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*Nigerian Journal
of
Clinical and Counselling Psychology*

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Prospective contributors should take particular note of the following details:

- (1) The entire manuscript, which includes the title page, abstract, and key words, text, tables, figures and legends, should be typewritten on A4 size paper, double-spaced. Manuscript length should not normally exceed 20 pages.
- (2) A concise abstract of not more than 150 words should be included.
- (3) Authors should follow the reference and citation styles as prescribed in the publication manual of the American Psychological Association (APA).
- (4) Each article submitted for consideration must be accompanied with non-refundable reviewer's fee of 145, 000 in cash or bank draft.

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Education,
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Education ,
Ahmadu Bello
University
Zaria, Nigeria

Anthony V.
Naidoo
University of
Western
Institute of
Counselling
Bellville 7535
South Africa

Adedeji S. Olugbenga
Department of
Educational
Management,
University of Ibadan
Ibadan, Nigeria

Virginia A.
Department of
Educational
Educational
Psychology
University of Port
Harcourt
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Nigeria.

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Guidance &
Counselling Centre,
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From the Editor

These fourteenth and fifteenth publication of the Nigerian Journal of Clinical and Counselling Psychology is thought out under a new Editorial Team, I therefore place on record the most invaluable editorial work of the former Editor, Professor Helen Nwagwu. Her editorial erudition for more than a decade has placed the Journal on an enviable position.

It is on this success note; I midwife the first publication and the fourteenth edition under my editorial leadership. While I appreciate the support of the contributions and our numerous reviewers, I want to stress it that it is the new policy of the Journal to ensure timely publication. This is in line with acceptable international practice. Suffice to note that sixteenth edition of the Journal (2010 and 2011) will be out before the end of the year. Efforts in this regards are on.

In this edition, twenty-six papers of two volumes are published. The papers not only cut across a wide spectrum of ideas and views in Psychology, Education, Management, Health and Spirituality, the papers are also well thought out and seasoned. Their preferment for publication by the Editorial Board of NJCCP is borne out of the profile of integrity of the Journal. This will be sustained.

Trust you will enjoy the articles in this edition.

Oyesoji Aremu, CF., JP.

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**Psychosocial Factors and Knowledge of Early
Adolescents' Attitude to HIV/AIDS in Ibadan, Nigeria**

**Aremu A. Oyesoji, Adindu Peace Akunna &
Adeyemi A. Olubisi**

Dept. of Guidance & Counselling,
University of Ibadan, Nigeria.

Abstract

The study investigated the influence of some psychosocial factors (self-efficacy, emotional Intelligence, gender and age) and knowledge on HIV/AIDS attitudes of early adolescents. 240 school-going early adolescents (132 males and 108 females) aged between 10 and 14 years participated in the study. The measured effects of the independent variables using the Pearson r and hierarchical regression statistics indicated a joint relationship of the measures on HIV/AIDS attitudes of early adolescents. Similarly, participants' self-efficacy, EI, knowledge of HIV/AIDS, and age also influenced their attitudes towards HIV/AIDS. These findings suggest that early adolescents' attitudes towards HIV/AIDS could be improved through the variables investigated.

Key words: Self-efficacy, Emotional Intelligence, Knowledge of HIV/AIDS, Early adolescents, Nigeria.

Introduction

The study of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) has not ceased to attract the attention of researchers. Hall, Holmquist, and Sherry (2004) report that approximately 15 million new sexually transmitted infections (HIV inclusive) occur annually; and majority of these infectious are among adolescents. Peltifor, et al (2003) assert that the peak incidence of HIV/AIDS occurs in young people aged 15 to 24 years. Similarly, Fleisher,

