states and external circumstances associated with substance abuse, self-components training adopts Schalet's (2011) proposed ABC-D approach, which is a new paradigm to enhance healthy sexuality among the adolescents. The new paradigm includes sexual *autonomy*, *building* good romantic relationships, *connectedness* with parents and other caregivers, and recognizing *diversities* and removing *disparities* in access to vital socioeconomic resources. This ABC-and-D directs attention to the fundamental skills, relationships, and resources that adolescents need to develop as healthy sexual and emotional beings. Gaining sexual autonomy involves knowing about sexual desire and pleasure, recognizing and articulating sexual wishes and boundaries, and learning to

anticipate and prepare for sexual acts. When youth have sexual autonomy, they can recognize their sexual feelings as separate from the desires and pressures of others, own their feelings, and exercise control over their sexual decision making (Tolman, 2002).

Acquiring such autonomy is easier when adolescents move slowly in sex, assessing their desires and comfort levels at every step before moving to the next. A sense of sexual autonomy helps adolescents to navigate sexual interactions. This principle is equally aided by the opinion of Pearson (2006) that teens who have a greater sense of control in sexual situations are more likely to refrain from intercourse and use condoms when they have sex. Also, self-esteem and self-efficacy, which are significant factors in discussing sexual health, are embedded in the self-components training. Self-esteem or self-worth is integral to sexual health because people must have some level of self-respect in order to develop the confidence to make independent, healthy decisions about the actions and behaviours in which they elect to engage. This finding was supported by the studies of Horne and Zimmer-Gembeck (2006) and Impett, Schooler and Tolman (2006) which revealed that adolescents who report more sexual self-efficacy ability to act on their sexual needs are more likely to have used condoms at first intercourse or refrain from sex when enticed.

Also, the result reveals that the participants in psycho-educational group therapy displayed higher sexual abstinence than those in self-components training. This implies that psycho-educational group therapy was more potent to enhance sexual abstinence better than self-components training. The plausible reason for this could be traced to the fact that psycho-educational groups are highly structured and often follow a manual or a preplanned curriculum. Psycho-education is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions. This finding is in congruence with Griffin-Shelley (1994) traced back to the last century in which he notably used psycho-educational group therapy to treat sexual addiction among adolescents with significant impact. This finding also corroborates Moore and Rosenthal (2007) whose study used psycho-education to significantly raise the awareness of adolescents about teenage pregnancy and prevention. Similarly, the stances of Martine and Marc (2010), Hebert and Tourigny (2010), Fishbein and Ajzen (2011), and Walsh and Tiffany (2013) who all found psycho-educational group therapy as an effective intervention in promoting healthy sexuality among adolescents and young adults.

Hypothesis Two

There is no significant main effect of gender on sexual abstinence of participants. The null hypothesis was accepted as the result indicated that there was no significant main effect of gender on sexual abstinence of in-school adolescents. This implies that there is no significant difference between the test scores of male and female in-school adolescents on sexual abstinence even though the mean score of male is slightly higher than that of female.

The outcome of this hypothesis is inconsistent with the work of Egbochukwu and Ekanem (2008) and Koffi and Kawahara (2008) who identified gender as significant correlate of sexual abstinence. This finding also disagrees with the submission of Pham, Nguyen, Tho, TanMinh, Lerdboon, Riel, Green and Kaljee (2012) that gender constructs result in differential knowledge and awareness of sexual health issues, ideologies, expectations, and norms for sexual behaviours, different motivations for sexual activity and relationships, and differential socio-cultural and economic power to negotiate sex and safer sex.

The current study demonstrates insignificant difference between gender and sexual abstinence. This could be as a result of the technology in the twenty-first century. The social media which has deeply permeated the fabrics of the adolescents' psyche and attention is not a respecter of gender. Both male and female adolescents are unduly exposed to technologically driven aids for sex through the use of hand sets. Many schools are seriously fighting the battle of restricting their adolescents from bringing cell phones to the school. The acceptance of this hypothesis, however, upheld the study of Masters, Beadnell, Morrison, Hoppe and Gillmore (2008) whose study's participants (both genders) reported positive attitudes about abstinence.

The finding of this study, however, indicated that the mean score of male is slightly higher than that of female. This implies that the males have tendency to practise sexual abstinence than the females. This finding is again contrary to the study outcome of Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo and Jinabhai (2009) who found that many young girls expressed positive attitudes towards abstinence, citing protection from pregnancy and sexually transmitted infections (STIs) as reasons. They also reported that younger girls perceived having sex at their age as inappropriate. The finding of this study favouring male's higher tendency towards sexual abstinence agrees with view of Plummer (2013) that male pupils seemed to understand better the knowledge of the risks and benefits of sexual abstinence than the

girls. This reflected on how the boys were typically favoured and encouraged more in their learning.

The likely reason for this shocking outcome may not be far-fetched from the submission of The National Center for Victims of Crime (2012) and Child Molestation Research and Prevention Institute (2012) which estimated that at least two out of every ten girls and one out of every ten boys are sexually abused by the end of their 13th year. However, the inherent advantage in this outcome is that sexual abstinence will gain more ground among the adolescents, since earlier researchers (Nnachi , 2003; Aji, Aji, Ifeadike, Emelumadu, Ubajaka, Nwabueze, Ebenebe & Azuike, 2013) have reported that sexual abuse or sexual debut are mostly experienced in between a young boy or girl and a older partner. With the sanction recently agreed upon by the National Assembly in Nigeria, the outcome of this study will in no doubt promote sexual abstinence once perpetrators of sexual abuse are squarely dealt with.

Hypotheses Three

There is no significant main effect of peer influence on sexual abstinence of participants. The null hypothesis was accepted as the result revealed that there is no significant main effect of peer influence on sexual abstinence of in-school adolescents. The implication of this is that there was no significant difference between the test scores of positively and negatively influenced in-school adolescents on sexual abstinence. This denotes an insignificant main effect of peer influence on sexual abstinence of participants. Worthy of note is the sharp difference between the scores of negatively peer influenced adolescents and the positively influenced ones.

The insignificant difference outcome of this study contradicts the finding of Miller and Benson (2001) alongside Babalola, Awasum and Quenum-Renaud (2002) whose studies documented the predictive role of perceived peer behaviour on early sexual experimentation and risky sexual behaviours. This finding even plays down the submission of Babalola, Awasum and Quenum-Renaud (2002) that the perception that most friends are having sex decreases the odds of sexual abstinence. The probable reasons for this finding could be hinged on the fact that sex related matters are not limited to adolescents only. There exist cases where significant older people in the lives of the young ones make the innocent adolescents to go astray. Adenegan and

Ojo (2015) documented instances of this. Thus, peer influence, though potent, has other significant predictive factors that determine adolescent sexual debut. This finding lays credence to the behaviour contagion theory as established by Oyeyemi (2004), which is commonly thought to contribute to many social problems such as sexual promiscuity among teenagers.

The finding of this study also showed sharp difference between the scores of negatively peer influenced adolescents and the positively influenced ones. The higher mean score for the negatively peer influenced adolescents indicates that they have the tendency to practise sexual abstinence after the treatments than their positively influenced counterparts. The reason for this compelling effect in enhancing sexual abstinence among the negatively peer influenced adolescents in the study could be traced to the kind of exposure they have gotten through the various negative influences. Having gotten many ill ideas about sex related matters and now receiving helping information about sex could be motivating enough to practise abstinence. This finding could probably explain why many innocent adolescents, who are refrained from receiving information about sex by parents for religious or personal reasons, easily fall prey at the slightest opportunity of sexual adventures.

This finding could be explained in the light of the discovery of Collins, Alagiri and Summers (2002) that credible research clearly demonstrated that some comprehensive sex education, or "abstinence-plus," programmes can achieve positive behavioural changes among young people and reduce STIs, and that these programmes do not encourage young people to initiate sexual activity earlier or have more sexual partners. In other words, the so-called negatively influenced adolescents are often proned to be exposed to advanced information about sexual matters, which when combined with treatment to enhance sexual abstinence triggered their decision.

Hypothesis Four

There is no significant interaction effect of treatment and gender on sexual abstinence of participants. The null hypothesis was accepted. This was sequel to the finding which signified that there was no significant interaction effect of treatment and gender on sexual abstinence of in-school adolescents; meaning that gender did not significantly moderate the effect of treatments on sexual abstinence of the in-school adolescents. This outcome does not

corroborate the finding of Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo and Jinabhai (2009) who established the moderating effect of gender in their study.

Investigating gender differences on adolescents' sexual abstinence tendency is important, given the fact that both genders are not identical because considering differences among them will help in the effort to empower individuals to achieve their full potentials and self-actualisation with reference to their sexuality. This study has however yielded contradictory finding. The probable explanation may be that male and female adolescents are exposed to virtually same psychological, social, cultural and environmental factors that could distort their minds towards sexual debut or otherwise. Both groups of adolescents could face challenges such as coping with stigma of being called those derogatory names identified by the various focus group discussions.

Hypothesis Five

There is no significant interaction effect of treatment and peer influence on sexual abstinence of participants. The null hypothesis was accepted resulting from the finding which denoted that there was no significant interaction effect of treatment and peer influence on sexual abstinence of in-school adolescents. This means that peer influence did not significantly moderate the effect of treatments on sexual abstinence of the in-school adolescents. This finding is at variance with study outcomes of Uwakwe, Onwu and Mansaray (1993), Falaye (2001), Izugbara (2001), Etuk, Ihejiamaizu and Etuk (2004) and Ankomah, Mamman-Daura, Omoregie and Anyanti (2011) who documented significant interplay of peer influence on adolescents' decision to initiate sex.

Significantly, peer group interactions provide a basis for adolescent self-evaluation and critical information on what he or she is like, how he or she should behave and so on. These interactions help the adolescent to compare self with other age mates; an important exercise, which an adolescent does to evaluate his or her actions, attitude, feelings and values. However, the finding from this study has shown otherwise. The insignificant interaction effect outcome of this hypothesis could be explained in the light of other extraneous variable such as the adolescent's intention to have sex. Aji, Aji, Ifeadike, Emelumadu, Ubajaka, Nwabueze, Ebenebe

and Azuike (2013) found significant interaction effects of sex and abstinence intention with increases in the predicted probability of having sex among teenagers.

Hypothesis Six

There is no significant interaction effect of gender and peer influence on sexual abstinence of participants. The null hypothesis was accepted sequel to the result which depicted that there was no significant interaction effect of gender and peer influence on sexual abstinence of in-school adolescents. This depicted that gender did not significantly moderate the effect of peer influence on sexual abstinence of the in-school adolescents. This finding differs from the results from the study of Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo and Jinabhai (2009), which reported the moderating effect of gender on peer influence regarding sexual abstinence. The finding, on the other hand, favours the discovery of Maguen and Armistead (2006), which indicated that both parental sexual attitudes and parent-adolescent relationship quality predicted abstinence after accounting for the variance associated with peer variables.

This finding suggests the possibility of other extraneous variables which could impart on the peers regarding the treatments. The submission of Santelli, Ott and Lyon (2006) and Advocates for Youth (2007) that counselling and moral promoting activities will help adolescents to abstain from sex until marriage could, among other factors, come to play in moderating the peer influence and the outcome behaviour.

Hypothesis Seven

There is no significant three-way interaction effect of treatment, gender and peer influence on sexual abstinence of participants. The null hypothesis was accepted owing to the fact that the result signified that there was no significant interaction effect of treatment, gender and peer influence on sexual abstinence of in-school adolescents. This portrayed that gender and peer influence did not significantly moderate the effect of treatments on sexual abstinence of the in-school adolescents. The finding implied an insignificant interaction effect of peer influence and treatment on sexual abstinence.

This finding again contradicts the observation of Etuk, Ihejiamaizu and Etuk (2004), Dlamini, Taylor, Mkhize, Huver, Sathiparsad, Vries, Naidoo and Jinabhai (2009), and Ankomah, Mamman-Daura, Omoregie and Anyanti (2011) who acknowledged the significant interaction of gender, peer influence and their treatments on adolescents' decision to initiate sex. The probable reason for the variance in this finding could also be ascribed to other variables such as parental monitoring and the home environment of the in-school adolescents.

This presumption supports the submission of Bhardwaj, Ramsay, Bain and Prakasam (2007) and Hammed, Odedare and Okoiye (2013) that parental monitoring is linked to the susceptibility of adolescents to peer influence and tendency to abstain or not abstain from sex. For adolescents without sexual experience (virgins) and the sexually experienced adolescents (non-virgins), Rijsdijk, Bos, Lie, Ruiter, Leerlooijer and Kok (2012) found one of the self-component training indices (self-efficacy) to be a significant predictor of intention to delay sexual intercourse.

Implications of the Study

The findings of this study have far reaching implications. The present study has proven that psycho-educational group therapy and self-components training are effective in enhancing sexual abstinence among in-school adolescents. The outcomes of this work are important for the government, non governmental organisations, parents, teachers, counselling psychologists, youths and adolescents. The enhancement of sexual abstinence of the adolescents may enable youths and adolescents to become more successful in life, career, health, among other areas of benefits, which will reduce the rate of dropout, under-achievement, depression, frustration, anxiety, sexually transmitted infections and other problems associated with adolescent sexuality.

Some of the problems that necessitated this study were the problems being faced by in-school adolescents as expressed in the media and by earlier researchers. These problems include peer pressure, social integration and psychological variables. The resultant effects of the problems observed include; teenage pregnancy, psychosocial ills, academic under-achievement and even untimely death among the adolescents. It was discovered that there is no significant difference between the sexual abstinence enhancement of male and female in-school adolescents. Most of the participants (males and females) indicated that their sense of sexual abstinence self-

efficacy was enhanced after they were exposed to treatments. Many of the in-school adolescents became adjusted as a result of the treatments in this study. These made them happy and at home with their sexuality, either male or female.

Adolescents are often confused and traumatised on assuming adolescent stage which is highly characterised with high libido and more tendencies to initiate sex because they lack the ability to handle their sexuality, which may be sequel to lack of balanced information regarding sexual matters. If in-school adolescents do not know how to handle their sexuality and the adolescent stage, they may become discouraged, frustrated and engaged in avoidance strategies, leading many of them to masturbate or practise every known alternative to sex. Therefore, the relevance of psycho-educational group therapy and self-components training is highly important.

Another implication of the findings of this study is that adolescents must be provided with sexual abstinence counselling services. Therefore, it is essential for counsellors to be alert to their responsibility in providing adolescents with well-packaged therapies on how to handle their sexuality by adopting psycho-educational group therapy and self-components training.

