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EFFECTS OF RATIONAL EMOTIVE BEHAVIOUR THERAPY AND ASSERTIVENESS SKILLS TRAINING ON HEALTHY SEXUAL BEHAVIOURS AMONG ADOLESCENTS WITH LEARNING DISABILITIES IN IBADAN, NIGERIA

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Abstract:
This study examined the effectiveness of Rational Emotive Behaviour Therapy (REBT) and Assertiveness Skills Training (AST) on healthy sexual behaviours among adolescents with learning disabilities in Ibadan, Nigeria. It also examined the moderating effects of age and gender. A pretest-posttest, control group, quasi-experimental design of 3x2x2 factorial matrix was adopted. Eighty-four adolescents with learning disabilities (42 males and 42 females) were purposively selected from three randomly selected public secondary schools in Ibadan metropolis. They were randomly assigned into two treatment conditions (REBT and AST) and control group consisting of 28 participants each. The training programmes lasted ten weeks. Three instruments were used for screening: Pupil Rating Scale (α = 0.71), Sexual Abstinence Scale (α = 0.89) and Safe Sex Behaviour Questionnaire (α = 0.79) while Adolescents with Learning Disabilities' Sexual Behaviour Scale (α = 0.76) was used for data collection. Five hypotheses were tested at 0.05 level of significance. Data were analysed using descriptive statistics and Analysis of Covariance. Early adolescents (10-13 years) and middle adolescents (14-16 years) were used for the study. There were significant main effects of treatments ($F_{(2, 71)}$ = 61.95; η^2 =0.64, $\bar{x}$ = 165.35) and ($F_{(2, 71)}$ = 61.95; η^2 =0.64, $\bar{x}$ = 159.64) on healthy sexual behaviours of adolescents with learning disabilities. Rational Emotive Behaviour Therapy had a higher mean score ($\bar{x}$ = 165.35) than those exposed to Assertiveness Skills Training ($\bar{x}$ = 159.64) while those in the control group had the lowest mean score (($\bar{x}$= 145.29). There was an observed interactive effects of treatment, age and gender on healthy sexual

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behaviours of adolescents with learning disabilities ($F_{(2, 71)} = 3.49$; $\eta^2 = 0.09$). Both treatment conditions were effective in fostering healthy sexual behaviours among adolescents with learning disabilities regardless of age or gender.

Keywords: adolescents with learning disabilities, assertiveness skills training, healthy sexual behaviour, rational emotive behaviour therapy

1. Introduction

Adolescents, including those with learning disabilities, routinely engage in behaviours that put their health at risk. Many adolescents engage in unhealthy sexual behaviours that can result in unintended health outcomes that place them at risk for human immunodeficiency virus (HIV), other sexually transmitted infections (STIs), and unintended pregnancy. Unhealthy sexual behaviour can be defined according to the behaviour itself: unprotected vaginal, oral, or anal intercourse and also according to the habits of the partner: HIV-positive individual and intravenous drug user. Unhealthy sexual behaviour can take several forms, ranging from a large number of sexual partners, or engaging in risky sexual activities, to sexual intercourse under the influence of substances such as alcohol or hard drug. However, it may be difficult for one to discern that these activities are occurring, especially since the adolescent is unlikely to volunteer this information. Nonetheless, adolescents frequently make risky choices that do not appear to be in line with appropriately considered consequences or are not in their own long-range interests. Study on adolescent sexual behaviours in several parts of Nigeria showed that premarital sexual intercourse was popular (Akinwale, 2009). Adebayo, Udegbe and Sunmola (2006) described the Nigerian adolescents' sexual attitudes as risky. They reported that Nigerian adolescents were largely characterized by early initiation into sexual activities (Falaye and Aremu, 2004), multiple sexual partners and poor attitude towards protective sex.

Many adolescents have struggled for years with various learning disabilities, oftentimes without parents or teachers recognizing the issue. Without proper intervention, these adolescents often end up frustrated and work far below their abilities. This leads to adolescents' loss of self-esteem and self-confidence. Aspen Education Group (2009) opined that adolescents who have learning disabilities are often bright, creative, and capable, but have neurological or behavioural/emotional issues that impact performance in certain areas, such as reading, mathematics and social skills. In addition, these adolescents might perform exceptionally well in one area but under achieve in another. Adolescents with learning disabilities have low academic achievement, which can have a negative impact on how they feel about school and themselves. It is estimated that one million adolescents affected by learning disabilities drop out of high school each year and within three to five years of dropping out, 50 percent of females with learning

disabilities are pregnant (Sexuality Issues for Youth with Disabilities and Chronic Health Condition, 2008).

In Nigeria, as elsewhere in sub-Sahara Africa, study confirms that a large proportion of adolescents including those with learning disabilities have unmet reproductive health needs (Ajuwon, 2000). Evidence of unmet need is reflected in the fact that some adolescents lack adequate knowledge and understanding of the reproductive process that may harbor misconceptions such as the belief that mosquitoes can transmit HIV infection, and false claims that use of contraceptives can cause infertility (Amazigo, Silva, Kaufman and Obikeze 1998). Among other things, adolescence aims at developing a healthy sense of sexuality which includes feeling good about one's body and sexual fulfillment as well as protecting oneself from sexually transmitted diseases (STIs) and unwanted pregnancy (Salazar, DiClemente and Wingood, 2004).