Ziervogel, Chalton, and Robertson (1994) contend that adolescents are move increasingly likely to become sexually active earlier in life, have more frequent sexual experiences with partners known for a short time, have more sexual partners, and to use contraception less frequently. From Fleisher et al's (1994) submission, it is clear that adolescents are capable of being sexually active very early. Oliver (1996) corroborates these assertions by summing up that although older adolescents (15 to 18 years) are more sexually active, younger adolescents (10 to 14 years) are also sexually active. As a corollary, Moore and Rosenthal (1991) examine adolescents' AIDS risk perceptions and conclude that 42 percent of their sample had engaged in vaginal sex with a casual partner (individual with whom one has had sexual intercourse on one occasion or rarely) and 80 percent with a regular partner (individual with whom one has an exclusive sexual relationship). They state further that of the 42 percent who had engaged in vaginal sex with a casual partner, 28 percent always used a condom, and 25 percent never did. With regards to the number of sexual partners involved. 28 percent had had no partners, 50 percent had had one partner, 12 percent had had two partners, and 10 percent had had three or more partners, all in the last six months of the survey. Steitz (1993) observes that many people who develop AIDS in their 20s encountered HIV virus while in their teens (early adolescents). He reports that the survey of adolescents' baseline knowledge about AIDS indicates a general increase since 1995 and suggests grade level differences, with older students having more knowledge. For instance, Price, Desmond and Kukulka (1985) posit that line, out of nineteen questions on HIV/AIDS were answered correctly by 75 percent of 16 to 19-year-old students in Ohm United States of America (USA). Similarly, Strunin and Hingson (1987) aver that in Massachusetts in the USA only two out of nine questions on HIV transmission were answered correctly by 75 percent or more of their adolescent participants. They conclude in their findings that knowledge of HIV did not guarantee a positive effect on the behaviour of the 70 percent who reported being sexually active, only 15 percent indicated that they had modified their behaviours.

Further, only 20 percent of those who had modified their behaviours used an effective method of protection. The import and reality of these findings speak volume about the level of poor knowledge of HIV/AIDS among adolescents. Therefore, more research should be conducted, most especially among early adolescents in Nigeria, where paucity of literature exist on the subject. Even the existing literature in Europe and America revealed little on early adolescents' knowledge of HIV/AIDS.

The question then is what prompts adolescents into taking such a risk; and or, what are the factors responsible for the risky behaviour. According to Havighurst (1953) and Louw, Van, and Louw (1998), adolescents are faced with the challenge of sexual development, which they describe as a task that arises in specific developmental stages within an individual's life. The period of adolescence is noted to be characterised by accelerated physical growth. Accompany this, among other things is the development of sexual maturity. This sexual maturation, for example, in adolescent girls is marked by the development of sexual characteristics (e.g., menarche-first menstruation); and in adolescent boys by the first seminal emission. Another developmental task confronting adolescents is holistic identity. According to Erikson (1968), the chief task of adolescence is to confront the crisis of identity versus identity confusion (or role confusion), so as to become a unique adult with a coherent sense of self and a valued role in the society. This identity crisis, Oliver (1996) remarks is unlikely to be fully resolved in adolescence. Chiefly, the adolescent begins to form sexual identity. This involves sexual experimentation and gratification, which leads to healthy psychological development. It is when these sexual needs are not met and satisfied in a socially accepted manner, that the adolescent develops biological problems such as the spreading of sexually transmitted diseases (Arnett, 1990; Burns & Dillon, 2005).

It requires more than the traditional intelligence for adolescents to overcome sexual challenges. The intelligence required by adolescents in this regard is emotional intelligence (EI). This is about a person's ability to understand and manage his/her own emotions and behaviours as well as

those of others (Goleman, 1995). Salovey and Mayer (1990) refer to it as a form of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action. They identify five ways through which people could be emotionally intelligent as self-awareness, self-regulation, motivation, empathy, and social skills.

The other psychological construct measured in this study is self-efficacy. In his unifying theory of behavioural change, Bandura hypothesised that expectations of self-efficacy determine whether instrumental actions will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and failures (Bandura, 1977; 1997). Bandura, Adams, Hardy and Howell (1980) postulate that people's self-efficacy expectancies have important effect on thought patterns, emotional arousal, and behaviour. Wiedenfeld, O' Leavy, Bandura, Brown Levine, and Raska (1990) report that people who have a high level of self-efficacy about their ability to cope with stress also exhibit an enhanced functioning of the immune system.

Studies have shown that self-efficacy training could reduce the risk of HIV/AIDS (Icard, Schilling & EI-Bassel, 1995; Bandura, 1989). For instance, Kang, Deren, India, Colon and Robles (2004) note that people with negative change in self-efficacy were more likely than those with positive change to engage in HIV infection and sex risk behaviours. Authoritatively, Kang, et al (2004) highlight that HIV/AIDS prevention programmes should include a focus on enhancing self-efficacy for reducing risk behaviours. Based on the review made, we test the following hypotheses:

- i. Early adolescents' socio-demographic characteristics, knowledge about HIV/AIDS, emotional intelligence (EI) and self-efficacy would be related significantly to their attitudes towards HIV/AIDS.
- ii. Early adolescents' socio-demographic characteristics, knowledge about HIV/AIDS, EI and self-efficacy would independently predict attitudes towards HIV/AIDS.