Counselling psychologists need to be proactive in re-educating the society regarding sexual abstinence and its inherent benefits. Catching the adolescents young will be highly productive rather than waiting for them to have inflicted injuries on themselves sexually before being informed to practise abstinence, which would then be at secondary level. Successful intervention is best achieved by initiating it early and perhaps right at the beginning of their post primary school stage to be at safe side.

The examination and investigation of the independent variables (Psycho-educational group therapy and self-components training) have given more insight on their relevance in enhancing sexual abstinence practice among in-school adolescents, and helped to unveil the undesirable effects of earlier initiation of the sexual acts. The study has provided an accurate and age appropriate human development and sexuality education that encourages parent/child communication, promotes abstinence and enables in-school adolescents to make responsible decisions regarding their health and sexuality.

In addition, the findings of this study has also offered challenge to adolescents and youth counsellors to rise up to the occasion and proffer psychological remedy, which could be applied by adolescents in handling their sexuality, regardless of their background, disposition, beliefs,

values, customs and culture. This study is significant as it has informed a major campaign promoting abstinence and delayed sexual debut among Nigerian adolescents. Since Nigeria is a very religious society and abstinence before marriage is in line with both Christian and Islamic beliefs (the two major religions practised in the country), the campaign that the findings inform will likely garner a lot of goodwill and support from the Nigerian populace as the findings from this study has corroborated the "Zip Up!" campaign in Nigeria.

Also, this study is significant and has far reaching implications to parents and teachers alike in assisting adolescents to handle negative peer influence and boost their self-efficacy in abstaining from premature sex. The adolescents themselves have benefited from the study by having clues to most of their unanswered questions regarding their sexuality. This would enable them navigate the adolescent stage with much ease as the treatments yielded positive results.

This study has provided a picture of possible contributions of psycho-educational group therapy and self-components training to enhancing sexual abstinence practice among adolescents in Nigeria. The outcome of the study has formed a basis for practical techniques for counselling secondary school adolescents on HIV/AIDS prevention in a developing country, such as Nigeria. Such counselling intervention strategies could impact greatly on fostering positive attitudinal dispositions and response to sexual abstinence practices.

Limitations of the Study

Despite the fact that this study demonstrated the effectiveness of psycho-educational group therapy and self-components training in enhancing sexual abstinence among in-school adolescents, the researcher encountered a number of limitations in the course of the study.

First, ninety-two (92) in-school adolescents were used for the quantitative study and one hundred and twenty-one (121) due to administrative, logistics, time and financial constraints. Appropriately, a greater number would have been preferred. This however does not diminish the usefulness of this study since taking into cognisance that the study is experimental in nature.

The researcher had a challenge initially in passing the message to the adolescents despite motivating strategies such as localising the concept as much as possible in their mother tongues giving them incentives such as cash, refreshment and gifts during sessions; some of the participants could not easily grasp the content. This might be because of their age and academic

foundation. To select mainly the brilliant ones would amount to sampling error. These limitations do not, however, render the outcomes of this study invalid.

Again, the treatment was carried out for consecutive sessions of eight weeks. Extending the time before measuring the behavioural outcome could help to establish the effectiveness of the treatments. The time constraint, in any case, is not sufficient to put aside the findings of this study.

Conclusion from Findings

The main objective of this study was to investigate the effects of psycho-educational group therapy and self-components training in enhancing sexual abstinence among in-school adolescents. The study made use of gender and peer influence as moderating variables. Training programmes were carried out, relevant data were collected and analysed using appropriate statistical methods.

Psycho-educational group therapy and self-components training were effective in enhancing sexual abstinence among in-school adolescents, thus, introduction of these techniques will help in enhancing sexual abstinence among in-school adolescents, if the principles are properly applied on this group of people.

Meanwhile, none of the moderating variables (gender and peer influence) played a mediation role on the causal effect of treatment on sexual abstinence of in-school adolescents. It is presumed that other extraneous variables could be responsible for the interaction effect.

Recommendations of the Study

Based on the findings of this study, the following recommendations were made:

1. This study is potent to provide useful information for understanding adolescent sexuality, sexual abstinence and the negative outcomes of initiating sex earlier than expected. Hence the results of the present study may provide valuable cues to the government, non governmental organisations, parents, teachers, counselling psychologists, adolescents and youths to maximise the psychological interventions such as psycho-educational group therapy and self-components training to enhance sexual abstinence thereby reducing the the negative effects of adolescent sexual debut.

2. Counselling centres in schools and adolescent friendly centres should utilise these treatments in helping adolescents to refrain from spur-of-the moment sex.
3. Adolescents in schools should avail themselves of these treatments to enhance their quality of life and in the management of their sexuality.
4. Parents should pay close attention to the sexual activities of their children and incorporate these treatments in the moral discuss between them and their adolescents.
5. Counselling psychologists and researchers can stem out intervention from the treatments for those who have been unduly introduced to sex and willing to practise secondary abstinence.
6. Initiatives to improve the school's response to promoting sexual abstinence should be integrated into on-going efforts to strengthen guidance and counselling and life skills education, especially with the new trend of civic study.
7. Government should encourage schools by posting at least two well trained guidance counsellors into secondary schools to carry out periodic seminars and counselling services to the adolescents to promote sexual abstinence.
8. Government should strengthen her policy framework on providing effective support services to the posted guidance counsellors and not load them with classroom work as in recent time; counsellors in schools were mandated to pick up teaching subjects in addition to their counselling work.
9. Future researchers could harvest ideas relating to sexual abstinence from this study as it laid precedence for further studies.

Contributions to Knowledge

This study has contributed to knowledge both theoretically and methodologically in the following ways:

- First, this study has provided an opportunity to bridge the gap in past studies on the use of interventions to enhance sexual abstinence of in-school adolescents.
- Also, this study is unique because, it used two creatively new treatments (psycho-educational group therapy and self-components training) in enhancing sexual abstinence among in-school adolescents in Ondo State.

- Although psycho-education had been used diffently in various studies, it's composition in this study is uniquely germane for a study as this. It proved to be more efficient than self-components training, which in its own also comprises of novel contents to enhance sexual abstinence.
- This study is unique as it stands out to clearly show that gender and peer influence do not moderate the effect of treatments on participants' sexual abstinence enhancement. The study depicts other likely factors such as parental monitoring, home environment, school climate and technology as potential moderating variables.
- The outcome of this research facilitates a clearer understanding of the relationship between sexual abstinence, gender and peer influence.
- The extensive reviewed literature on sexual abstinence and the relationship with the independent variables provides researchers and practising counsellors with valuable information regarding the psychological factors entrenched within the presenting exertions of sexual abstinence.

Suggestions for further studies

Based on the findings of this study, additional studies are suggested in the following areas:

The study should be replicated with another category of in-school adolescents or out of school adolescents to see if similar results would be obtained. A similar study utilising a larger sample size could increase the observed power and may yield more information about the impact of psycho-educational group therapy and self-components training on in-school adolescents' sexual abstinence.

A study on sexual abstinence could be conducted on a large-scale among adolescents across the country using survey method. This study should also be replicated, replacing the SAS and SATA scales with foreign, valid and reliable scales to see if the result obtained will be maintained. A similar study should be completed over a longer period of time to give in-school adolescents more time to internalise the process of the therapies. Also a similar study, using other potential moderating variables (such as sexual status, parental monitoring, home environment, school climate, technology) could be carried out for comparison of findings.

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APPENDIX I

FGD GUIDE ON SEXUAL ABSTINENCE FOR IN-SCHOOL ADOLESCENTS

Session I: General Orientation about Sexual Abstinence

Introduction

The researcher/research assistant:

- welcomes participants and describes what the focus group is- a group discussion forum that allows you to discuss among yourselves the topic rather than lone talking or teaching.
- states the purpose of the discussion group and tells participants he is interested in all their ideas, comments and suggestions regarding sexual abstinence. All comments both positive and negative are welcome.
- encourages participants to feel free to disagree with one another, as many points of views are expected.
- emphasizes that all comments are confidential and are for research purposes only.
- asks for nomination of secretary among participants to document the contribution of group members alongside the recording devices used.
- asks each participant to introduce him/herself by stating the first name and something about him/herself.

Points/Questions for Discussion

1. What we consider important differs depending on our experiences of life. What do we think young people value as most important to them these days?
2. What do we understand by the term sexual abstinence?

Explore for:

- Primary abstinence
- Secondary abstinence
- Other types of abstinence
- Local slang for abstinence

The researcher/research assistant wraps up the session by reiterating the contributions/points raised by the group members.

Session II: Advantages of Practising Sexual Abstinence

Introduction

The researcher/research assistant:

- welcomes participants and appreciates their attendance and cooperation.
- encourages participants to feel free to disagree with one another, as many points of views are expected.
- Reminds participants that all comments are confidential and are for research purposes only.

Points/Questions for Discussion

1. Some people feel they should wait until certain age or perhaps be married before having sexual intercourse while others have had it already. Is there any 'big deal' waiting before engaging in sexual intercourse as a youth?

Explore for:

- How long should adolescents wait before having sex?
- How do we see those who have or have not had sex before now?
- People stay away from sex for varying reasons which may either be personal or otherwise. What do we think will make some people stay away from having sex? Or what are the advantages of practising sexual abstinence?

Explore for:

- Fear of getting pregnant
- Fear of abortion
- Pains during sexual intercourse
- Fear of contracting STIs and HIV
- Fear of stigmatization from society
- Socially desirable

2. We can avoid contracting HIV/AIDS via sexual intercourse by either abstaining; or by being mutually faithful or using condom consistently particularly in non-spousal relationship. Which is the most practised by young persons?

Explore for:

- The easiest among the three and reasons why?

- The most difficult and reasons

The researcher/research assistant wraps up the session by reiterating the contributions/points raised by the group members.

Session III: Sexual Abstinence and Challenges

Introduction

The researcher/research assistant:

- welcomes participants and appreciates their attendance and cooperation.
- encourages participants to feel free to disagree with one another, as many points of views are expected.
- Reminds participants that all comments are confidential and are for research purposes only.

Points/Questions for Discussion

1. Some people feel it is very difficult to abstain from sex. How confident are our adolescents in their ability to say NO to sex?

Explore for:

- adolescent male/female's ability
- types of persons who can say no
- the role of power relations (eg. age, teachers, older men etc)

2. There are various mechanisms set up in society to guide young people towards achieving societal goals. How much have these mechanisms assisted in making the adolescents stay away from sex?

Explore for:

- The role of the family (father, mother and older sibling)
- Schools (Teachers-male, female)
- Media (Television, Radio, print medias)

3. Myths simply mean the supernatural beliefs people have that affect the way they relate with life generally. Do we have such beliefs about sex and abstinence in our community? In other words, what are the misconceptions about sexual abstinence?

Explore for:

- Misconception about sex among adolescents
- Misconception about abstinence
- Popular slang for sex
- Popular slang for abstinence

The researcher/research assistant wraps up the session by reiterating the contributions/points raised by the group members. He appreciates participants for their time and attention.

APPENDIX II – INTERVENTIONS

Experimental Group A_1 - Psycho-educational Group Therapy (PGT)

The Psycho-educational Group Therapy is a humanistic approach to changing the behaviour patterns, values, interpretation of events, and life outlook of individuals who are not adjusting well to their environment(s) (e.g. home, school, workplace, and in this case sexual stimuli). Inappropriate behaviour is viewed as a person's maladaptive attempt to cope with the demands of that environment. Appropriate behaviours are developed by helping the individual to recognize the need for change, and then helping that person to display better behaviour choices. Psycho-educational interventions tend to be "packaged" plans that are implemented and modified to the needs of the adolescent to address surfaced crisis in the participants' sexual desires.

The Psycho-educational viewpoint seeks to understand the adolescent who is engaged in a struggle to adequately handle life situations. In doing so, it looks at both individual and social explanations for inappropriate, anti-social, and otherwise unacceptable sexual behaviour patterns. The eight sessions will cover the following:

Session I: General orientation and administration of instrument to obtain pre-test scores

Session II: Relationship/Friendship

Session III: Values Clarification

Session IV: Learning to Negotiate

Session V: Assertive Communication

Session VI: Decision Making

Session VII: Behavioural Modification towards Sexual Abstinence

Session VIII: Revision of all activities in the previous sessions and administration of post-treatment measures.

The researcher will conduct the sessions based on time, days of the week, duration and venue as agreed by participants. There will be group discussion in line with the aim and objectives of the treatment package. The outline is as follows:

Session I

General Orientation and Administration of Instrument to obtain Pre-test Scores.

The researcher will assemble all the participants for an interactive session and welcome them to the programme. The researcher will introduce himself to the group and review the Psycho-educational Therapy package. There will be room for questions before proceeding. The researcher will facilitate good rapport with participants to enhance their readiness to participate well in the programme.

The researcher will proceed with the session by telling the participants that they are going to benefit immensely from the programme as it will create in them new process of thinking and handling sexual pressure. Prompt attendance is also very important, as any break in the sessions will create a gap in knowledge which might deprive participants from full benefits of the programme and will affect the desired result. Participants will be encouraged to comply with all instructions and complete all assignments to enhance efficiency and quick improvement as these will provide greater opportunity to practise and get familiar with the skills needed to enhance in them sexual abstinence.

Participants will be encouraged to be free to ask questions for clarifications. Each of the group participants will be encouraged to arrive on time so that they could exchange ideas before the session begins. The researcher will assure participants of keeping to time. Also, the researcher will announce the number of sessions done so far and the number of sessions remaining at each meeting.

At this point, the researcher will inform the participants of the instrument to be completed which would help him determine the present status of the participants on sexual abstinence. The researcher will tell them that their objective, honest and independent responses are very vital. There will be provision of writing materials – books and pens to jot important points at each session.

The researcher will administer the instrument for the pre-test measure to all the members in the group A_1 copies of Sexual Abstinence Scale (SAS), Peer Pressure Inventory (PPI), and the Sexual Abstinence Achievement Test for Adolescents (SAATA). He will explain how participants are expected to respond to the instruments. Participants will be encouraged to be independent and be objective in responding because the scores will be for research purpose.

Questions will be asked for clarification from participants on the instruments. The researcher will collect the instruments after they had all responded. Scores collected from these instruments completed during this session will be used as the pre-test scores.

The researcher will appreciate the participants for their voluntary participants in the training programme, and will encourage participants to be available for the next session, same time, same venue and assignment will be given to participants.

Home Assignment: The researcher will ask participants to write down, in the provided jotters, their view about sexual abstinence before the next session. Participants will be encouraged to visit the internet if they can do so.