According to McNamara, Vervaeke and Willoughly (2008), sexual behaviours among adolescents are increasing. Often the outcome of these behaviours which include risky sexual behaviours can have adverse consequences on the adolescent such as unplanned pregnancy and sexually acquired infections. While many studies have explored the relationship between adolescents and risk-taking behaviour including sexual activity, however, only a few studies have examined this relationship in adolescents with learning disabilities. Adolescents with learning disabilities usually experience some difficulties in problem solving. These problem solving difficulties in relation with sexual problem affect these adolescents' inability to refuse sexual advances and recognise inappropriate sexual behaviours. The problems begin in elementary school, when a child with learning disabilities experiences difficulties with tasks such as word recognition, spelling and computation. These difficulties become generalized as the child ages. Adolescents with learning disabilities typically have difficulties with skills of high-order processing which are difficulties with problem solving (Swanson, 2008).

Adolescents with learning disabilities often have few opportunities to develop loving relationships and have their sexual needs met. This may be due to the fact that they are not supported to be all they can be and to achieve their fundamental human rights, including the right to make an informed choice about whether or not to engage in relationships. They find it difficult to get the information they need about relationships and sex. Adolescents with learning disabilities are also about four times more likely to be sexually abused than the general population (Mencap, 2001). One probable reason is that they are more likely to be socially isolated and are left to suffer material and emotional poverty. The range of emotional reactions in care givers can vary at different times from extreme overprotection, through relative equanimity, to sometimes outright hatred and rejection of the child. Society largely reflects this, only rarely viewing the individual with learning disability in a positive way, choosing often to pity, patronise, ignore, ridicule or openly despise. These attitudes are internalised by adolescents with learning disability, who invariably suffer from low self-esteem. All of these factors combine to facilitate abuse including sexual abuse (Allington-Smith, Ball and Haytor, 2002).

Quite often, adolescents with learning disabilities were seen as eternal children because they were considered innocent and asexual and, consequently, adults often assumed that sexuality was irrelevant because of the young people's level of cognitive and communication impairments (Morris, 2001). People with learning disabilities have also been labelled as vulnerable to abuse (Joint Committee for Action in Community Care, 2007) and at risk of being sexually abused, all of which, has given professionals and parents reasons to be cautious in terms of encouraging them to have any form of intimacy. In recent years, major changes have taken place in the way adolescents with learning disabilities are thought of and in the approaches to their needs and those of their families. According to Youth Embassy (2004), all human beings are sexual beings. Sexuality is not an optimal extra. Everyone has sexual needs, feelings and drives. The question here is: how can adolescents with learning disabilities be helped to channel their needs, feelings and drives towards fostering healthy sexuality from their close personal relationships. Adolescents with learning disabilities are grown-ups. Although puberty may be slightly delayed for those with profound cases, they go through the same process as any other child. Voices start to break, body hair starts to grow, girls begin their periods, boys start to have wet dreams, mood swings become more extreme. All these are the biological processes of puberty which, cannot be stopped, even if sometimes parents would want it to. However, adolescence is a social process whereby the youngster develops a personal understanding of his/her adult social and sexual identity.

East and Adams (2002) opined that when adolescents are sufficiently mature and responsible, they should be able to come to terms with their own sexual needs and desires, and when the timing is right, they should learn to enjoy a healthy, developmentally appropriate sexuality. Therefore, if adolescents choose to become sexually involved, then they need to understand that it is their right to experience sexuality free of violence, risk of pregnancy and disease, and exploitation, and that any partner who does not respect their wishes for effective protection is not a desirable partner. An important part of adolescence including those with learning disabilities is the development of sexuality and the achievement of good sexual health. Sexual development is characterized by the acquisition of skills used to control feelings of sexual arousal and to manage the consequences of sexual behaviour, as well as by the development of new forms of sexual intimacy. Also given the elevated risk of dating violence among adolescents and the concomitant threats of unintended pregnancies and sexually transmitted infections (STIs), strategies and skills that promote effective communication about sexual contact is of considerable value (Rickert and Wiemann, 1998).

Gender, our social conditioning as males and females, is an important determinant of sexual risk taking behaviours. Gendered attitudes and beliefs like "the more sex I have, the more manly I will be" or "sometimes you have to do what your boyfriend wants, even if you don't want to, so that he doesn't break up with you," pressure many boys and girls into engaging in sexual behaviour that they may not want, and as a consequence increase

their risk for unintended pregnancy and sexually transmitted infections. When traditional male and female gender norms work together, they compound and reinforce each other, making their effect on sexual risk taking behaviour even greater. For example, consider a young man who believes he should be the one to decide whether or not the couple use condoms, and his female partner believes she should let the boyfriend make the condom decision -- doing otherwise would cause conflict, which is in direct contradiction to the traditional feminine gender role of "smoothing things over" to create a harmonious relationship. In the case of this couple, perfect conditions have been created for avoiding condoms, resulting in higher risk for sexually transmitted infections and unintended pregnancy. Boys often face pressure to become sexually active to prove their manhood and be accepted by their friends. Girls may face pressure not to seek information about sexual matters for fear of being thought "loose" or alternatively to have sexual intercourse in return for benefits (Rolleri, 2013).

There is general consensus that the proportion of adolescents who engage in behaviours that put them at risk of pregnancy and of HIV and other sexually transmitted infections (STIs) remains too high at early adolescent age. Each year, approximately one million young women aged 15-19 years or one-fifth of all sexually active females in this age-group become pregnant; the vast majority of these pregnancies are unplanned. Wind (2013) reported that very few early adolescents (both boys and girls) have had sex (0.6% of 10-year-olds, 1.1% of 11-year-olds and 2.4% of 12-year-olds), and the incidence of pregnancy among girls aged 12 or younger is minuscule. But adolescence is a time of rapid change, and sexual activity is more common among older teens, including one-third (33%) of those aged 16, nearly half (48%) of those aged 17, and 61% and 71% of 18- and 19-year-olds, respectively.