Methods

Participants

Participants were 240 early adolescents aged between 10 and 14 years (132 males and 108 females) attending Junior Secondary Schools in Ibadan, the capital of Oyo State, Nigeria. Of this number 77(32.1%) were from polygamous background. 147(61.3%) from monogamous background, while 16(16.7%) indicated no family background.

Measures

Demographic Questionnaires: A demographic questionnaire developed for and used in this study, included items about age, gender, class, and family background.

Emotional Intelligence Test: It is a 33-item instrument developed by Schutte, *et al* (1998). Ten of the items in the instrument were adapted to suit the current study, and for the purpose of the attention span of the participants. An alpha coefficient of .73 was obtained for this scale. Examples of two of the items statements in the scale were:

- i. I know when to speak about my personal problems to others; and
- ii. I find it hard to understand the non-verbal messages of other people.

Self-efficacy: This was measured using a ten-item scale developed by Schever, *et al.* (1992). An alpha coefficient of .71 was obtained, Examples of the items in the scale were:

- i. I feel that I have a number of good qualities; and
- ii. I feel that I am a person of worth, at least, on an equal basis with others.

Knowledge of HIV/AIDS: It is a self developed six-item scale. The items in the scale measured how confident the respondents felt in providing correct information about HIV AIDS. An alpha coefficient of .69 was obtained. Examples were:

- i. A person can get infected with HIV through mosquito bite; and
- ii. Using condom in intercourse can prevent HIV infection

Attitude towards HIV/AIDS: This was measured with a nine item self developed scale. The items were designed to measure participants' attitudes towards HIV/AIDS. The reported coefficient value was .78 with the following examples:

- i. I would visit my friend, if she/he is HIV positive; and
- ii. People with HIV/AIDS are loose sexually.

All the items on the four instruments used in the study were rated on a 4-point Likert format scale, with higher scores indicating appropriate behaviours.

Procedures

Participants' inclusion and exclusion criteria. Data collection occurred during the second term of 2006/2007 school session. Permission to administer the survey instrument was first sought from the school authorities. In recruiting participants for the study, consent forms requesting for the approval of parents/guardians to allow their wards to participate in the study were given only to early adolescents who were found in schools and who voluntarily indicated interests to participate in the study. Participants who returned complete and duly filled and signed forms participated in the study.

Of the 350 early adolescents who indicated interest in the study and given consent forms, 284 met the inclusion criteria. Out of this number, 240 participants who correctly filled the questionnaires eventually participated in the study.

Data collected were analysed using the Pearson r statistics to examine the magnitude and direction of relationships among the variables investigated (EI, Self-efficacy, gender (Female = 2, male = 1) and age (actual). Hierarchical regression analysis was also used to test hypothesis 2.

Results

The mean, standard deviation and zero-order correlations of each of the outcome measures are presented in Table 1. As shown in the Table, participants EI ($r = .17$, $P < .001$), self-efficacy ($r = .19$, $P < .001$), Knowledge about HIV/AIDS ($r = .21$, $P < .001$), and age ($r = .12$, $P < .001$), had significant positive relationship with attitudes towards HIV/AIDS. The results in Table 1 also reveal that gender had significant negative relationship with attitudes towards HIV/AIDS.

Table 1: Means, Standard Deviations and Zero-Order Correlation (N = 240)

Variables	1	2	3	4	5	6	Mean	SD
1. Attitude	-	.17**	.21**	.19**	.12**	-.12*	16.50	4.47
2. Emotional Int.		-	.15**	.07**	-.11*	-.14*	19.17	4.40
3. Knowledge			-	.27**	-.02	.04	17.83	3.39
4. Self-efficacy				-	-.16**	.01	25.22	6.18
5. Age					-	-.17**	12.38	1.21
6. Gender						-		

* $P < .05$ ** $P < .001$

Consistent with hypothesis one, the pattern of results in Table 1 suggests that an increase in participants' EI, knowledge of HIV/AIDS, self-efficacy, and age are associated with a corresponding improvement and better attitudes to HIV/AIDS. The significant negative relationship between participants' gender and attitudes towards HIV/AIDS suggests that male participants had more risk disposition attitudes towards HIV/AIDS.