Session II

Topic: Relationship/Friendship

The researcher will welcome the participants to the second session class. Appreciation will be given for their participation so far in the training programme, and will thank them for being available again. The researcher will then identify the objectives for the second session.

Objectives: At the end of the session participants should be able to:

1. Define relationship/friendship.
2. State 4 types of relationship
3. State 4 qualities/criteria for establishing friendship and relationship
4. Mention 3 boundaries to be set in a relationship
5. Mention 3 unhealthy relationships that could have adverse effects on friendship.

Materials to be used: Flip Chart, Markers, Chalk Board, Chalk and Masking Tape

Method/Content

A. Introduction: The researcher

- tells participants that a common life style of young people is that they enter into different types of relationships. Although this is quite normal, adolescents need to be guided to set limits in any type of relationship they may form with one another.
- requests participants to read out the objectives in turn
- encourages questions and responds accordingly

B. Definition: The researcher

- asks participants to brainstorm the definition of relationship/friendship
- writes responses on flip chart/chalk board
- displays or writes the definition as follows:

  Relationship: A relationship is an association between two or more people. It is the basis of human interaction, the expression of love and intimacy, without exploitation or manipulation.

  Friendship: Is a feeling or relationship that exists between friends.
- explains that friendship is a form of relationship which involves caring and getting to know each other.

C. Types of Relationship: The researcher

- asks participants to mention the types of relationships they form
- jots responses on a flip chart
- clarifies and presents the types of relationship on a flip chart as follows:

Relationship

a. Blood relationship e.g. parents, siblings, cousins, grandparents, uncles
b. Relationship by marriage e.g husband/wife

Friendship

a. Parents
b. Girl to girl
c. Boy to girl

D. Group Work (Criteria for Establishing Friendship/Relationship): The researcher

- divides participants into 3 groups
- asks each group to appoint a group leader a recorder/presenter
- requests the group to appoint a group leader a recorder/presenter
- allows each group 5 minutes to present to the whole group.

  Group 1: Criteria for establishing friendship and relationship

  Group 2: Boundaries to be set in any relationship

  Group 3: Activities that can make relationships unhealthy among adolescents
- expands on the presentations as follows:

E. Criteria for Establishing Friendship/Relationship

a. Respect: To respect means to honour, to hold in high regard or esteem, to treat others as worthwhile even when the person is different from you, to obey parents, rules and regulations.

b. Responsibilities: To be responsible means that others can depend on you, that you will fulfil your obligations and will be able to distinguish right from wrong.

c. Understanding: To be understanding means to be knowledgeable about another person, what she or he wants and needs and how she or he feels. It means being able to put yourself in someone else's position and imagine what life looks like from another person's point of view.

d. Labour: To labour means to work hard, to put effort into the relationship to benefit both individuals.

e. Caring: To be caring means to be concerned and interested in another person's feelings, needs, and wants and to want what is best for that person. It means feeling love or a liking for a person and wanting to protect, provide for or pay attention to that person.

F. Boundaries to be set in any Relationship/Friendship

- The researcher reminds participants that friendship is a form of relationship hence both words would be used together.
- Agree on how the relationship will be conducted and what you expect from each other.
- Friends should respect each other's beliefs and values.
- Friendship is reciprocal and based on trust and honesty.
- Relationship does not mean falling in love. You can love your friends, both male and female, as you love your family.
- Relationship does not mean having a sexual relationship.
- If your relationship with someone of the opposite sex is developing into a closer physical relationship, you will have to agree together whether to continue or discontinue the relationship.

G. Unhealthy Relationship in Adolescents

The researcher explains that the following are some of the unhealthy relationships that could have adverse effect on friendship

Sexual intercourse

Visiting obscure places

Staying alone most times

Cheating on one another etc.

H. Summary: The researcher summarizes the session by explaining to participants that friendship and relationship play a key role in life. The most important relationship is the family relationship. The researcher stresses that every person's family is unique and must not compare with others. It is very important to be very careful when choosing friends to avoid regret.

I. Review/Evaluation: The researcher asks participants the following questions:

1. Define relationships and friendship.
2. State 4 types of relationship
3. State 4 qualities/criteria for establishing friendship and relationships
4. Mention 3 boundaries to be set in a relationship
5. Mention 3 activities that can make a relationship/friendship unhealthy.

J. **Home Assignment:** The researcher asks participants to make a list of all their friends including that of opposite sex and then identify activities that can make their relationship/friendship unhealthy.

Session III

Topic: Values Clarification

Objectives: At the end of this session, participants should be able to:

1. Define values
2. Explain values clarification
3. Mention 5 sources of values
4. Identify the relationship between values and sexual abstinence

Materials: Flip chart, flip chart stand, markers, cardboard and pins

Method/Content

A. **Introduction:** The researcher welcomes participants, appreciates their attendance and explains that there are certain ideas or beliefs that we hold very dear to our hearts and some of these we may not like to part with. Many of these values are acquired from friends, parents, society, culture and the people we love.

B. **Definition:** The researcher

- asks participants to brainstorm the definition of values
- Jots responses and clarifies points raised
- Defines values as follows:

Values are beliefs, principles, and standards to which we attach a lot of importance. Explain that as young people grow up, they start to develop their own values which are influenced by family, friends, society, education etc.

C. **Examples of Personal Values:** The researcher

- asks participants to identify some of their values
- jots responses and clarifies
- Responses may include:
  a. Honesty
  b. Loyalty
  c. Respect for elders
  d. Having friends
  e. Being fashionable
  f. Helpful/useful at home
  g. Respect for other people's opinion
  h. Religion
  i. Education

D. **Values Clarification**

The researcher explains to participants that individuals and society have different values which are freely chosen. When a person acts on a freely chosen value, he or she feels happy about himself/herself. This also enables individuals to stand up against external pressure or behaviour contrary to their values.

Activity: The researcher

- identifies 3 locations in the classroom and places an inscription, written on cardboard, at each of the identified locations. The inscriptions should read:

  a. AGREE b. DISAGREE c. INDIFFERENT
- explains that they will participate in an activity called "Values Voting"
- informs the participants that they will read out some statements and at the end of each statement participants should move to any location of their choice based on their choice, based on their values.
- After each voting exercise let the participants explain why they choose their option and discuss the chosen option.
- Voting statements may include the following:

  Voting Statement

  It is okay to have sex before marriage

  Virginity is a disease

  Virginity is a pride

  HIV/AIDS is a disease sent by God to curb sexual immorality

Processing the Responses: The researcher

- Processes the exercise by asking the participants why they think the voting was sometimes equal or nearly all on one side.
- Provides a written definition of values clarification as:

  "The sorting of one's values, from the values of others, and those of the outside world".

E. Sources of Values: The researcher

- asks participants to mention sources of values
- jots responses and clarifies
- Responses may include

  a. The family

  b. The society

  c. Education

  d. Religion

  e. Peer group

F. Relationship between Values and Sexual Abstinence

Group work: The researcher

- divides the class into 3 groups
- requests that each group should elect a leader and a recorder
- asks each group to identify the relationship between values and sexual abstinence
- allows 10 minutes for discussion
- reconvenes groups and asks each group to present for 5 minutes
- discusses the presentations

If one values life in the real sense of it one will be:

a. able to avoid risky sexual behaviour even if your peers are indulging in such.
b. proud to counsel peers on practising sexual abstinence.
c. able to refuse being lured into premarital sex.

G. Summary

The researcher summarises that it is very important for young people to have clear values that reflect what they really believe in. Having clear values means that you are not easily affected by peer and societal pressure, and you will be empowered to protect yourself from early sexual debut or avoid any other trouble that could destroy your dreams.

H. Review/Evaluation: The researcher asks participants to:

1. Define values
2. Explain value clarification
3. Mention 5 sources of value clarification
4. Identify the relationship between values and sexual abstinence.

I. Assignment: The researcher gives home work to the participant to list at least three areas of their core values with reference to their life dreams.

Session IV

Topic: Learning to Negotiate

Objectives: At the end of the session, participants should be able to:

1. Define negotiation
2. Explain 2 reasons why negotiation is important

3. Mention 2 appropriate skills necessary for effective negotiation

Materials: Flip Chart, markers, masking tape and copy of role play scenario.

Method /Content

A. Introduction: The researcher welcomes participants, appreciates their attendance and introduces the session by explaining that negotiation is very important in our various interactions with people, e.g. we negotiate with our parents about what we want to buy or eat. When we have conflicting ideas or practices to our peers, the ability to stand up for our values and beliefs is very important. Friends and colleagues may come up with unacceptable or dangerous suggestions and put pressure on us to accept them. This is where our negotiation skills are useful. It is very important that as young people we know how to negotiate appropriately in order to avoid running into problems.

B. Definition: The researcher

- asks the participants to brainstorm on the definition of 'negotiation'.
- notes all their responses on flip chart,
- clarifies points raised by participants, and then defines as follows:
  ''Negotiation is a discussion aimed at reaching an agreement. Negotiation allows people to solve a problem or resolve a conflict amicably."

C. Importance of Negotiation: The researcher

- asks participants why they think learning how to negotiate is important to them at this time of their lives.
- writes all the responses on the board and expands as follows:
  a. To enable us get our needs met without feeling guilty, angry or intimidated.
  b. When negotiation is used effectively it enhances relationships.

D. Skills Required for Negotiation: The researcher

- asks participants to brainstorm the skills they think are necessary to negotiate effectively.
- notes responses.
- expands on points as follows:

Effective communication skills: speak, using clear and simple words and sentences so that it is easy for the other person to understand your intention. Using positive language (such as smiling

and looking at the other person while speaking to her/him) can help you communicate your intention even more effectively.

Listening skills: listen carefully to what the other person is saying. Use positive body language (such as nodding) to show that you understand what they have said. Ask questions if you do not understand or need further clarification.

Observation skills: carefully observe the other person's non-verbal intentions/cues while both you and they are speaking. These non-verbal cues can include positive body language such as nodding to show that they understand what you are saying or negative cues such as looking around at other things which could show that they are not listening.

Critical thinking skills: having listened to and observed the other person's intentions, carefully weigh up the implications of their suggestions.

Peer resistance skills: Use of positive body language to further help you to communicate your intention.

Problem solving skills: ability to quickly think out the solution to a problem.

Peer resistance skills: ability to say "no" to your peers when you do not agree with their suggestions.

E. Demonstrate the Skills Required in Negotiation

Role Play (10 minutes): The researcher

- divides participants into 3 groups
- provides the groups with different scenarios on negotiation issues

  E.g. **Group I:** A girl being pressurized to have sex

  Group II: A boy being forced to join a cult gang.

  Group iii A girl about to be given out in early marriage
- asks each group to role play the scenario within their group.
- The other members of the group should comment after the role play.
- Comments should be recorded and then presented to the whole group.
- Notes contributions.
- After the presentations, guides a discussion on the whole group and on the various scenarios.

F. Tips on Effective Negotiation: The researcher provides tips on how negotiation could be improved upon:

- Always use "I" statements. Say what you want to say as clearly as possible. Do not expect the other person to read your mind. The other person cannot give you what you want unless you explain what it is. You can deal with many potential conflicts by developing the ability to say "I need" or "I would like."
- Explain to the person what it is about their behaviour that has displeased you. Do not criticize or put the person down.
- Be a good listener. If you do not understand what the other person is saying, ask for an explanation. Show respect for the other person even when you are being assertive.

G. Summary: The researcher reminds participants that good negotiation skills are important as problems and situations of conflict will always present themselves. To any problem there may be more that one solution, but the important thing is that the solution is agreed between the parties concerned and is mutually beneficial.

H. Review and Evaluation: The researcher asks the participants to:

1. Define negotiation
2. Explain 2 merits of negotiation
3. Mention 2 appropriate skills necessary for effective negotiation
4. Demonstrate the skills needed to negotiate effectively.

I. Assignment: The researcher gives home work to the participant to identify individuals they need to negotiate with in order to fulfil their life dreams.

Session V

Topic: Assertive Communication

Objectives: At the end of this session participants should be able to:

1. Describe (a) Assertiveness
   (b) Non assertiveness
   (c) Aggressiveness
2. State 3 reasons for being assertive
3. State 3 behaviours that can enhance assertive behaviour

Materials: Flip chart, Hand out

Content/Method

A. Introduction: The researcher welcomes participants, appreciates their attendance and introduces the session by explaining that communicate is the way we express our feelings, thoughts and ideas. People often think that communication just happens, but to have a good communication there are skills one needs to acquire in order for communication to be effective.

B. Definition of (a) Assertiveness (b) Non-assertiveness and (c) Aggressiveness: The researcher

- asks participants to brainstorm the meaning of each word
- writes responses on the flip chart
- explains as follows:

1. "Assertiveness means standing up for your rights without violating anyone else's

The researcher explains further that assertive behaviour makes you feel better about yourself, be confident, be in control, and be respected by others. The **outcome** of being assertive is that:

a. You do not hurt others
b. You gain respect for yourself
c. Your right and those of others are respected; and
d. Everyone feels good

2. "Aggressiveness means you stand up for your rights at the expense of someone else's".

The researcher explains further that aggressive behaviour makes you feel angry, frustrated, bitter, guilty or lonely. The **outcome** is that:

a. You dominate
b. You humiliate and
c. You win at the expense of others.

3. "Non aggressive behaviour means giving up your basic rights so that others can achieve theirs".

The researcher explains further that non aggressive behaviour makes you feel helpless, resentful, disappointed and anxious. The **outcome** is that:

a. You do not get what you want
b. Anger builds up in you
c. You feel lonely and
d. Your rights are violated.

C. Examples of Each Type of Behaviour: The researcher

- asks 3 participants to volunteer to give examples of each type of behaviour
- lists responses on the flip chart
- asks participants the following:
  a. What were the situations like with each form of behaviour?
  b. How did you feel afterward?
- The researcher explains that sometimes each type of behaviour may be misunderstood but it is often effective as it shows self respect.

D. Exercise on Response Options: The researcher

- tells participants that they will carry out an exercise on response options:
- distributes the copy of the response options continuum to each participant
- writes the following life situation on the flip chart
- asks each participant to choose whatever options they think are most suitable to indicate the type of behaviour for the options chosen, using abbreviations e.g.

  For 'Non Aggressive' use letters N/A

  For 'Aggressive' use letters AG

  For 'Assertive' use letter A

  Situation 1: You and a friend have been asked to select the University of your choice in the obtained Unified Tertiary Matriculation Examination form.

  Response Options:

  a. "You choose, you always know what is best"
  b. "I like Achievers University, Owo, which university do you prefer?"
  c. "Private universities are very expensive. I say University of Ibadan. So University of Ibadan it is going to be".