Rational emotive behaviour therapy (REBT) is an active directive, solution-oriented therapy which focuses on resolving emotional, cognitive and behavioural problems in clients, originally developed by the American psychotherapist Albert Ellis. REBT views that emotional suffering result primarily, though not completely, from our evaluations of a negative event, not solely by the events per se. In other words, human beings on the basis of their belief system actively, though not always consciously, disturb themselves, and even disturb themselves about their disturbances. REBT helps clients to replace absolutist philosophies, full of 'musts' and 'shoulds', with more flexible ones; part of this includes learning to accept that all human beings (including themselves) are fallible and learning to increase their tolerance for frustration while aiming to achieve their goals (Kumar, 2009).

The goal of REBT is to replace dysfunctional beliefs (which are rigid, inconsistent with reality and illogical) with a new set of rational beliefs (which are flexible and non-extreme). Rational beliefs which help the adolescents live longer and happier are developed through this therapeutic process (Watson, 1999). Since REBT is a form of tolerance training, three of the most important approaches to achieving tolerance are: unconditional self-acceptance, unconditional other-acceptance, and unconditional life-

acceptance (Ellis, 2004a; Gazibara and Ross, 2007). In general, REBT is an approach which is problem-focused, goal-directed, structured and logical in its practice, educational focused, primarily present-centered and future-oriented, skills emphasized and having largely active and directive therapist (Dryden, 2006).

Therefore, the use of REBT on healthy sexual behaviours of adolescents with learning disabilities is important because it disputes any irrational beliefs and misconceptions about adolescent sexual behaviours and replaces such beliefs with rational beliefs and facts.

Assertiveness is defined as a way of thinking and behaving that allows a person to stand up for his or her rights while respecting the rights of others. It is the ability to state positively and constructively your rights and needs without violating the rights of others (Franklin, 1998). Assertiveness skills training is a form of behaviour therapy designed to help people stand up for themselves to empower themselves in more contemporary term. The purpose of assertiveness skills training is to teach persons appropriate strategies for identifying and acting on their desires, needs and opinions while remaining respectful of others (Encyclopedia of Mental Disorders, 2007). To Hammed (1996), assertiveness training is a term used to refer to a programme of learning designed to increase a person's competence in dealing with other human beings. The emphasis in assertiveness training is on skills and putting these skills into action. Sexual assertiveness on the other hand means recognizing the warning signs of inappropriate sexual advances and potentially controlling abusive relationships, and having the sense of empowerment and the skills to say no.

East and Adams (2002) defines sexual assertiveness as having the rights to receive a comprehensive education about sexuality one that educates all options and that bolsters all necessary skills; and for adolescents who choose to be sexually active, it means having the right to protect themselves against the risk of pregnancy, HIV and other sexually transmitted infections. They opined that understanding one's rights and developing a sense of empowerment to enforce them; however, are just the first steps toward sexual assertiveness. Eventually, when adolescents are sufficiently mature and responsible, they should be able to come to terms with their own sexual needs and desires and when the timing is right, they should learn to enjoy a healthy developmentally appropriate sexuality. If adolescents choose to become sexually involved, then they need to understand that it is their right to experience sexuality free of violence, risk of pregnancy and disease and exploitation and that any partner who does not respect their wishes for effective protection is not a desirable partner. The construct of sexual assertiveness has been developed to further the understanding of adolescents' communication strategies to protect their sexual health and autonomy and is predicated on the assumption that adolescents have rights over their bodies and to behavioral expressions of their sexuality (Rickert, Sanghvi and Wiemann, 2002). Therefore the use of Assertiveness Skills Training on healthy sexual behaviours of adolescents with learning disabilities is important because it teaches adolescents with learning disabilities how to assert their sexual rights

in a non-aggressive manner and be able to negotiate to get what they want in their relationships without violating the other person's right.

2. Literature Review

Sexuality is a central aspect of being a human throughout life and encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (WHO, 2004). Adolescent sexuality as a vital aspect of adolescents' lives refers to sexual feelings, behaviour and development in adolescents. It is also a stage of human sexuality. Sexual development is an important part of human health, similar to other measures of physical growth, such as height and weight. Sexual behaviour, which is related to sexual development, has important health implications for everyone, especially for adolescents and those with learning disabilities. It is particularly important that adolescents be well informed about all aspects of sex and sexual health (Benson, 2011).

According to Youth Embassy (2004), all human beings are sexual beings. Sexuality is not an optional extra. Everyone has sexual needs, feelings and drives including adolescents with learning disabilities. Learning about sexual behaviour is a lifelong and often haphazard process. Babies learn from birth onwards about the bodily pleasure of being warm, being cuddled, being tickled and interacted with. Others learn from watching the ways in which parents show affection to each other and from spoken and unspoken messages about private parts; also, from films, advertisements and soap operas on television (Outsiders, 2009). Sadly, it is often the case that adolescents with learning disabilities only get a very negative form of sex education. Not giving them any positive formal or sensible sex education does not mean that they don't pick up many enticing ideas. They need to be protected from people who seek them out in order to exploit their ingenuity.

Also, to Outsiders (2009), adolescents with learning disabilities grow up. Although, puberty may be slightly delayed for those with profound or multiple disabilities. They go through the same process as any other child. Voices start to break, body hair starts to grow, girls begin their periods, boys start to have wet dreams, mood swings become more extreme. All that is the biological process of puberty which cannot be stopped, even sometimes parents would want it to.

The rights of people with learning disabilities have improved with legislation, sometimes they are still on the receiving end of negative attitudes and lack of information. Shakespeare, Gillespie-Sells, and Davies (1996) suggest that People with learning difficulties face some of the biggest restrictions in terms of availability of sex education. Whereas in other areas of life the trend is towards normalization, in other words, fitting people with learning difficulties into the roles and values of the rest of society (Wolfensburger, 1972), this does not seem to prevail in the area of sexuality (Shakespeare, Gillespie-Sells, and Davies, 1996).