In Table 2, the order of entry of the variables into the regression analysis is presented. Entry of the predictor variables was determined on the basis of their relative

strengths as revealed by the Pearson coefficient in Table 1. In order to control for their positive influence, gender and age were introduced (Step 1). Thereafter, knowledge about HIV/AIDS was entered (Step 2), Lastly, EI and self-efficacy were entered as step 3 to test for their main effects.

Table 2: Results of Hierarchical Multiple regression analysis for Attitudes towards HIV/AIDS (N = 240)

Variables	STEP 1			STEP 2			STEPS			STEP 4		
	B	SEE	P	B	SEE	P	B	SEE	P	B	SEE	P
Age	.36	.24	.10	.40	.24	.11	.24	.13*		.19	.09	.14
Gender	.86	.59	-.10	-.96	.58	.11	-.91	.57	-.10	9.72	.57	-.08
Knowledge				.28	.09	.20*	.21	.09	.16*	.19	.09	.14
Self-efficacy							.13	.05	.17*	.11	.05	.16*
Emotional										.13	.06	.13*
R ²		.02			.06			.09			.11	
Adjusted R ²		.02			.04			.03			.03	
F		2.60			5.18			5.71			5.44	

*p<.05 **p<.001

Results of the hierarchical multiple regression analysis presented in Table 2 show that the overall model was significant ($R^2 = .11$, adjusted $R^2 = .09$, $f(5,232) = 5.44$, $P < .001$). Thus, the entire set of variables explained 11% of the total variance in attitudes towards HIV/AIDS. As predicted, a significant main effect was observed for knowledge on HIV/AIDS ($R^2 = .04$, $F(1, 234) = 5.18$, $P < .001$) self-efficacy

($R^2 = .03$, $F(4,234) = 5.71$, $P < .001$); and EI ($R^2 = .03$, $F(5,232) = 31.62$, $P < .001$). The results suggest four percent of the total variance in attitudes towards HIV/AIDS, three percent of EI, and three percent of self-efficacy.

Discussion

This study shows that the predicting variables, self-efficacy, EI, Knowledge of HIV/AIDS and age had joint significant relationship with early adolescents' attitudes towards HIV/AIDS. Of these, knowledge of HIV/AIDS, self-efficacy and EI were significantly independent of early adolescent's attitudes towards HIV/AIDS. Our findings show that the higher the early adolescents' scores on self efficacy, EI and knowledge of HIV/AIDS, the better their attitudes towards HIV/AIDS. The inference that could be drawn from this is that early adolescents are capable of positive safer sexual behaviour if they are exposed to training in self-efficacy, EI and better knowledge on HIV/AIDS.

From the results obtained in this study, the combined significant effect of the predictors (self-efficacy, EI, knowledge of HIV/AIDS and age) show positive relationship to attitudes towards HIV/AIDS of early adolescents. In line with this finding, early adolescents' attitudes towards HIV/AIDS can be improved through joint exposure to the influence of these variables. These results suggest the combined potency of the predicting variables on early adolescents' attitudes towards HIV/AIDS. The finding indicates that early adolescents' attitude to HIV/AIDS is amenable to positive change if the appropriate psychological education and right knowledge are provided.

The second hypothesis on independent contributions of the predictors to attitudes towards HIV/AIDS interestingly shows that results of the hierarchical regression analysis reveal that self-efficacy, EI, knowledge of HIV/AIDS and age separately predicted attitudes towards HIV/AIDS. They respectively contributed three percent, three percent, four percent, and two percent to the total variance of attitude towards HIV/AIDS. The explanation on the findings suggests

that with proper exposure of early adolescents to the training of EI, they could positively develop safer sexual behaviour.

The implications of the findings notwithstanding, some limitations of this study are noted. The findings of this study can only be generalised on early stage of adolescence. Similarly, the independent measures (age, gender, EI, self-efficacy, and knowledge of HIV/AIDS) are not exhaustive as to influence early adolescents' attitudes towards HIV/AIDS.

In conclusion, the results of this study are a pointer to the relevance of some constructs on a population that has not been well investigated in Nigeria. The findings would therefore enrich HIV/AIDS counselling education on this population.

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