Situation 2: Your friend did not turn up for an appointment.

Response Options:

a. Say nothing at all or "It did not really matter"

b. "I was mad when you did not show up last night! What happened?"

c. "You are such a fool, I hope I never lay eyes on you again!"

Situation 3: A friend has asked to copy your homework assignment

Response Options:

a. "I do not know I spent so much time doing it".

b. "I get really frustrated when you ask to copy my work because I know I put hours into it while you were messing around. No I really do not want you to just copy it".

c. "You were messing around having a great time while I was home studying and then you expect me to just hand over to you! Who are you kidding? You can drop dead for all I care!"

Situation 4: You left the workshop to go shopping yesterday when the trainer was out to the field. Today the trainer confronts you and she is very angry.

Response Options:

a. "I really did not know what to do! Asked the group leader and she thought it would be okay for me to leave since I had to go for my community development assignment."

b. "I had intended to ask you if I could leave, but I forgot. When the time came and you were not here I decided that I really did not need to get to work. So I left the class. Was that the appropriate thing for me to do?"

c. "What did you expect me to do? You were nowhere around and I had to go! Most trainers do not bother to hang around during the class."

- asks each participants to share their response option on each situation
- commends and provides the answers as follows:

Answer to Options (from Researcher's Note)

Situation 1 a = NA
b = A
c = AG

Situation 2 a = NA
b = A
c = AG

Situation 3 a = NA
b = A
c = AG

Situation 4 a = NA
b = A
c = AG

- explains further with copies of Handout on Responses Option Continuum, appropriately linking the various types of behaviour with sexual abstinence.

Response Option Continuum

NON ASSERTIVE	ASSERTIVE	AGGRESSIVE
Tends to show appreciation for self	Tends to show appreciation for self and others	Tends to show appreciation for self only
Indirect or no expression of self	Honest and direct expression of self without infringing on others' rights	Threatening, demanding, hostile expression of self
Hopes other will guess one's thought and feelings	Uses "I" messages to express thoughts and feeling	Uses "You" messages to blame others
Places responsibility for making the decision on the person	Assumes responsibility of thoughts, feelings and behaviour	Assumes little responsibility for the consequences of own behavior
Always gives in when a disagreement occurs	Compromises when possible (without compromising values)	Always wants own way
Soft, uncertain voice; poor eye contact; tense and fidgety; poor posture	Clear, firm voice; comfortable eye contact; relaxed: good posture	"Superior" tone of voice: overly direct eye contact: sharp, abrupt gestures: stiff and rigid posture

- explains that although non assertive behaviour and aggressive behaviour often have their purposes, assertiveness offers us the personal power to manage and solve many of life's problems.

E. Why Assertiveness is Necessary: The researcher

- guides discussion about the need for assertiveness in sexual situations
- notes continuation
- explains to participants as follows:
  a. To prevent sexual exploitation
  b. To resist peer pressure

  Encourage questions and respond

- encourages questions and responds

F. Behaviours that Enhance Assertiveness: The researcher

- asks participants to brainstorm the type of behaviours that enhance assertive assertiveness
- notes responses and expands on points as follows:
  a. Being alive
  b. Being honest
  c. Being spontaneous in communication
  d. Expressing your need and feelings instantly rather than waiting
  e. Using assertive body language e.g. standing up. Looking directly at the person you are talking to.

G. Summary: The researcher explains that the way people choose to interact with other people will greatly affect how well they will be listened to, as well as how others will respond. Non assertive, assertive and aggressive response options allow people to choose how to say what they want to say. Although people find reasons for aggressive and non assertive behaviour, it is assertive communication that often helps people get along with others without infringing on their rights.

H. Evaluation: The researcher asks participants to:

1. Define the terms
   a. Assertiveness
   b. Aggressiveness
   c. Non aggressiveness (passive)
2. Explain 3 reasons for the use of assertive behaviour
3. Describe 3 types of behaviour that can enhance assertiveness

I. Assignment: The researcher gives home work to the participants to practise the use of assertive communication in imagined cases of sexual harassments.

Session VI

Topic: Decision Making

Objectives: At the end of the session, participants should be able to:

1. Define decision making.
2. Give 2 reasons for making decisions.
3. State 2 factors that influence decision making.
4. State 2 consequences of making a decision without thinking of its effect

Materials: Flip Chart, marker, masking tape

Method/Content

A. Introduction: The researcher welcomes participants, appreciates their attendance and informs the participants that decision making is an everyday occurrence. Some decisions are very important and have a great impact on our lives while others are less significant, i.e. the difference between deciding on which career t follow and deciding which of your friends to spend your holiday with. Taking a decision is the act of choosing, selecting and deciding from several possibilities through one's judgment.

B. Definition: The researcher

- asks participants to brainstorm on the topic, decision making.
- notes responses on flip chart and clarifies as follows:

"Decision making is the act of making up one's mind. It is a frequent activity and examples include deciding on our career, deciding on the type of friends to keep, etc".

- explains further that youths today have many concerns and problems and the decision people make can have serious consequences. It is very important to think carefully before taking a decision.

C. Reasons for Making Decisions: The researcher

- asks participants to brainstorm the reasons for making decisions.
- notes responses on flip chart
- expands on the points as follows:
    a. To help one to accomplish one's goals
    b. To determine one's position
    c. To guide the action one takes so that one does not regret anything

D. Decision Making Activity – Grab Bag Game: The researcher

- introduces the grab bag game by placing 4 prepared nylon bags containing different objects such as a banana, an onion, a bottle filled with water, etc. at the front of the class.
- asks for 4 volunteers to come forward
- asks each participant to "Pick a bag".
- asks each volunteer to hold on to the bag they chose (there will be one extra bag)

The researcher processing questions;

- Once this is done, asks volunteers why they chose the bag they did.
- asks participants to open the bag, bring out the content and state how they feel about the choice made.
- asks participants if, given another opportunity to choose and based on the fact that they now have more information to help them in their decision, they would now choose a different bag and why?
- notes comments

E. Making Good Decisions: The researcher

- guides the discussion on decision making using the following discussion points:
- asks participants
  a. What they have learnt from the exercise
  b. Are decisions always easier to make if you have all the information?
  c. Do we sometimes decide to do something without thinking about it?
- notes participants' comments and contributes as follows:
  a. It is important for one to clarify his/her values i.e. understand and be sure of personal and family values as a basis for good decision making.
  b. Before making an important decision, it is necessary to have enough facts or information about all aspects of the issue in order to weigh the options and make an informed decision.
  c. It is most important to think critically and determine how to make the most effective use of one's opinions and values so as to bring about a good result.

F. Factors that influence Decision Making: The researcher

- explains to participants that before a decision is made, there are some factors that influence such actions.
- asks participants to brainstorm the factors they think may influence decision making
- Responses may include:

  Religion

  Society

  Government policy

  Family values

  Environment

  Personal preferences
- guides a discussion on each of the factors.
- notes points on flip chart and expands where necessary.
- encourages students to ask questions and provides appropriate clarification.

G. Consequences of Making Wrong Decisions: The researcher

- guides a discussion on the consequences of making wrong decisions.
- notes comments.
- expands on comments as follows:
  a. Experience regret
  b. Inability to meet goals
  c. Loss of time
  d. Not focused
  e. Being misled
- wraps up the discussion by stressing the importance of making good decisions.

H. Summary: The researcher summarizes the session by reminding participants of the importance of clarifying their values; and making sure that they have information that will guide them to think critically about the consequences of the decisions they want to make, before taking the decision.

I. **Review/Evaluation:** The researcher asks participants the following questions:

1. What is your understanding of decision making?
2. Give 2 reasons for making decisions.
3. Mention 2 factors that influence decisions.
4. State 2 consequences of making a decision without thinking of its effect.

J. **Assignment:** The researcher gives home work to the participants to highlight and write out 3 major decisions they will like to make about their future, and keep the write up where they can easily see it at least 5 days in a week.

Session VII

Topic: Behavioural Modification towards Sexual Abstinence

Objectives: At the end of the session, participants should be able to:

1. Develop positive attitude towards sexual abstinence
2. Master the ABSTINENCE acronym

Materials: Flip Chart, marker, masking tape

Method/Content: The researcher

- warmly welcomes participants and appreciates their attendance
- encourages participants to develop positive attitude to sexual abstinence
- teaches participants the ABSTINENCE acronym and application as follows

ABSTINENCE

A – Always say 'NO' to premarital sex
B – Beware of enticement and tempting environment
S – Set limit for yourself
T – Turn down every sexual advancement/harassment
I – Insist and Incline your heart/mind on moral values
N – Negotiate abstinence with your partner
E – Exercise self control
N – Never compromise your stand
C – Correct and help others
E – Esteem yourself before the opposite sex and others.

- encourages participants to master the acronym and appropriately apply it in real life situations

Session VIII

Topic: Revision of All Activities in the Previous Sessions and Administration of Post-Treatment Measures.

Objectives: At the end of the session, participants should be able to:

1. Summarise their experience based on what they have learnt from the treatment
2. Respond to the post-test instruments

Materials: Flip Chart, marker, masking tape, post-test instruments

Method/Content: The researcher

- warmly welcomes participants and appreciates their attendance at all sessions
- asks participants to share their experiences based on their developed positive attitude to sexual abstinence
- distributes copies of the post-test instruments for the participants' responses
- retrieves the completed responses from the participants
- thanks the participants for their attendance and cooperation and then gives them incentives – light refreshment, copies of books (The Beauty in Virginity, Adolescent Sexuality; Implications for Counselling, Staircase to Happiness, Love or Lust?, and Integrity – all written by the researcher), and token for their transportation.

Experimental Group A_2 – Self-components Training (SCT)

Self-components Training attempts to address issues relating to adolescents' ability to understand self and hence strengthen their coping skills for sexual abstinence. The eight sessions will cover the following:

Session I: Administration of instrument to obtain pre-test scores

Session II: Understanding Your Self; The Human Sexuality

Session III: Sexual Self-concept

Session IV: Sexual Self-esteem

Session V: Sexual Self-efficacy

Session VI: Sexual Self-determination

Session VII: Behavioural Modification towards Sexual Abstinence

Session VIII: Revision of all activities in the previous session and administration of post-treatment measures.

The researcher will conduct the sessions based on time, days of the week, duration and venue as agreed by participants. There will be group discussion in line with the aim and objectives of the treatment package (Self-components Training). The outline is as follows:

Session I

General Orientation and Administration of Instrument to obtain Pre-test Scores

The researcher will assemble all the participants for an interactive session and welcome them to the programme. The researcher will introduce himself to the group and review the Self-components Training package. There will be room for questions before proceeding. The researcher will facilitate good rapport with participants to enhance their readiness to participate well in the programme.

The researcher will proceed with the session by telling the participants that they are going to benefit immensely from the programme as it will create in them new process of thinking and handling sexual pressure. Prompt attendance is also very important, as any break in the sessions will create a gap in knowledge which might deprive participants from full benefits of the programme and will affect the desired result. Participants will be encouraged to comply with all instructions and complete all assignments to enhance efficiency and quick improvement as these

will provide greater opportunity to practise and get familiar with the skills needed to enhance in them sexual abstinence.

Participants will be encouraged to be free to ask questions for clarifications. Each of the group participants will be encouraged to arrive on time so that they could exchange ideas before the session begins. The researcher will assure participants of keeping to time. Also, the researcher will announce the number of sessions done so far and the number of sessions remaining at each meeting.

At this point, the researcher will inform the participants of the instrument to be completed which would help him determine the present status of the participants on sexual abstinence. The researcher will tell them that their objective, honest and independent responses are very vital. There will be provision of writing materials – books and pens to jot important points at each session.

The researcher will administer the instrument for the pre-test measure to all the members in the group A_2 copies of Sexual Abstinence Scale (SAS), Peer Pressure Inventory (PPI), and the Sexual Abstinence Test for Adolescents (SATA). He will explain how participants are expected to respond to the instruments. Participants will be encouraged to be independent and be objective in responding because the scores will be for research purpose. Questions will be asked for clarification from participants on the instruments. The researcher will collect the instruments after they had all responded. Scores collected from these instruments completed during this session will be used as the pre-test scores.

The researcher will appreciate the participants for their voluntary participants in the training programme, and will encourage participants to be available for the next session, same time, same venue and assignment will be given to participants.

Home Assignment: The researcher will give participants some materials on sexual abstinence for participants to read before the next session. Participants will be encouraged to visit the internet if they can do so.

Session II

Topic: Understanding Your Self; The Human Sexuality

The researcher will welcome the participants to the second session class. Appreciation will be given for their participation so far in the training programme, and will thank them for being available again. The researcher will then identify the objectives for the second session.

Objectives: At the end of the session participants should be able to:

1. Identify the need for sex education with reference to adolescence
2. State 5 features of puberty in boys and in girls
3. Explain menstruation in girls and wet dream in boys
4. Describe the human reproductive system
5. Explain sexual desires in humans

Materials to be used: Flip Chart, Markers, Chalk Board, Chalk and Masking Tape

Method/Content

A. **Introduction:** The researcher welcomes and appreciates participants and starts by stating the need for sex education

Sex education is a very sensitive e topic, which often times most families shy away from due to fear of unknown and insecurity, what might be the consequences if the child is unduly exposed, without realizing that inherent danger in ignorance is greater than having the required knowledge. The period of adolescence is a very delicate phase of life from biological, psychological and social perspectives. This special age group ranges between 12 and 19 years. Adolescence is characterized psychologically with the onset of secondary sexual characteristics, the growth spurt, final development of central nervous system as well as hormonal neurotransmitter and biochemical changes. It is also the time they integrate sexual impulse into self-concept. There is high sexual awareness, sexual activity and interest in the opposite sex.

B. **Puberty and Adolescence:** The researcher explains as follows:

Puberty is the period an individual becomes capable of sexual reproduction, that is, it denotes the series of biological changes leading up to reproduction capability. Puberty marks the beginning of adolescence and sexual maturation. It is a stage of rapid physical growth and development. The start of each stage varies from one individual to another. Puberty starts earlier in girls than in boys, usually around the age of 10 and 11 for girls and around the age of 14 for

the boys, although it m ay begin before or after this age. People can only have children at adolescence and it is the period when the individual becomes sexually matured. Sexuality is fully developed during adolescence and it is the awareness of being a male or female in one's feeling, thought, behaviour, ambition, etc.