The incidence of sensory and other communication difficulties is markedly increased in adolescents with learning disabilities, rendering them both more vulnerable to, and less likely to report, sexual abuse. The provision of multi-modal assessment (and treatment) services alongside communication aids and adaptations must be regarded as a priority if these adolescents are to receive anything resembling a service appropriate to their needs. As always with adolescents (or adults) with special needs, it is necessary to find a way to drop the barriers to allow them access to services, whether they be interpretive psychotherapies or arts therapies. Technical aids can be used to establish communication, as can the co-opting of trustworthy advocates or family members as surrogate communicators (Allington-Smith, Ball and Haytor, 2002),

An adolescent with a learning disability has more difficulty in understanding and communicating and has an increased level of vulnerability. As they are unable to understand tasks as well as other normal children of the same age, they are often brought up with low self-esteem as their caregivers perform more of the task for them than they would for other children. This also leads onto a greater vulnerability and increased risk of sexual abuse than what is seen in children of the same age and normal development (Public Health Agency, 2005).

Adolescents who have learning disabilities will almost certainly show gaps in knowledge and erroneous beliefs when compared with more able peers of the same age, and the degree of these problems will correspond to the extent and nature of their learning disability. They will also reflect the child's history of exposure to comprehensible family and school based education about personal relationships, privacy, safe touching and, later, sexual expression, dating and choosing partners. These gaps in knowledge and understanding will probably reflect the general belief that children (and adults) with learning disabilities are best excluded from sexual education and expression, lest they 'get into trouble' or pose a danger to themselves or others (Allington-Smith, Ball and Haytor, 2002).

According to Allington-Smith, Ball and Haytor (2002), adolescents who have a learning disability are more susceptible to being sexually abused and where abuse is detected, assessment and treatment should be available to all, irrespective of their intellectual impairment. Interventions will help to resolve maladaptive behaviours, which, if left, will further decrease the child's level of functioning. They will also reduce the risk of the child seeking to reproduce in later life what may have been their only sexual experiences. Treatment will generally take longer and will need to include strategies to maximise the communicative abilities of the young person. It is helpful for the therapist to have experience with young people with learning disabilities but not absolutely essential. Issues of attachment and of the intellectual disability itself will often need to be addressed. Work with family and care givers is a vital component of therapy. Sexual education and management of any associated behavioural problems may need to complement the abuse-centred work. Little research is available on treatment and should be strongly encouraged.

Therefore, in attempting to explore and explain the phenomena of young people who sexually abuse others, Vizard, Monck and Misch (1995), in their review of the research literature on young people who sexually abuse stated that "*learning difficulties and poor school achievement are commonly noted*". As evidence for this assertion they cited a study which found that 44% of referrals to a specialist clinic for young people who sexually abused others had some degree of learning disability, with half of these having attended a special school.

James and Neil (1996) found that 58.1% of the cases identified in their prevalence survey of juvenile sexual offending were individuals of "below average ability". Dolan, Holloway, Bailey and Kroll (1996) undertook a retrospective analysis of case study notes on 121 young people referred to an adolescent forensic unit because of their sexually abusive behaviour. They found that: "*Just over half (68, 56.2%) required special schooling. A total of 55 (45%) had learning difficulties with 46 (38%) classified as mildly impaired, 7 (5.8%) moderate and 2 (1.6%) severely impaired*".

O'Callaghan (1998) writing about a service for young abusers, commented that "*While the project has continued to work with young people from across the ability spectrum, young people assessed as having some form of learning disability now constitute approximately half of all referrals to the service*." Similarly, Manocha and Mezey (1998) analysed the background characteristics of 51 young people referred to a specialist assessment and treatment facility for young sexual abusers and found that: "There were 17 (33.3%) who were described as poor academic achievers with 10 (19.6%) formally diagnosed as those with learning disability (mild 8, moderate 2). Boswell and Wedge (2002) reported, in their evaluation of a residential therapeutic community for sexually abusive adolescent males, that eight out of ten of those who completed the therapeutic programme and participated in their study "had been assessed as having mild, moderate or serious learning difficulties". Yet, despite these findings, few researchers have chosen to focus their work directly on young people with learning disabilities who sexually abuse. The limited evidence which is available about this sub-set of abusers tends to be drawn from research based on clinical samples, studies which by their very nature are skewed (O'Callaghan, 1999; Balogh, Bretherton, Whibley, Berney, Graham, Richold, Worsley and Firth, 2001).

Gilbey, Wolf and Goldenberg (1989) compared adolescents with learning disabilities with those without learning disability who had been referred to a specialist psychiatric service. They found that adolescents with learning disability were not likely than others to have perpetrated sexual assaults, but they were more likely to have engaged in 'nuisance' behaviours, including flashing, public masturbation and voyeurism. It was also noted that the adolescents with learning disabilities appeared to be less discriminating in their choice of victim, offending equally against males and females, and in 30% of cases offending against victims of both genders. This finding is in line with findings from studies of men with learning disabilities who sexually abuse (Thompson and Brown, 1997) and has been interpreted as suggesting that people with

learning disabilities who sexually abuse may often do so in a less planned, more impulsive, manner.

Myths and Misconceptions about sexuality of persons with disabilities according to Silverberg (2009) which have relevance to Nigerian situation include:

- People with disabilities and chronic illness are not sexual;
- People with disabilities and chronic illness are not desirable;
- There is a right way and a wrong way to have sex;
- People with disabilities and chronic illness cannot have "real" sex;
- People with disabilities and chronic illness are a bad choice for romantic partners;
- Disabled people have more important things than sex to worry about;
- People with disabilities and chronic illness are not sexually adventurous;
- People in institutions should not have sex;
- People with disabilities and chronic illness don't get sexually assaulted;
- People with disabilities and chronic illness don't need sex education.

3. The Concept of Rational Emotive Behaviour Therapy

Rational Emotive Behavior Therapy (REBT), previously called rational therapy and rational emotive therapy, is a comprehensive, active-directive, philosophically and empirically based psychotherapy which focuses on resolving emotional and behavioral problems and disturbances and enabling people to lead happier and more fulfilling lives (Ellis, 1994a). REBT was created and developed by the American psychotherapist and psychologist Albert Ellis who was inspired by many of the teachings of Asian, Greek, Roman and modern philosophers (Ellis, 2004b; McMahon and Vernon, 2010). REBT is one form of cognitive behavior therapy (CBT) and was first expounded by Ellis in the mid-1950s; development continued until his death in 2007 (Ellis, 2007; Velten, 2010).

In rational emotive behaviour therapy, the first step often is that the client acknowledges the problems, accepts emotional responsibility for these and has willingness and determination to change. This normally requires a considerable amount of insight, but as originator Albert Ellis (Ellis, 2003b) explains:

> *"Humans, unlike just about all the other animals on earth, create fairly sophisticated languages which not only enable them to think about their feeling, their actions, and the results they get from doing and not doing certain things, but they also are able to think about their thinking and even think about thinking about their thinking."*

Through the therapeutic process, REBT employs a wide array of forceful and active, meaning multimodal and disputing, methodologies. Central through these methods and techniques is the intent to help the client challenge, dispute and question their destructive and self-defeating cognitions, emotions and behaviors.

REBT posits that the client must work hard to get better, and in therapy this normally includes a wide array of homework exercises in day-to-day life assigned by the therapist. The assignments may for example include desensitization tasks, i.e., by having the client confront the very thing he or she is afraid of. By doing so, the client is actively acting against the belief that often is contributing significantly to the disturbance.

4. The A-B-C-D-E Mnemonic of Rational Emotive Behaviour Therapy

According to Dewey (2007), Ellis used an "ABCDE" mnemonic or memory system to teach the basics of rational-emotive behavior therapy. Here are the five elements:

- A = Activating event,
- B = Belief system,
- C = Emotional Consequences of A and B,
- D = Disputing irrational thoughts and beliefs,
- E = Cognitive and Emotional effects of revised beliefs.

A is the *activating event*—the event that triggers stress or worry. It might be a crisis in a personal relationship, a speech to be given, chronic lack of confidence, job dissatisfaction, or sexual problems...anything that sends a person to a counselor. Like Rogers, Ellis was willing to tackle any problem.

B stands for *"belief system"*—the cognitive component in a person's reaction to events. Ellis found that people often state beliefs that are counterproductive and reduce clear thinking. For example, a man whose wife is leaving him might comment, "This is the end of the world for me; I'll never find somebody who matters as much to me as Mabel." Ellis would challenge this belief directly. "Is it really the end of the world? Do you mean you're going to die tomorrow, if she leaves you? Have you gotten to know all the women in the world, so you know that you can't love any of them?

C stands for *consequences* of irrational beliefs. Irrational thoughts produce bad consequences. They can be self-fulfilling prophecies. For example, if you expect to feel nervous and do poorly, you are setting yourself up to feel nervous and do poorly. Some people repeat negative thoughts again and again. This repetitious thinking is called rumination and it is a bit like self-programming. A person who is constantly thinking, "This is horrible!" (or some other irrational idea) may stay in a bad mood because of the constant negative self-coaching. Replacing irrational thoughts and fears with a calmer, more reasonable assessment can improve a person's mood and lead to more adaptive behavior that addresses a problem rationally.

D stands for *disputing* irrational beliefs. Ellis's treatment consists of challenging (disputing) a client's irrational beliefs as directly as possible. Transcripts of REBT sessions show Ellis in his prime was willing to be therapeutically obnoxious. He cussed, interrupted, shouted, and otherwise drew attention to irrationalities. However, this is not necessarily part of REBT therapy. The important thing is to replace negative, unrealistic thinking with a more realistic and adaptive appraisal of problem situations.

E stands for the *effects* of changing one's interpretation of a situation. If REBT is effective, a person loses their symptoms of anxiety or distress and sees a situation differently (something other therapists call cognitive restructuring). Ideally the client now takes practical action to solve the problem or has a less troublesome reaction to the situation.

5. The Concept of Assertiveness

Franklin (1998), defined assertiveness as a way of thinking and behaving that allows a person to stand up for his or her rights while respecting the rights of others. It is the ability to state positively and constructively your rights and needs without violating the rights of others. Assertive attitudes and behaviours are at the heart of effective advocacy. A person with an assertive attitude recognizes that each individual has rights. These rights include not only legal rights but also rights to individuality, to have and express personal preferences, feelings and opinions. The assertive individual not only believes in his or her rights but is committed to preserving those rights. An assertive attitude is important in recognizing that rights are being violated.

5.1 Ten Assertive Rights of an Individual

According to Smith (1975) "Bill of Assertive Rights"

1) You have the right to judge your own behaviour, thoughts, and emotions, and to take the responsibility for their initiation and consequences upon yourself.
2) You have the right to offer no reasons or excuses for justifying your behaviour.
3) You have the right to judge if you are responsible for finding solutions to other people's problems.
4) You have the right to change your mind.
5) You have the right to make mistakes - and be responsible for them.
6) You have the right to say, 'I don't know'.
7) You have the right to be independent of the goodwill of others before coping with them.
8) You have the right to be illogical in making decisions.
9) You have the right to say, 'I don't understand'.
10) You have the right to say, 'I don't care'.