More broadly speaking, however, puberty encompasses all the physical changes that occur in the growing girl or boy as the individual passes from childhood into adulthood. The following are the five chief physical manifestations of puberty:

a. A rapid acceleration in growth, resulting in dramatic increases in both height and weight.
b. The development of primary sex characteristics, including the further development of the gonads, or sex glands, which are the testes in males and the ovaries in females.
c. The development of secondary sex characteristics, which involve changes in the genitals and breasts, and the growth of pubic, facial, and body hair, and the further development of the sex organs.
d. Changes in body composition, specifically, in the quantity and distribution of fat and muscle.
e. Changes in the circulatory and respiratory systems, which lead to increased strength and tolerance for exercise.

C. Features of Puberty in Boys and in Girls: The researcher highlights them as follow:

Specifically, changes that occur in adolescent girls when growing up include enlargement of the breasts and buttocks due to increase in adipose tissue (fat); broadening of the hip and pelvis; development of soft and smooth skin, growth of hair in the armpit and in the pubic region; and onset of menstruation (**menarche)**. While in boys, there is sudden increase in height, which continues every year for the next 2 to 4 years; development of deep voice, larger muscle, thicker and tougher skin, together with long and heavy bones in the leg or arms; growth of hair in the armpit, chest, an d pubic region; enlargement of penis, production of sperm (**spermache**); and wet dreams.

Each of these sets of changes is the result of developments in the endocrine and central nervous systems, many of which begin years before the external signs of puberty are evident. Some occur even before birth. Tables 6:1 and 6:2 show the sequence of physical changes at puberty in both boys and girls.

Table 6:1: THE SEQUENCE OF PHYSICAL CHANGES AT PUBERTY (BOYS)

	Characteristic	Age for First Appearance (Years)
1.	Growth of testes, Scrotal sac	10 – 13½
2.	Growth of pubic hair	10 – 15
3.	Body growth	10½ – 16
4.	Growth of penis	11 – 14½
5.	Change in voice (growth of Larynx)	About the same time as penis growth
6.	Facial and underarm hair	About 2 years after pubic hair appears
7.	Oil-and sweat-producing glands, acne	About the same time as underarm hair

Table 6:2: THE SEQUENCE OF PHYSICAL CHANGES AT PUBERTY (GIRLS)

	Characteristic	Age for First Appearance (Years)
1.	Growth of breast	8 – 13
2.	Growth of pubic hair	8 – 14
3.	Body growth	9½ – 14½
4.	Menarche	10 – 16½
5.	Underarm hair about	2 years after pubic hair
6.	Oil-and sweat-producing glands, acne	About the same time as underarm hair

D. Menstruation and Wet Dream: The researcher explains thus:

Menstruation is the monthly passing out of the lining of the uterus (womb) in the form of blood that occurs in a girl who has reached puberty. It is a physiological process occurring once in a month in women when the inner lining of the uterus is shed and released in form of blood. It is also called menses or period. This starts between the ages of 10 and 12 years and ends when a woman reaches menopause between the ages of 45 and 55. Menstruation is a sign that a girl can get pregnant. However, pregnancy is very dangerous because the body of a girl of that age is yet to develop. Getting pregnant could result in death of the girl and/or the baby.

It is very important to keep clean by maintaining good personal hygiene always most especially during menstruation. Girls menstruating should bath everyday (morning and evening) and clean their private parts (space between the legs) very well. This will prevent smelling. They must change their sanitary pad and pants at least twice a day or when soaked. They should eat plenty of fruits and take plenty of water to avoid constipation. They should also do mild exercise regularly to reduce pain and keep healthy.

Wet dream is a natural occurrence that can be an unsettling experience for a boy who is unprepared for it. If he awakens to find his short wet and sticky or hardened to a starch consistency, he may needlessly alarmed. That has happened is that pressure has built up because of the increasing rate at which sperm are manufactured. Wet dream, also known as nocturnal emission is the passage of fluid (an ejaculation of semen) during sleep from the penis of an adolescent boy at puberty. He would have noticed increase in the size of his penis and scrotum within the period and an unconscious loosing of a small amount of milky fluid from his penis at night or during sleep. Wet dream is sometimes triggered by erotic dreams, which are not always remembered. In addition, conscious sexual thoughts, prolonged sexual arousal or masturbation not resulting in ejaculation may cause wet dreams. This can happen several times in a month especially anytime the boy gets himself excited thinking about girls but can be controlled as he is getting older. Boys having wet dreams should bath everyday and clean their private parts very well to prevent seminal smell. They must change their shorts when wet, wash and dry. To prevent their bedspread from stain, thick shorts are recommended for them.

E. The Human Reproductive System: The researcher

- asks participants to mention parts of the human reproductive system they know
- notes participants' lists
- expands on lists, with the aid of a diagrammatic chart, as follows:

Sexuality is a term used to describe the feelings and activities connect with a person's sexual desires and development. I t refers to one's sexual identity and sexual feelings. Sexuality is a more complex phenomenon, which is difficult to define but perhaps easy to understand. Sexuality refers to the total sexual make up of an individual. It includes sex, sexual behaviour, and sexual intercourse. It is not confined to sexual intercourse but includes touching, talking, embracing, fantasizing, kissing, caressing or just holding hands. In addition to covering the physical aspects, sexuality also encompasses feelings, attitudes, values and preferences. It involves a lot of caring and sharing.

The reproductive organs in male and female are called gonads. These and other organs responsible for reproduction constitute the reproductive system. Both the male and female reproductive organs can be grouped into external and internal organs.

Male External Organs

Penis: It is a rod shaped organ, which hangs downward in front of the man's two thighs. It becomes erect when the man is sexually excited/aroused. Not all penises look the same. They come in a variety of shapes and sizes, which do not affect the functions of the penis. It is used for sexual intercourse, serves as passage for sperm and urine.

Scrotum: It is a bag found behind the penis. It contains the two testes, and protects the testes from damage.

Male Internal Organs

Testes: They are two round ball shaped organs held inside the scrotum. They produce the male egg (sperm cells) and store them. They also produce the male sex hormones known as testosterone.

Vas Deferens: They are tubes, which pass from each testis to the urethra. Serve as passages for sperm.

Prostate Gland: It is a gland that secretes a special fluid like substance, which helps the sperm move as they journey towards the female ovum.

Seminal Vesicle: It secretes a fluid like substance, which forms part of the semen, and provides nutrients to nourish the sperm when they are inside the woman's body.

Cowpers gland: It is below the prostrate gland. It secretes fluid that protects the sperm.

Urethra: a tube that passes through the penis. It serves as a passage for urine. Sperm passes through it during sexual intercourse.

Female External Parts

Labia Majora: Two thick outer lips or fatty pads immediately below the pubis. They cover the labia minora, and protect the vaginal opening.

Labia Minora: Two thin soft lips. Pinkish in colour and very sensitive, they are enclosed by the labia majora. They protect the opening of the urethra and vagina.

Clitoris: It is a pointed area that lies between the labia majora and labia minora. It is the area that is usually removed when circumcision is done (a harmful practice). It is the most sexually sensitive art of the woman. It serves as a point of enjoyment for the woman during sexual intercourse.

Urethra Opening: It is a small opening between the vagina and clitoris. It serves as t he outlet for urine

Vaginal Opening: An opening to the mouth of the womb (cervix) . It serves as the outlet for menstruation, holds the penis and semen during intercourse, and serve s as a passage for the delivery of the baby.

Hymen: A thin membrane covering the vaginal opening when a girl is still a virgin. It protects the vagina from infection before puberty.

Female Internal Parts

Vagina: It is the opening to the mouth of womb. It holds the penis and semen during sexual intercourse, serves as a passage for the delivery of the baby, and serves as outlet for menstruation.

Cervix: It I s the neck of the womb. It feels like the tip of the nose when touched. It opens up to allow the baby to be delivered and serves as a passage for menstruation.

Uterus (Womb): It is a big sac inside the pelvic cavity. It accommodates and protects the fertilized female egg that gets implanted until it grows into a baby. It helps to push the baby out during labour.

Fallopian Tubes: They a re two tubes that connect the ovaries to the womb. They serve as a meeting place for the sperm and female egg to be fertilized, and a passage for the fertilized egg to move to the womb.

Ovaries: They are like two small egg shape bags on each side of the fallopian tube. They produce the female egg, and produce the female hormones known as Estrogen and Progesterone that make a female look like females.

F. Sexual Desires in Humans: The researcher explains as follows:

Physiological and biological development in the individual is a continuing process from birth to old age and death. Man, like other organisms, has a biological nature. His bodily system consists of fluids, bones, skin and connective muscular and neural tissue. The functioning of these, separately or in various combinations, is the physiology of the organism.

Sexual feelings are a natural part of growing up. Adolescence is a time when an individual becomes more aware of himself as a person who has sexual feelings, which can lead to falling in love. Falling in love involves getting close to one person in mind, heart and body. It is a very powerful feeling. When two people fall in love they want to be together, talk to each other and touch each other. Biologically, they want to touch, to hold hands, to kiss, ultimately to make love. Psychologically, they want to touch too: to explore a personality distinct from their own, to love and be loved, to expose their thoughts and their fears, to be naked and unashamed, t o never to alone again. Isn't that wonderful? God make it so.

Biologically, your potential was wired in at birth. Yu have the proper organs, a male and female mix of hormones. Your sexuality is like a network of wires hidden in a wall, plastered and painted. At puberty, your wiring gets hooked into power. Suddenly sexuality becomes an active potential. Males and females are charged particles ready to bond. When the power turns on, you begin to feel that the wonder of the opposite sex is more than something to wonder of the opposite sex is more than something to wonder about. If you are a boy, you want a girl for your own. If you are a girl, you want a boy. It is a strong and thrilling (sometimes frightening) urges.

Young people have a choice about whether to show their sexual feelings and in what way. Some people decide to enjoy their sexual feelings without any action at all. Some people decide to spend more time with the person they have feelings for. They may express their feelings through kissing or hugging. Again, some people who have sexual feelings masturbate

(masturbation is the act of touching one's own sexual organs including the penis, vagina, breasts, or other parts of the body that are sensitive to sexual stimulation. It is a self-stimulation of the genitals by touch or pressure, to provide sexual arousal and satisfaction). While some may decide to have sexual intercourse with the person they are interested in.

G. Summary

The researcher summarizes that the sexual drive of the female is more complex than that of the male. The ovaries are responsible for the secretion of the principal sex hormones estrogens and progesterone. Estrogens are secreted into t blood stream each moth at the time of ovulation. The female sexual drive is definitely influenced by these hormones. This relationship is most clearly observable in the lower mammals. At ovulation, when the bloodstream is enriched with estrogens, the female dog or to her mammal not previously interested in the male becomes very receptive or aggressively suggestive in her sexual behaviour.

H. Evaluation: The researcher asks the participants to:

1. Identify the need for sex education with reference to adolescence
2. State 5 features of puberty in boys and in girls
3. Explain menstruation in girls and wet dream in boys
4. Describe the human reproductive system
5. Explain sexual desires in humans

I. Assignment: The researcher gives home work to participants to identify how they can manage their reproductive systems to practise sexual abstinence.

Session III

Topic: Sexual Self-concept

Objectives: At the end of the session, participants should be able to:

1. Define self-concept ditto sexual self-concept
2. Differentiate between self-concept and self-esteem
3. Explain how to develop and maintain sexual self-concept
4. Distinguish between negative and positive self-concepts

Materials: Flip Chart, marker, masking tape

Method/Content

A. Introduction: The researcher welcomes participants, appreciates their attendance and reviews together the home work given to them.

B. Definition: The researcher defines self-concept

Self-concept or self-identity is the mental and conceptual awareness and persistent regard that conscious beings hold with regard their own being. Self-concept is the cognitive or thinking aspect of self (related to one's self-image) and generally refers to "*the totality of a complex, organized, and a dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his or her personal existence".* By self, we generally mean the conscious reflection of one's own being or identity, as an object separate from other or from the environment.

Components of a being's self-concept include physical, psychological, and social attributes; and can be influenced by its attitudes, habits, beliefs and ideas. These components and attributes can each be condensed to the general concepts of self-image and the self-esteem. The self-concept is, perhaps, the basis for all motivated behaviour. It is the self-concept that gives rise to possible selves, and it is possible selves that create the motivation for behaviour."

C. Differences between Self-concept and Self-esteem: The researcher differentiates between self-concept and self-esteem

Self-concept is related to self-esteem in that people who have good self-esteem have a clearly differentiated self-concept. When people know themselves they can maximize outcomes because they know what they can and cannot do. It would seem, then, that one way to impact self-esteem is to obey the somewhat outworn cliché of "Know thyself." Self concept represents the picture that each of us has of ourselves. It refers to the way in which a person views himself

or herself. It is sometimes used interchangeably with self-esteem. Self-esteem is the evaluative component of self-concept.

D. How to Develop and Maintain Sexual Self-concept: The researcher explains how to develop and maintain self-concept

We develop and maintain our self-concept through the process of taking action and then reflecting on what we have done and what others tell us about what we have done. We reflect on what we have done and can do in comparison to our expectations and the expectations of others. That is, self-concept is not innate, but is developed or constructed by the individual through interaction with the environment and reflecting on that interaction. This dynamic aspect of self-concept (and, by corollary, self-esteem) is important because it indicates that it can be modified or changed. If a child is born in a royal wealthy lineage and perceives himself as such as indicative of a positive self-concept, his attitude and behavioural component that makes him to comport himself as a prince and heir however constitute his positive self esteem. It is not who you are or what you do that determines your self esteem but how much control and responsibility you assume for your relationship with yourself. Therefore a Reverend Father who rapes his church member does not have a good self-esteem.

One of the most important resources that any child can have as he or she makes life choices is a positive self-concept. All life skills that are necessary to implement knowledge, attitudes and values (life-skills, such as assertiveness, decision making, negotiation, communication, and refusal skills) are based on a healthy, positive self-concept. In addition, the role that significant others, teachers, and parents play in a child's life is crucial for a robust self-concept. It is therefore essential for parents and teachers to make children feel that they are special, likeable, worthwhile human beings who are valuable in themselves.

Adults must help children and adolescents to increase their self confidence by being honest with them, by providing reinforcement. Social forces play an important role in the adolescent's sense of self. The people with whom the adolescent interact serve as mirrors that reflect information back to the adolescent about who he or she is and who he or she ought to be. Self-concept is also influenced by a child's own achievements and by the degree to which he or she has the ability to regulate his or her own behaviour. It is therefore vitally important to

develop a high self efficacy or faith in their (adolescents') ability to meet personal and social requirements.