5.2 The Skills of Assertiveness

According to Lindenfield (2001), the following are the skills of assertiveness:

5.3 Use 'I' statements

Be specific. Decide what you want or feel and say so simply, focusing on saying the word 'I'. So, if someone says or does something that hurts you and makes you feel angry, you may want to try saying something like: 'When you say (I'm stupid) that makes me feel

(hurt/angry) and I want (you to stop saying that to me.) If we stick with the word 'I' it can be harder for people to argue - i.e. for them to say something like 'No, you don't feel like that.' Whereas if we say 'you' (do this and that) it makes it easier for people to argue back, deny their behaviour or simply walk away if they feel attacked or accused.

5.4 Repetition (the 'Broken Record' Technique)

You may find yourself in a situation where you are trying to make a point, or say 'No' but the other person seems to be avoiding or ignoring what you say, distracting you with side issues. Choose a phrase which you feel comfortable with and without getting angry or loud, repeat your assertive statement each time the person tries another manipulation to persuade you to change your mind. You don't have to justify yourself either. For example, if someone tells you 'You are going to work late tonight' you may want to use an assertive response to repeat: 'I can't work late tonight.'

- Don't answer questions;
- Don't respond to insults;
- Just keep repeating your statement.
  Broken records (or stuck CD's!) eventually get heard!

5.5 Fielding the Response

It is necessary to indicate to the other person that you have heard what they're saying without getting 'hooked' by it. This skill allows you to acknowledge the response, which shows some care for the other person, and still allows you to continue confidently with your own statement, refusal or requests. For example: 'I realise you are disappointed, but I still have to refuse' or 'I know you are hurting but I really don't want to continue with our relationship.'

5.6 Saying 'No'

Many people do find it difficult to say 'No' and it can take a bit of practice! Think about some situations when you may find it easy or more difficult to say 'No' to friends, family, partners or course mates. For example, if they want to go out with you when you have work to do, if they want you to take drugs with them, or if they want you to jump over a cliff. Decide whether what the person has asked you for is reasonable or not. Do you want to do it or not? If you are not sure, you probably want to say 'No.' simply say 'No,' 'No thank you' or 'No, I don't want to'. Don't give reasons or make excuses as this encourages people to argue with you or try to persuade you. You don't have to explain why; the important thing is that you have given your answer and your intention. If you are genuinely undecided about whether to go along with the other person's request, the assertive thing to do is to say you need some time to think about it, before giving your answer. Allow yourself as much time as you need to feel comfortable with your decision.

5.7 Dealing with Criticism

If someone criticises you, ask yourself is it true or not? If it is true, hard as it is, it may help to admit it. It's OK to have faults and to make mistakes, this is what makes you human and enables you to learn. You can also say sorry if that seems right to you. If the criticism isn't true, say so, keep repeating it if necessary, don't respond to insults, don't get angry, don't criticise them in return or fall into aggressive behaviour.

5.8 Assertiveness Training

Encyclopedia of Mental Disorders (2007) defined assertiveness training as a form of behaviour therapy designed to help people stand up for themselves—to empower themselves, in more contemporary terms. Assertiveness is a response that seeks to maintain an appropriate balance between passivity and aggression. Assertive responses promote fairness and equality in human interactions, based on a positive sense of respect for self and others. Assertiveness training has a decades-long history in mental health and personal growth groups, going back to the women's movement of the 1970s. The approach was introduced to encourage women to stand up for themselves appropriately in their interactions with others, particularly as they moved into graduate education and the workplace in greater numbers. The original association of assertiveness training with the women's movement in the United States grew out of the discovery of many women in the movement that they were hampered by their inability to be assertive. Today, assertiveness training is used as part of communication training in settings as diverse as schools, corporate boardrooms, and psychiatric hospitals, for programs as varied as substance abuse treatment, social skills training, vocational programmes, and responding to harassment.

The purpose of assertiveness training is to teach persons appropriate strategies for identifying and acting on their desires, needs, and opinions while remaining respectful of others. This form of training is tailored to the needs of specific participants and the situations they find particularly challenging. Assertiveness training is a broad approach that can be applied to many different personal, academic, health care, and work situations. Learning to communicate in a clear and honest fashion usually improves relationships within one's life. Women in particular have often been taught to hide their real feelings and preferences, and to try to get their way by manipulation or other indirect means. Specific areas of intervention and change in assertiveness training include conflict resolution, realistic goal-setting, and stress management. In addition to emotional and psychological benefits, taking a more active approach to self-determination has been shown to have positive outcomes in many personal choices related to health, including being assertive in risky sexual situations; abstaining from using drugs or alcohol; and assuming responsibility for self-care if one has a chronic illness like diabetes or cancer (Encyclopedia of Mental Disorder 2007).

The next stage in assertive training is usually role-plays designed to help participants practice clearer and more direct forms of communicating with others. The role-plays allow for practice and repetition of the new techniques, helping each person learn assertive responses by acting on them. Feedback is provided to improve the response, and the role-play is repeated. Eventually, each person is asked to practice assertive techniques in everyday life, outside the training setting. Role-plays usually incorporate specific problems for individual participants, such as difficulty speaking up to an overbearing boss; setting limits to intrusive friends; or stating a clear preference about dinner to one's spouse. Role-plays often include examples of aggressive and passive responses, in addition to the assertive responses, to help participants distinguish between these extremes as they learn a new set of behaviours (Encyclopedia of Mental Disorder, 2007).

Assertiveness training promotes the use of "I" statements as a way to help individuals express their feelings and reactions to others. A commonly used model of an "I" statement is "when you _____, I feel _____", to help the participant describe what they see the other person as doing, and how they feel about that action. "I" statements are often contrasted with "you" statements, which are usually not received well by others. For example, "When you are two hours late getting home from work, I feel both anxious and angry," is a less accusing communication than "You are a selfish and inconsiderate jerk for not telling me you would be two hours late." Prompts are often used to help participants learn new communication styles. This approach helps participants learn new ways of expressing themselves as well as how it feels to be assertive.

6. Sexual Assertiveness and Adolescents

The construct of sexual assertiveness has been developed to further the understanding of adolescents' communication strategies to protect their sexual health and autonomy and is predicated on the assumption that adolescents have rights over their bodies and to behavioural expressions of their sexuality (Rickert, Sanghvi and Wiemann, 2002). For example, a young person's ability to engage in safe sexual practices is dependent on her partner's willingness to take measures to avoid unintended pregnancy and STDs. If a young girl does not believe that she has the right to assert her desire for effective protection she increases her risk of pregnancy and infection, regardless of whether she experiences any overt sexual coercion.

Research on sexual assertiveness has focused on its role in negotiating safer sex behaviours (Snell and Wooldridge, 1998; Noar, Morokoff and Harlow, 2002). Existing research suggests that greater sexual assertiveness may be associated with greater sexual pleasure. For women, higher level of sexual assertiveness correlates with greater satisfaction with sexual intercourse (Ferroni and Taffe, 1997; Bridges, Lease and Ellison, 2004), as well as greater frequency of sexual activity and greater sexual excitability

(Hurlbert, 1991; Hurlbert, Apt and Rabehl, 1993). According to Diclemente (2001) sexual assert beliefs, behaviours and practices including acquiring knowledge about preventing pregnancy and STDs; adopting health promoting values, attitudes and norms and building proficiency in risk-reduction skills, are important component in the development of sexual health during adolescence.

East and Adams (2002) opined that understanding one's rights and developing a sense of empowerment to enforce them; however, are just the first steps toward sexual assertiveness. Eventually, when adolescents are sufficiently mature and responsible, they should be able to come to terms with their own sexual needs and desires and when the timing is right, they should learn to enjoy a healthy developmentally appropriate sexuality. If adolescents choose to become sexually involved, then they need to understand that it is their right to experience sexuality free of violence, risk of pregnancy and disease and exploitation and that any partner who does not respect their wishes for effective protection is not a desirable partner. Also, to East and Adams (2002), sexual assertiveness means recognizing the warning signs of inappropriate sexual advances and potentially controlling abusive relationships and having the sense and empowerment and the skill to say no. it means having the right to receive a comprehensive education about sexuality; one that educates about all options and bolsters all necessary skills.

Not surprisingly, aspects of sexual assertiveness are included in many behavioural interventions designed to promote healthy sexual decision-making. Almost all programmes teach adolescents how to refuse unwanted sexual activity and abstinence, how to use and negotiate protective methods (Kirby, 2002). Shafer (1977) indicates that sexual assertiveness is a sub-type of sexual communication and has been defined as a person's ability to communicate sexual needs and initiate sexual behaviour with a partner. There are at least two forms of sexual assertiveness. One involves communicating one's sexual needs and desires. Even many adults have inhibitions about asserting their sexual desires openly and clearly. And even in the most loving and caring relationships, asking for what you want can be hard: What if your partner perceives a request as a threat or a criticism? What if the request simply is too embarrassing to make out loud? These skills, however, are merely supplementary to a second form of sexual assertiveness, which is reflected in the understanding that it is not okay for anyone to touch or kiss you when you do not want it, that you do not have to have sex if you do not want to, and that you need not be pressured into doing anything sexually with which you are not comfortable. These beliefs and, indeed, the skills required to act on them are invariably rooted in how we feel about ourselves and our bodies, and how we allow others to treat us on a day-to-day basis. To be "assertive" means to pursue one's goals or to state with assurance and self-confidence (East and Adams, 2002).

7. Materials and Methods

The study adopted a pre-test, post-test, control group quasi experimental design using a 3x2x2 factorial matrix with treatment strategies at two levels. It was used to examine the effects of rational emotive behaviour therapy and assertiveness skills training on healthy sexual behaviours of adolescents with learning disabilities in Ibadan metropolis, Nigeria. The design is represented below:

Experimental group 1	(E1):	O_1	X_1	O_4
Experimental group 2	(E2):	O_2	X_2	O_5
Control group 3	(C):	O_3		O_6

Where O_1, O_2, and O_3 represent pre-test, observations of experimental group 1 (E1), experimental group 2 (E2), and the control (C) respectively. While O_4, O_5, and O_6 represent post-test observations for experimental groups 1, 2, and the control respectively. X_1 represents the treatment programme 1 (Rational Emotive Behaviour Therapy). X_2 represents the treatment programme 2 (Assertiveness Skills Training).

The target population for this study was all adolescents with learning disabilities who practice risky sexual behaviours and are between the ages of 10-16 years in Ibadan metropolis, Nigeria.

Three schools were selected within Ibadan metropolis. Also, in each of the three selected schools, class teachers nominated adolescents with record of poor academic performance based on their past examination records as this is associated with learning disabilities. Then there was a general screening of the selected students for learning disabilities with Pupil Rating Scale. Students identified as having learning disabilities were randomly assigned to treatment and control groups.

Finally, there was a further screening of all the assigned adolescents with learning disabilities for sexual abstinence and healthy sexual behaviour using Sexual Abstinence Scale and Safe Sex Behaviour Questionnaire. Adolescents with learning disabilities who do not practice abstinence and safe sex behaviours were then re-assigned into three groups (the two treatment groups and control). Each of the three groups consisted of twenty eight (28) participants which gave a total of eighty four (84) participants used for the study.