E. Negative and Positive Self-concepts: The researcher distinguishes between negative and positive self-concepts

Negative self-concept in children is produced by many critical factors some of which include the following: insufficient appreciative attention or regard from parents or members of the family, the conviction that they are constantly ignored and not noticed (this makes children feel invisible and therefore worthless), ridicule, excessive and irrational punishments and the insecurity that is caused by harsh and rigid rules, or the insecurity caused by too few or no rules or parental guidelines, physical violence, threatening behaviour, psychological neglect, sexual and emotional abuse, cruel and humiliating labels that make children feel worthless, useless and anxious. Additionally, other factors identified as causes of negative self concept in children are: inconsistency on the part of parents towards their children, unrealistically high expectations or inconsistent standards from parents, teachers and significant others to children, over protective attitude of parents towards their children (this makes children insecure about their own judgment and thus increases their anxiety), deprivation of basic necessities such as food, clothing, safety, shelter, and lastly, a physical disability, or a perceived physical disability, unfavourable, or humiliating comparisons based on racial characteristics.

Children with positive self esteem were found to be more independent, creative, energetic, optimistic, self reliant, sociable, assertive, self confident, relaxed, extroverted, popular at school and less self-conscious than children with a low self-esteem. The boy or girl who has a strong self-concept and who recognizes a type of behaviour as inconsistent with that self-concept characteristically will avoid that behaviour. This is congruent with the role of the self-image and self-respect in bringing consistency into behaviour. A girl who thinks of herself as master of her behaviour, who takes pride in being a person who cannot be manipulated by others, and who feels that being used for someone else's pleasure is beneath her dignity and standards is unlikely to indulge in behaviour that would injure that self-concept. Similarly, the boy who thinks of himself as a responsible person of honour and integrity, who feels contempt for preying on weaker or less knowledgeable people, and who takes pride in the honesty of his dealing with

everyone in unlikely to attempt to persuade a girl to engage in activities that might expose her to injury or criticism.

Influencing behaviour through sex education is principally an attempt to get boys and girls to form self-concepts of themselves as people who are above anything that would lessen self-respect (especially for girls), or would take advantage of another to that person's possible hurt (especially for boys). Adolescent boys and girls respond amazingly well to discussions that help them acquire firm, clear pictures of themselves as people of pride, honour, and integrity, as people who will not act out of character with the self-concept they develop and want to maintain.

F. Summary: The researcher summarizes the session by reminding participants of the importance of self-concept to sexual abstinence.

G. Review/Evaluation: The researcher asks participants the following questions:

1. Define self-concept
2. Differentiate between self-concept and self-esteem
3. Explain how to develop and maintain self-concept
4. Distinguish between negative and positive self-concepts

H. Assignment: The researcher gives home work to the participants to highlight and write out the relationship self-concept has with self-esteem, self-efficacy and self-determination in practising sexual abstinence.

Session IV

Topic: Sexual Self-esteem

Objectives: At the end of this session, participants should be able to:

1. Define self-esteem ditto sexual self-esteem
2. State 2 types of self-esteem
3. State 4 characteristic of low and 4 of high self-esteem
4. Discuss individual strengths and weaknesses of participants
5. State 4 strategies that can be developed to improve sexual self-esteem

Materials: Pieces of paper, flip chart, markers and masking paper

Method/Content

A. Introduction: The researcher welcomes and appreciates participants;

- starts the session by stating that many people have questions about their feelings and thoughts, and often doubt themselves. This happens to everybody and is a way of weighing one's society to see whether one is acceptable or not.
- states that building high self-esteem is one of the most important ingredients of a happy life.

B. What is Self-esteem? The researcher

- explains self-esteem to the participants using the following points:
  f. If you like and value yourself, and have confidence in yourself you are said to have self esteem.
  g. When you see yourself in a positive way and accept both your strengths and weaknesses, there is self-esteem.
  h. Having self esteem does not mean that you behave as if you are better than other people, rather it is that you have accepted yourself as you are.
- encourages questions and responds accordingly.

C. Characteristics of a Person with High or Low Self-esteem: The researcher

- asks participant to work in 4 groups to identify and list the characteristics of someone with low self-esteem and someone with high self-esteem.
- Each group to appoint a presenter, recorded and timekeeper
- allows 5 minutes for group work
- recalls groups after 5minutes to present
- notes comments
- encourages other participants to contribute
- expands on points as follows:

High Self-esteem	Low Self-esteem
Assertive	Very arrogant
Confident	critical attitude
Caring attitude	Rebellious
Uses interaction	Suspicious of people
Respects authority	Has an inferiority complex
Authoritative	Allows self to be pushed around ineffective

D. Individual Strengths/Weaknesses: The researcher

- explains to participants that the person you know best is yourself. This exercise will help to examine yourself more.
- distributes pieces of paper to each participant
- asks participants to write what they do best (strengths), and what they know they are often unable to do (weaknesses)
- reminds participants to include what they have heard other people say they like about them, and what they like about them
- asks a few participants to share their ideas with the larger group
- notes the strengths and weaknesses on the flip chart
- comments on points raised by participants.

E. Strategies for improving Sexual Self-esteem: The researcher

- informs students that an individual must like him/herself before others can like him/her. People who think badly of themselves often adopt bad habits and negative attitudes.
- asks participants to brainstorm the strategies that can be developed to improve self-esteem
- notes participants' contributions
- expands on points as follows:
  a. Be patient with yourself.
  b. Set goals that can be accomplished so that you will be successful, and gain confidence in your abilities.

c. Reward your successes.
d. Improve your self-image by meeting and establishing new friends.
e. Use your family as a support system.
f. Stand firm when your group members try to influence your behaviour negatively.
g. Make a decision to change what you do not like about yourself

F. Summary

The researcher summarizes that building self-esteem is a necessary skill which helps to resist peer pressure and develop positive attributes (strengths). Positive activities produce strengths while negative ones cause weaknesses. Low self-esteem results in lack of direction.

G. Evaluation: The researcher asks the participants to:

1. Define self-esteem.
2. State 2 types of self-esteem
3. State 4 characteristics of low and 4 of high self esteem

H. Assignment: The researcher gives home work to participants to identify how they can align their self-esteem to practise sexual abstinence.

Session V

Topic: Sexual Self-efficacy

Objectives: At the end of the session, participants should be able to:

1. Define self-efficacy ditto sexual self-efficacy
2. Explain how sexual self-efficacy can be developed
3. State the relationship between self-efficacy and sexual abstinence

Materials: Flip Chart, marker, masking tape

Method/Content

A. Introduction: The researcher warmly welcomes participants and appreciates their attendance and reviews the last home work with them

B. Definition of Self-efficacy: The researcher defines self-efficacy

Self-efficacy is one's belief in one's ability to succeed in specific situations (in this case, sexual abstinence). Self-efficacy values are not about individual's skills objectively; they are really about the persons' decisions of the things they can accomplish with those skills. Self-

efficacy is a term used in psychology, roughly corresponding to a person's belief in their own competence. It has been defined as the belief that one is capable of performing in a certain manner to attain certain goals. One's sense of self-efficacy can play a major role in how one approaches goals, tasks, and challenges. It is believed that our personalized ideas of self-efficacy affect our social interactions in almost every way. Understanding how to foster the development of self-efficacy is a vitally important goal for positive psychology because it can lead to living a more productive and happy life.

C. How it works: The researcher describes how self-efficacy works

Self-efficacy beliefs have an effect on psychosocial conduct. These beliefs have an effect on thought patterns, emotional reactions and thought patterns in various situations. For instance, individuals will avoid situations they believe they're not capable of handling; their level of self-efficacy also will influence their amount of effort and determine the amount they persist when confronted with failure. Those with high self-efficacy can focus more effort on the task at hand and persevere more than individuals with low self-efficacy.

D. Developing Self-efficacy: The researcher explains how self-efficacy can be developed

Self-efficacy beliefs are formed due to advanced thoughts of self-appraisal and self-persuasion from distinct efficacy resources; he listed these sources of information as past performance successes, vicarious experiences, verbal persuasion and physiological states. Past performance achievements have shown to be the most influential supply of efficacy information since they're based on a person's own experiences of success or failure. People that view past performance as positive results are going to have increased self-efficacy beliefs; however, if these experiences are deemed as failures, then self-efficacy beliefs will probably decrease.

Vicarious experiences have an impact on self-efficacy as information can be derived through persons paying attention to and looking at themselves to others. This process involves watching the performance of others, coding the result which has been observed, noting the result of the performance and then finally using that information to make decisions about your own amount of mastery. Vicarious influences likewise incorporate social judgements, including, considering other individuals in terms of their physique might have an impact on self-efficacy. Vicarious sources of efficacy information are generally regarded as weaker than past performance accomplishments.

Verbal persuasion information affects self-efficacy through elements which includes evaluative feedback, anticipation by others, self-talk, imagery together with other cognitive strategies; self efficacy beliefs determined by these sources are additionally considered to be weaker compared to those of performance accomplishments. Physiological information impacts self-efficacy as persons cognitively evaluate their physiological condition and state to make decisions about their efficacy. Physiological facts are produced from factors such as fitness, levels of fatigue and pain; as well as psycho-physiological factors just like arousal, fear, a lack of self-confidence and ones ability to get psyched up and ready for performance. Physiological information has been shown to be considered a more important supply of info affecting self-efficacy in physical exercise tasks compared to nonphysical tasks.

E. Application of Self-efficacy to Sexual Abstinence: The researcher explains as follows

In a very sports circumstance, an athlete or coach with previous high levels of performance are going to have higher self efficacy, these feelings of high self efficacy thus have a favourable effect on performance. An individual's actions and reactions in almost every situation are influenced by the actions which that individual has observed in others. People observe others acting within an environment whether natural or social. These observations are remembered by an individual and help shape social behaviours and cognitive processes. This theoretical approach proposes the idea that by changing how an individual learns their behaviours in the early stages of mental development could have a large impact on their mental processes in later stages of development. Since self-efficacy is developed from external experiences and self-perception and is influential in determining the outcome of many events, it is an important aspect of social cognitive theory. Self-efficacy represents the personal perception of external social factors. According to Bandura's theory, people with high self-efficacy – that is, those who believe they can perform well – are more likely to view difficult tasks as something to be mastered rather than something to be avoided.

Specifically, self-efficacy is relevant to adolescents' sexual abstinence practice. According to Hulton (2010), self-efficacy for sexual abstinence represents the subjects' level of confidence that they can resist having sexual intercourse across a number of tempting situations. Thus, self-efficacy for sexual abstinence is conceptualized in two ways: confidence in ability to change risk behaviours, and ability to continue these behaviours despite temptation. Bandura's

(1977) pioneering self-efficacy theory has important implications for understanding the relationship between adolescents' use of cognitive resources in pursuit of ongoing recovery from sexual initiation or for delaying sex.

F. Summary

The researcher summarizes that self-efficacy is a crucial element toward prevention and coping with the sexual urges to enhance sexual abstinence.

G. Evaluation: The researcher asks the participants to:

1. Define self-efficacy
2. Explain how self-efficacy can be developed
3. State the relationship between self-efficacy and sexual abstinence

H. Assignment: The researcher gives home work to participants to identify aspects of their lives where self-efficacy is applicable.

Session VI

Topic: Sexual Self-determination

Objectives: At the end of the session, participants should be able to:

1. Define self-determination
2. Explain self-determination in relation to sexual abstinence

Materials: Flip Chart, marker, masking tape

Method/Content

A. Introduction: The researcher warmly welcomes participants and appreciates them for their attendance at all the previous sessions.

B. Definition: The researcher defines self-determination as the quality that makes an individual to continue to do something even when this is difficult. In this case, it is the resolution and commitment to abstain from sex despite pressures.

C. Self-determination in Relation to Sexual Abstinence: The researcher explains this using 3Ds.

1. **Decision:** Make up your mind before time that you will always say 'no' to premarital sex. This will help you to accomplish your goals, determine your position and guide the action you take so that you do not regret anything.

2. **Determination:** Be firm, resolved, and determined never to have anything to do with premarital sex. Without somebody monitoring you, your decision and determination will help you out in practising sexual abstinence.
3. **Dedication:** Be committed to your resolution in words and actions.

D. Summary

The researcher summarizes that self-determination is fundamental to sexual abstinence.

E. Evaluation: The researcher asks the participants to:

1. Define self-determination
2. Explain self-determination in relation to sexual abstinence

F. Assignment: The researcher gives home work to participants to identify aspects of their lives where self-efficacy is applicable.

Session VII

Topic: Behavioural Modification towards Sexual Abstinence

Objectives: At the end of the session, participants should be able to:

1. Develop positive attitude towards sexual abstinence
2. Highlight and explain the ABSTINENCE acronym and the 3 M-Ps

Materials: Flip Chart, marker, masking tape

Method/Content

A. Introduction: The researcher

- warmly welcomes participants and appreciates their attendance
- encourages participants to develop positive attitude to sexual abstinence
- teaches participants the ABSTINENCE acronym and application of the 3 M-Ps as follows:

B. ABSTINENCE: The researcher explains abstinence with acronym as modelled by him

A – Always say 'NO' to premarital sex
B – Beware of enticement and tempting environment
S – Set limit for yourself
T – Turn down every sexual advancement/harassment
I – Insist and Incline your heart/mind on moral values
N – Negotiate abstinence with your partner
E – Exercise self control
N – Never compromise your stand
C – Correct and help others

E – Esteem yourself before the opposite sex and others.

C. The 3M-Ps as formulated by the researcher.

Mind Programming: The seat of all actions is the mind. Whatever can be processed and achieved in the mind can be realized physically. Have a mindset that you can practice abstinence irrespective of how overwhelming your urges are. You may not be able to influence or determine the actions of others but you can determine your own action by controlling what you think. Let it sink into your subconscious mind that you cannot grow above your thought. So, on daily basis, consciously think about abstinence as a dream that can come true in your life. Turn down every word, literature, film that can or has misinformed you that you cannot be abstinent in this age.

Mind Projection: The mind is like the processor of a computer. It is able to store and retrieve data stored through experience and thought. Learn to speak to yourself daily about abstinence. Stand before a mirror and address yourself "Come what may, I will not involve in premarital sex", "I will wait to have sex in marriage". Touch your sex organs an echo same words to yourself. Funny? Yes, so it seems. Do you know that the dream you have in the night sometimes or often results from the rooted thought in your subconscious mind during the day? So also is what you can constantly say and do to yourself. You will soon discover that even if you are seduced in your dream, you will vehemently refuse, as often demonstrated during your wake up hours. That is the power of the mind.

Mind Pastoral: This practice involves you, each day you wake up in the morning, to empower your mind with at least a word or quotation that will remind you of your values, and help to sustain your decision to remain abstinent. Find below seven nuggets, one for each day of the week, to strengthen your commitment to abstinence.

- *A physical expression of intimacy (sexual intercourse) is an extension of the mental experience. The act that has not taken place in your mind cannot be physically expressed.*
- *There is no possibility of having sexual intercourse without meshing a part of your non-physical self. Sex is such a definite experience that a part of each of you remains forever a part of the other. How many times and how casually are you willing to invest a portion of your total self and accept such an investment from another person, with no assurance that the investment is for keeps?*
- *Sex is inherently good! But inherently good sex is debased when used in an improper context.*

- *No one knows what effect sex, precociously experienced, will have on the immature mind. Sex experience before confidentiality, empathy, and trust have been established can hinder and may destroy the possibility of a solid, permanent relationship.*
- *A relationship based on physical attraction may hold itself together for three to five years. During that length of time two people are fooled into thinking, "Well, we've been going together for so long, surely we can make it for a lifetime. This must be love". On the other side of marriage, they wake up to see they had little in common and no basis for a quality relationship.*
- *There is only one safe way to remain healthy in the midst of a sexual revolution. It is to abstain from intercourse until marriage, and then wed and be faithful to an uninfected partner.*
- *Sexuality is a major part of every human being, a very integral feature of the male/female relationship, and a gift to be used and given freely and wonderfully in the proper context.*

▪ encourages participants to master the acronym and appropriately apply it in real life situations

D. Summary

The researcher summarizes that sexual abstinence requires discipline and conscious efforts to achieve, which the highlighted acronyms can help sustain.

E. Evaluation: The researcher asks the participants to:

1. Enumerate what each letter in the ABSTINENCE acronym stands for
2. Explain each of the M-Ps model

F. Assignment: The researcher gives home work to participants to map out how they can apply the ABSTINENCE and M-Ps models to practise sexual abstinence.

Session VIII

Topic: Revision of All Activities in the Previous Sessions and Administration of Post-Treatment Measures.

Objectives: At the end of the session, participants should be able to:

1. Summarise their experience based on what they have learnt from the treatment
2. Respond to the post-test instruments

Materials: Flip Chart, marker, masking tape, post-test instruments

Method/Content: The researcher

- warmly welcomes participants and appreciates their attendance at all sessions
- asks participants to share their experiences based on their developed positive attitude to sexual abstinence from the self-components training
- distributes copies of the post-test instruments for the participants' responses
- retrieves the completed responses from the participants
- thanks the participants for their attendance and cooperation and then gives them incentives – light refreshment, copies of books (The Beauty in Virginity, Adolescent Sexuality; Implications for Counselling, Staircase to Happiness, Love or Lust?, and Integrity – all written by the researcher), and token for their transportation.

The Control Group

The control group (A_3) will contain the participants selected for the training but this group will not be treated for the eight weeks, but be subjected to a non-therapeutic talk titled, "goal setting towards academic excellence".

Session I

Administration of Instruments to obtain Pre-test Scores

The researcher will assemble all the participants for an interactive session and welcome them to the programme. The researcher will introduce himself to the group and at this point inform the participants of the instruments to be completed which would help him determine the present status of the participants on sexual abstinence. The researcher will tell them that their objective, honest and independent responses are very vital. There will also be provision of writing materials – books and pens to jot important points at the second session of interaction for talk delivery.

The researcher will administer the instrument for the pre-test measure to all the members in the group A_3 copies of Sexual Abstinence Scale (SAS), Peer Pressure Inventory (PPI), and the Sexual Abstinence Achievement Test for Adolescents (SAATA). He will explain how participants are expected to respond to the instruments. Participants will be encouraged to be independent and be objective in responding because the scores will be for research purpose. Questions will be asked for clarification from participants on the instruments. The researcher will collect the instruments after they had all responded. Scores collected from these instruments completed during this session will be used as the pre-test scores. The researcher will announce date, time and venue for the next session for the talk delivery.

Session II

Talk Delivery: The researcher will welcome participants and appreciate their commitment. He will then introduce the topic of interest for consideration, "Goal Setting towards Academic Excellence".

Goal Setting Towards Academic Excellence

Excellence is a quality of being very good, distinguished and outstanding; it is not a trait, hence it cannot be inherited. There is no one way of achieving excellence academically; it is how you apply the principles governing it that determines the outcome. Excellence comes with a price, only those who understand its worth can pay for it. The following are some tips that can help you in your quest for success; they are relative but sure you will find them fascinating.

- **Have a Sense of Direction**

Don't start your session without having a sense of direction; if you do not set an achievable target for yourself, you will discover very late that you are studying aimlessly. Be ambitious and always aspire to be the best because you deserve it; don't settle for less, believe in yourself, set out plans and develop strategies to accomplish them. **Setting targets ignite your passion** and that is the driving force that will propel you towards excellence.

- **Prioritize**

Many students have problems of misplaced priorities because they find it very difficult to order things according to their importance. You have to understand that **your primary reason for being in school is to study** in order to come out with good grades that will give you an edge in this highly competitive world; every other thing is secondary such as clubs, associations, parties etc. How you channel your resources and apportion your time is a function of what your scale of preference is like. If your academics is important to you, you will invest your time, money and energy; you will do anything to get the right materials and textbooks to upgrade you and make you a better student, but if you pay more attention to trivial and inconsequential things; you might soon be on your way to failure.

- **Be Disciplined**

Discipline is a very essential principle of excellence that is lacking in the lives of so many youths hiding under the shadow of freedom to do anything. **Self discipline is a conscious control over your lifestyle** and you need to nurture it because it is one of an achiever's greatest weapon.

Some students have worn indolence as a robe, nonchalance as a footwear and procrastination as a hat getting dressed to travel the road of shambles; they look into the mirror of stupidity with so much satisfaction and bid their studies goodbye. They get to the end of the road only to see an ocean of failure; they skillfully dive into it and continue to swim in confusion until they are being swept away by a tide of destruction. You should be disciplined enough to have a study timetable that guides you like a map in a journey; be punctual for all lectures and complete your assignments without waiting for deadlines; be committed to your study time and you can be sure of remarkable results and robust grades.

- **Stay Focused**

You must not just gaze but condition your mind to one important goal you must achieve**. Know what you want and go for it with all determination, enthusiasm and optimism**. Distraction can come in any form such as businesses, relationships, friends, families and so on; note that not so many things can travel with you on the way to success; a lot of unwanted baggages have to be dropped because they might slow you down. There are things that can wait because they will always be there; however if you cannot make sacrifices for your academics, then don't think about excellence. Excellence is not plucked from a tree or picked on the road; it takes a lot of commitment and discipline to achieve it. When your eyes are fixed on something, you can hardly miss any detail and even when there are times when you are tempted to shift grounds, return as soon as you acknowledge it because the farther you move away from your goals, the lesser the chances of achieving them. In-school adolescents need to be very careful not to allow "campus love" or relationships to sweep their quest for academic excellence under carpet.

- **Be a Time Manager**

As endless as TIME is, you cannot hold onto it; as the clock ticks and seconds count, you're getting closer to your end no matter how old you live. Time management is the act of controlling and organizing events as they are being influenced by time; this has become a skill because many students are guilty of mismanagement. Even if 24 hours were increased to 48 hours in a day, many will still complain it's not enough. There is time for everything; time to be admitted and time to graduate, time to study and time to write exams. Procrastination has eaten deep into the minds of some students such that everything is always for a later date, they start their day without proper planning on how to apportion their time and instead of controlling the events,

they end up being controlled by them, they slump into their beds at the end of each wasted day, wake up the next day worthlessly and remain the same. At the start of each semester, many busy about with frivolities and when exams draw close; they start expecting miracles, rush and muddle up things, write exams ill-prepared and expect fantastic results. Instead, make a deliberate effort to plan your day, make a list of events and appointments and make sure you are disciplined enough to meet up. **Time is a free but non-renewable resource, so spend each moment wisely.**

- **Keep the Right Company**

You are who you move with, there are different kinds of companies you can keep in an academic environment but the choice of those that can make or mar you is entirely yours to make. Students form cliques for different reasons; to some, it gives them a feeling of importance while for others; it's a way of being a part of something. For good companies, it has to do with mingling with people of similar interests and goals, people of like minds, passion and vision who have excellence as their watch word, people who believe in your dreams and are ready to push you through. It can be a study group where you exchange ideas, learn and also impart others. Although you must develop yourself independently, you cannot be an island because **the more you share your knowledge, the more you know**; don't be scared of making mistakes, you stand to be corrected but remember that your clique can only help you outside the examination hall, so maximize the moments you share with them. If you ever develop any form of academic apathy, the best thing to do is to talk about it; let people with positive thinking advise you and deliver you from misery.

For bad companies on the other hand, your circle of friends are like viruses that corrupt your mind, becloud your thinking and cause you to lose yourself and your purpose for living. They lure you into all forms of vices such as drugs, gambling, prostitution, cultism, internet fraud, examination malpractices and so on. If they determine the kind of life that you lead, so mighty will be your fall and guess what - you will be falling alone; some are in complete jeopardy and are looking for partners in failure. Quickly identify bad friends and dissociate yourself before you become entangled. Evil and Excellence both start with the letter 'E' but they are two separate roads you cannot travel at the same time.

- **Don’t Be a Photocopy**

Carve out your own niche; know what you are capable of doing and the extent you can go. Be yourself and never try to study like someone else; understand your pattern of learning and develop your style of studying. Never compare yourself with anyone because people apply principles of success differently; this is what I mean, for example, students in the same class receiving the same lecture under the same condition cannot assimilate at the same rate. Know your pace, never give up, try to catch up and you will soon be up. Recognize your time of maximum assimilation, day or night and fix up your study timetable; **never follow friends to study when it is very inconvenient for you**, you might just be the greatest loser, so be wise.

- **Prepare Effectively**

Examination is a test designed to measure the academic aptitude of students to ascertain their level of understanding of a particular subject. Knowing fully that you have to pass it to be promoted to the next level, why won’t you give it your best shot. Don’t start studying too close to exams, you will only be tasking your brain too hard, denying yourself of enough rest and putting your entire body system in a state of higgledy-piggledy. Information is being stored over time and not spontaneously, no magic will magnetize answers to your brain, so why don’t you make sacrifices, burn the mid night oil, go the extra mile and do your best, stay healthy with a good diet and be punctual for all your exams . **You don’t have to cheat if you have played your role well** because you will be destroying your image and peradventure you get caught, the consequences are very severe, so beware.

Tips to Boost your Academic Performance

1. Go to Class Regularly

Availability of textbooks and e-library can sometimes make it tempting to skip class, access the lecture notes from colleagues, and learn the material on your own. Although you can probably get away with this in easy courses, you’ll face problems in challenging ones. By skipping class, you miss out on a few important things: detailed verbal explanations that are germane to understanding the material; the chance to ask questions and listen to the questions and answers of other students; and special announcements. It’s also important to consider how skipping class affects your reputation. In most classes, grades are somewhat subjective. This means that the

grader's perception of you can make or break your grade. If you frequently miss class, you'll be perceived as someone who lacks respect for the lecturer and the subject matter. It will be practically impossible for you to enjoy any opportunity of upgrade from marginal scores such as 39F to be rounded up to 40E. It sounds like a no-brainer, but it's too important to not mention. Skipping class can make you look bad in the eyes of your teachers. Since grades are somewhat subjective, it's a good idea to avoid irritating the person who will be handing out the marks. If attendance is an issue, you could be stuck with a C or D versus the A or B you ought to have.

2. Participate in Class

If you're shy or new to system, it may be difficult to muster enough courage to participate in class. Nevertheless, that is exactly what you need to do. Class participation shows the lecturer you are eager to learn. It also increases the likelihood that you will remember material from class to class. Not only will sitting in the front row build self confidence, it will automatically engage you in the lecture. You'll appear to be an eager student and highly visible to the lecturer. This will help your academic reputation and make it more likely you'll develop a relationship with the lecturer. You'll have a much easier time maintaining focus and will feel more like a participant than a passive observer. Lectures tend to build on previous material. If you encounter a lecture or concept that you do not understand, you should address the issue immediately to avoid getting completely lost. Confusing points can be clarified with help from your lecturers, classmates or library resources.

3. Organize Yourself and Take Notes By Hand

If you don't have a study strategy, you can study all day and night and still not get anywhere. The only sure way to make the most of your study time is to employ a study strategy that complements your schedule and learning style. Getting organized is one of the easiest ways to make good grades in school. When you're organized, you automatically reduce the amount of time and effort that it takes to do well in the tertiary institution. Things you should organize (besides your thoughts) include: your class schedule, notes, study time, reading assignments and handouts. Different lecturers have different teaching styles. Some lecture, some use power point slides and some depend on handouts and textbooks. The inconsistency can make note-taking problematic from class to class. The best way to handle this is to develop a note-taking system that works with each lecturer's teaching style. The sooner you can get started on your

assignments, the better. Try keeping a list of proven information sources, web apps and other dependable resources so that you can find something the second you need it. The saved time can be used to study, have fun or just sleep. One unfortunate side effect of the PowerPoint revolution is that it discourages students from taking notes. Taking notes by hand will improve your grades because: it forces you to pay attention; and the physical act of writing aids memorization. If you take notes, you'll find it much easier to stay engaged. Your notes also provide a point of reference that will help you build a mental link between a written concept and the professor's verbal explanation. This is key for efficient studying.

4. Do a Weekly Study Review

A common problem students encounter is trying to learn an enormous amount of material right before the mid-semester or final exam. This is practically impossible. You'll find it much easier if you take a gradual approach to studying. At least once a week, review your notes starting from the beginning of the course. This only needs to take 15 or 20 minutes, just enough time to build familiarity with the material. By doing a weekly review you'll gradually memorize everything and will better understand how one concept builds on the next. Putting in small amounts of effort on a consistent basis will drastically reduce the amount of studying you need to do right before the test.

5. Go to Office Hours

Teachers usually make themselves available at regular times during the break for students to ask questions about assignments. Do yourself a favour by taking advantage of this opportunity. First, attending office hours will motivate you to get ahead on your work and prepare questions to ask. This will give you a huge edge in understanding problems that aren't clearly explained in the classroom. Second, it will build your reputation as a high-effort student who deserves high grades. If you aren't happy with the grades you're currently getting, you may want to consider talking to your teachers. Just remember to be polite.

6. Befriend Smart Students with High Grades

In subjects that involve group work, this is essential. No one wants to get stuck with bunch slackers, have to do all the work themselves, and end up with a poor grade to show for it. The quality of your learning experience is directly related to the attitudes of the people you work with. Working with smart people will facilitate discussion. The best way to understand an idea is

talking about it with other intelligent people. Who you work with also affects your academic reputation. If you associate with students that aren't interested in learning, teachers will assume you feel the same way. It's also a great way to connect with people who have similar interests and ambitions. You're bound to make lots of friends in your citadel of learning. If you can, try to spend some time with a study friend who performs well in the class. Your smart friend will be able to help you out when you struggle and may prove to be a good influence should you feel the urge to slack. Taking part in a study group is one of the best ways to stay on track and make good grades. Study groups not only make you accountable, they also force you to become more organized and talk about what you have learned. If you can't find a study group to join, try forming one yourself.

7. Avoid All-Nighters

Generally, having to pull an all-nighter means that you slacked off all semester and need to fit 3 months of learning into one day. If you use a gradual study strategy this will never be necessary. All-nighters don't work! Yes, it might be possible to get a good grade if the course is easy, but it's much more likely that your grade will be significantly lower. All-nighters harm performance because they make you tired and stressed. You'll also forget most of what you learn right after the test, decreasing the practical value of your education. Rote learning is not the best. Although it's good to spend a fair amount of time studying before a test or examination, it's just as important to get enough rest. Sleep improves concentration, solidifies what you have learned and improves your ability to organize and recall information. Poor performance in school can often be directly linked to sleep deprivation.

8. Make Use of Library

Hostels or dorm rooms aren't the best place to study. It's way too easy to get distracted by roommates and visitors. Your study time can be more productive if you use your school's library or a similar facility. Every time you enter that building, your mind will shift into work mode and stay there until you decide to leave. You should read everything that is assigned to you and then some. Reading a lot makes you a better thinker, better writer and, most importantly, better student. Although certain classes are more interesting (and more important) than others, it's essential that you take every class seriously. If you can maintain a good grade in each class, it will make a huge difference on your overall cumulative performance.

9. Study Smart

To make sure you're ready on exam day, begin studying as soon as you can. Take a little time to review the subject matter each day so you'll be better prepared than you would be if you waited until the last minute to cram.

10. Set a Goal and Reward Yourself

Good grades are their own reward, but it doesn't hurt to have a little extra incentive. Try setting a goal on scores or grades you want and rewarding yourself with something that you really want after you achieve it. Celebrate yourself as much as possible when you achieve your goal. As you follow these steps, you will see your academic performance boosted. Good luck!

Session III

Administration of Post-test at the Eight Week.

The researcher will warmly welcome the participants and appreciate their commitment at the last session. He will then go ahead to administer the instruments to obtain post-test scores of the participants, to be used for the purpose of analysis.

Method/Content: The researcher

- warmly welcomes participants and appreciates their attendance at the last session
- asks participants questions from the talk delivered at the last session on achieving academic excellence
- distributes copies of the post-test instruments for the participants' responses
- retrieves the completed responses from the participants
- thanks the participants for their attendance and cooperation and then gives them incentives – light refreshment and copies of pamphlets (Education Digest and Towards Academic Excellence: Boost your CGPA – written by the researcher).

APPENDIX III – THE INSTRUMENTS

- **Sexual Abstinence Scale (SAS)**

- **Sexual Abstinence Test for Adolescents (SATA)**

Instruction: This questionnaire is intended for gathering relevant information from in-school Nigerian adolescents about their sexual experiences. The information gathered is strictly for academic purpose. Therefore, all needed information should be relevantly and honestly given, as the responses shall be treated confidentially.

Read each item carefully and fill/thick ( ) the appropriate alternative.

Part I

(1) School: ……

(2) Sex: Male ( ) Female ( )

(3) Age: …….....

(4) Class: …….

(5) Birth Order: First born( ) Second born ( ) Last born ( ) Others ( )

(6) Family: Monogamy( ) Polygamy( )

(7) Family size (total no of your family members): ……..

(8) Father's occupation: ……

(9) Mother's occupation: ……..

(10) Parents status: Divorced ( ) Living together ( )

(11) Religion: Christian ( ) Muslim ( ) Traditionalist ( )

Part II

1. Have you started menstruating/having wet dream? Yes ( ) No ( )
2. Your age at first menstruation/wet dream: …….
3. Have you voluntarily chosen to abstain from sex? Yes ( ) No ( )
4. Have you ever had sexual intercourse? Yes ( ) No ( )
5. Your age at first intercourse: …….
6. Did you use any contraception (e.g. pill, condom) at first intercourse? Yes ( ) No ( )
7. What led to your first sexual contact? Rape ( ) Force ( ) Carelessness ( ) Mutual consent/agreement ( )
8. Your feeling at first intercourse: Depressed ( ) Guilty ( ) Unhappy ( ) Satisfactory ( )

9. If you have never had sex; Why? Fear of pregnancy ( ) Fear of HIV/AIDS ( ) I'm not yet mature ( ) my religion prohibits it ( ) Nobody demands sex from me ( ) *Tick as many as applicable to you*
10. Did you personally set goal to abstain from sex before marriage? Yes ( ) No ( )
11. Do you receive support from your parent to abstain from sex? Yes ( ) No ( )

- **Peer Pressure Inventory (PPI)**

Here are some *PAIRS of STATEMENTS* describing *PEER PRESSURE* -- which is when your friends encourage you *to do* something or to *not do* something else. For each pair, *READ* both statements and decide whether friends mostly encourage you to do the one on the *LEFT* or the one on the *RIGHT*. Then, *MARK AN "X"* in one of the boxes on the side toward the statement you choose, depending on *HOW MUCH* your friends encourage you to do that (*"A Little," "Somewhat" or "A Lot"*). If you think there's *no* pressure from friends to do *either* statement, mark the middle ("*No Pressure*") box.

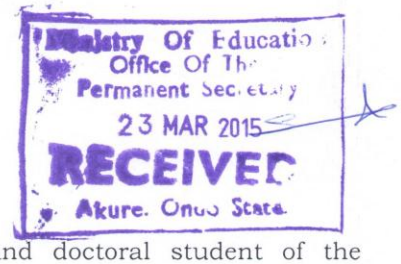
Remember, mark *just ONE "X"* for *each* pair of statements.

HOW STRONG is the pressure from your FRIENDS to:	**A LOT**	**SOMEWHAT**	**A LITTLE**	**NO PRESSURE**	**A LITTLE**	**SOMEWHAT**	**A LOT**	**Or to: .....**
Try to do what your parents want you to do	3	2	1	0	-1	-2	-3	Go against your parents' wishes
Have a steady boyfriend or girlfriend	3	2	1	0	-1	-2	-3	NOT just go out with one guy or girl
Get home by the time your parents say you should be	3	2	1	0	-1	-2	-3	Stay out past the curfew time your parents set
NOT go to parties	-3	-2	-1	0	1	2	3	Go to parties

Wear the SAME types of clothes your friends wear	3	2	1	0	-1	-2	-3	Wear styles of clothes DIFFERENT than your friends
"Make out" (kissing or petting)	3	2	1	0	-1	-2	-3	NOT "make out" (kissing or petting)
Spend your free time alone or with your family	-3	-2	-1	0	1	2	3	Spend your free time with your friends
Go out with boys/girls (opposite sex)	3	2	1	0	-1	-2	-3	NOT go out with boys/ girls (opposite sex)
Talk back or "smart off" to adults	-3	-2	-1	0	1	2	3	Show respect for adults
NOT cut classes or skip school	3	2	1	0	-1	-2	-3	Cut classes or skip school
Ignore what your parents tell you	-3	-2	-1	0	1	2	3	Do what your parents tell you
Have the SAME opinion about things as your friends do	3	2	1	0	-1	-2	-3	Have DIFFERENT opinions than your friends do
NOT let your parents know where you go,	-3	-2	-1	0	1	2	3	Tell your parents where you go and what you do
NOT go "all the way" (not have sexual intercourse)	-3	-2	-1	0	1	2	3	Have sexual intercourse (go "all the way")
Do things to impress members of the opposite sex	3	2	1	0	-1	-2	-3	Try NOT to impress members of the opposite sex

General Studies Unit,
Achievers University,
Owo.
30th January, 2015.

The Permanent Secretary,
Ondo State Ministry of Education,
Akure.



Dear Sir,

Request for Ethical Approval

I, Taiwo Samuel ADENEGAN, a researcher and doctoral student of the Department of Guidance and Counselling, University of Ibadan; and a lecturer in Achievers University, Owo, hereby humbly request your permission and approval to administer my research questionnaires among some selected JS 2 students in Ondo State (Owo and Akure Metropolis as case study), and consequently give a moral training among the sampled participants in congruence with the purpose of the research.

The research is geared towards increasing the campaign against moral decadence in our society and to prevent among the in-school early adolescents, sexually transmitted infections, teenage pregnancy, and academic under-achievement, among other ills. The exercise is for academic purpose and will be beneficial not only to the recipients, but also to the school authorities, parents, government and the society alike.

Consequently, I shall be very grateful if my request can be approved for this result-oriented exercise. Please find attached a letter of introduction from the Department of Guidance and Counselling, University of Ibadan, Ibadan.

Thank you for your understanding and anticipated cooperation.

Yours faithfully,

ADENEGAN, Taiwo Samuel
Researcher
0803-690-5869

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

DEPARTMENT OF GUIDANCE AND COUNSELLING

Head of Department
PROF. J. O. OSIKI
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Other Professors:
C.B.U UWAKWE
AJIBOLA O. FALAYE
S. O. SALAMI

Date: 30th January, 2015

The Permanent Secretary
Ministry of Education (Ondo State)
Akure

LETTER OF INTRODUCTION

This is to certify that ADENEGAN, Taiwo Samuel with Matric No. 130643 is one of our M.Phil/Ph.d students in the Department of Guidance and Counselling, University of Ibadan. He/She would like to collect data for his/her thesis titled: Psychoeducational Group Therapy and Self-Components Training in Enhancing Sexual Abstinence among In-School Early Adolescents in Ondo State.

Kindly assist him/her in any way you can.

Thank you.

DEPARTMENT OF GUIDANCE & COUNSELLING
30 JAN 2015
Head of Dept.
Prof. J. O. Osiki,
Head of Department.
UNIVERSITY OF IBADAN

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

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AJIBOLA O. FALAYE
S. O. SALAMI

Date: 30th January, 2015

The Principal,
Amunye C.A.C. High School,
P. M. B. 1050,
Ondo.

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Kindly assist him/her in any way you can.

Thank you.

DEPARTMENT OF GUIDANCE & COUNSELLING
30 JAN 2015
HEAD OF DEPT
UNIVERSITY OF IBADAN

Prof. J. O. Osiki,
Head of Department.

General Studies Unit,
Achievers University,
Owo.
30th January, 2015.

The Principal,
Amunye C.A.C. High School,
P.M.B. 1050,
Owo.

Dear Sir,

Request to Carry Out Research and Training among Your Students

I, Taiwo Samuel ADENEGAN, a researcher and doctoral student of the Department of Guidance and Counselling, University of Ibadan; and a lecturer in the above named Institution, hereby humbly request your permission and approval to administer my research questionnaires among your JS 2 students, and consequently carry out training to enhance sexual abstinence practice among the sampled participants.

The exercise, which will take a period of 8 weeks, is for academic purpose and will be beneficial not only to the recipients, but also to the school authority, parents and the society alike. The research is geared towards increasing the campaign against moral decadence in our society and to prevent among the in-school early adolescents, sexually transmitted infections, teenage pregnancy, and academic under-achievement, among other ills.

Consequently, I shall be grateful if a convenient time (not less than 45 minutes) of one day in a week can be administratively and officially approved for this training and result-oriented exercise. Sequel to your approval, consent forms will as well be given to the subjects for their assent and permission from their parents/guardians.

Thank you for your understanding and anticipated cooperation.

Yours faithfully,

ADENEGAN, Taiwo Samuel
Researcher
0803-690-5869

Approved

PRINCIPAL
AMUNYE C.A.C HIGH SCHOOL
O W O.
2-2-15

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

DEPARTMENT OF GUIDANCE AND COUNSELLING

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Other Professors:
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AJIBOLA O. FALAYE
S. O. SALAMI

Date: 30th January, 2015

The Principal,
St. Michael Secondary School,
Iyota Road
Akure

LETTER OF INTRODUCTION

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Kindly assist him/her in any way you can.

Thank you.

DEPARTMENT OF GUIDANCE & COUN... 30 JAN 2015 HEAD OF DEPT UNIVERSITY OF IBADAN

Prof. J. O. Osiki,
Head of Department.

General Studies Unit,
Achievers University,
Owo.
30th January, 2015.

The Principal,
St. Michael Secondary School,
Ijoka Road,
Akure.

Dear Sir,

Request to Carry Out Research and Training among Your Students

I, Taiwo Samuel ADENEGAN, a researcher and doctoral student of the Department of Guidance and Counselling, University of Ibadan; and a lecturer in Achievers University, Owo, hereby humbly request your permission and approval to administer my research questionnaires among your JS 2 students, and consequently give a moral and academic training among the sampled participants, to enhance their better academic performance.

The exercise, which will serve as control measure to my experimental groups, is for academic purpose and will be beneficial not only to the recipients, but also to the school authority, parents and the society alike. The research is geared towards increasing the campaign against moral decadence in our society and to prevent among the in-school early adolescents, sexually transmitted infections, teenage pregnancy, and academic under-achievement, among other ills.

Consequently, I shall be grateful if my request can be administratively and officially approved for this result-oriented exercise.

Thank you for your understanding and anticipated cooperation.

Yours faithfully,

ADENEGAN, Taiwo Samuel
Researcher
0803-690-5869

The school administrator will assist you. Your request is approved.

ST. MICHAEL CATHOLIC HIGH SCHOOL, AKURE
V. P. ADMIN
DATE 4/3/2015

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

DEPARTMENT OF GUIDANCE AND COUNSELLING

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S. O. SALAMI

Date: 30th January, 2015

The Principal,
Ovo High School,
P. M. B. 28,
Ovo.

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Kindly assist him/her in any way you can.

Thank you.

Prof. J. O. Osiki,
Head of Department.


Self-Components Training Session at Owo High School


Focus Group Dicussion Sessions at Owo High School


Pre Test Session at Owo High Schoo


Focus Group Discussion Sessions at Amunye Grammar School


Pre Test Session at St. Michael School, Akure Post Test Session at Amunye Grammar School


Interactive Sessions at Owo High School

Post Test Session at Amunye High School

Psycho-educational Group Therapy Session at Amunye

Screening Test at Owo High School

Control Group at St. Michael School, Akure

Post Test at St. Michael School, Akure

General Talk at St. Michael School, Akure