The adolescent students with learning disabilities used for this study were pre-tested with Adolescents with Learning Disabilities' Sexual Behaviour Scale for the three groups. This was done before the treatment proper during the first week of the training programme.

The participants in the two experimental groups were exposed to treatment for ten weeks of a lesson per week. This lasted for forty-five minutes per lesson. Participants in the control group were not given any treatment. Participants in the two experimental groups received training in rational emotive behaviour therapy and assertiveness skills

training. Active-directive strategies were employed to enhance the acquisition of the basic skills. These include:

- Setting of behavioural objectives;
- Giving systematic instructions on topics being considered;
- Demonstration or role-play aspects of sexual discussions;
- Giving participants opportunity to apply self therapy and to rehearse what they observed in role-play;
- Giving participant opportunity to think and perform the observed knowledge which they already rehearsed;
- Giving the participants behavioural homework on each lesson taught.

6.1 Brief Description of the Treatment Sessions

Experimental Group A: Rational Emotive Behaviour Therapy

The session entails:

Session 1: General Orientation and pre-test Administration;
Session 2: The Meaning of Rational Emotive Behaviour Therapy;
Session 3: Core Irrational Beliefs of REBT;
Session 4: The ABCDE of Rational Emotive Behaviour Therapy;
Session 5: Rational and Irrational Thinking;
Session 6: Disputing Irrational Beliefs;
Session 7: Concept of Adolescents Sexual Behaviour;
Session 8: Identification of the Ranges of Adolescents Sexual Behaviour;
Session 9: Irrational Beliefs and Misconception about Sexual Behaviours;
Session 10: Revision and post-test administration.

Experimental Group B: Assertiveness Skills Training

The session entails:

Session 1: General orientation and pre-test administration;
Session 2: The Meaning of Assertiveness;
Session 3: Ten Assertive Rights of an Individual;
Session 4: The Skills of Assertiveness;
Session 5: Forms of sexual assertiveness;
Session 6: Sexual Rights of an Adolescent;
Session 7: Concept of Adolescents Sexual Behaviour;
Session 8: Identification of the Ranges of Adolescents Sexual Behaviour;
Session 9: Role-Play on Sexual Assertiveness using Assertiveness skills;
Session 10: Revision and post-test administration.

Control group C: Pre and post-test administration with conventional method of training that is not in line with the two treatment packages used for experimental group 1 and 2.

The data collected were analyzed using mean and standard deviation. The Analysis of Covariance (ANCOVA) was also used to test the significant differences among several mean scores in the data. Also, the SCHEFFE Post Hoc Test was used to isolate the source of significant main effects and to determine which of the independent variables is more significant than the other.

8. Results

Five null hypotheses were tested at the significance level of 0.05.

Hypothesis One: There is no significant main effect of treatment on sexual behaviours of adolescents with learning disabilities.

Table 1: Summary of Analysis of Covariance (ANCOVA) of Pre-Post Test Interactive Effect of Sexual Behaviours of Adolescents with Learning Disabilities in the Treatment Groups, Age and Gender

Source	Sum of Squares	Df	Mean Square	F	Sig.	Eta Squared
Corrected Model	9678.602[a]	12	806.550	15.931	.000	.729
Intercept	3249.142	1	3249.142	64.176	.000	.475
Covariance	2708.222	1	2708.222	53.492	.000	.430
One-way interaction						
Treatments	6272.473	2	3136.237	61.946	.000	.636
Age	72.939	1	72.939	1.441	.234	.020
Gender	68.260	1	68.260	1.348	.249	.019
Two-way interactions						
Treatment x Age	268.128	2	134.064	2.648	.078	.069
Treatment x Gender	169.399	2	84.699	1.673	.195	.045
Age x Gender	183.143	1	183.143	3.617	.061	.048
Three-way interactions						
Treatment x Age x Gender	353.476	2	176.738	3.491	.036	.090
Error	3594.636	71	50.629			
Total	2077514.000	84				
Corrected Total	13273.238	83				
a. R Squared = .729 (Adjusted R Squared = .683)						

The result of hypothesis one from Table 1 shows that there is significant main effect of treatments in the pre-post test scores on sexual behaviours of adolescents with learning disabilities in the experimental and control groups ($F_{(2, 71)} = 61.95$, $p < 0.05$). This means that there was significant main effect of treatment in the mean posttest scores on healthy sexual behaviours of participants exposed to the treatments. This indicates that adolescents with learning disabilities in the experimental groups benefitted from the treatment packages in fostering healthy sexual behaviours better than those in the control group. Therefore, hypothesis one is not accepted.

To further establish and determine the actual source of the observed significant main effect in ANCOVA, a Scheffe Post Hoc Analysis was carried out on the post test mean scores of the three groups as presented in Table 2.

Table 2: Scheffe Post Hoc Multiple Comparison of the Mean Differences of Treatments and Control Groups on Sexual Behaviours of Adolescents with Learning Disabilities

(I) Treatment group	(J) Treatment Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
REBT	AST	5.71429	2.53452	.085	-.6061	12.0347
	Control	20.07143*	2.53452	.000	13.7511	26.3918
AST	REBT	-5.71429	2.53452	.085	-12.0347	.6061
	Control	14.35714*	2.53452	.000	8.0368	20.6775
Control	REBT	-20.07143*	2.53452	.000	-26.3918	-13.7511
	AST	-14.35714*	2.53452	.000	-20.6775	-8.0368
*. The mean difference is significant at the 0.05 level.						

The post hoc multiple comparisons in Table 2 shows the performance of the participants in all the groups. The direction of decreasing main effect of treatment on sexual behaviour of adolescents with learning disabilities is Rational Emotive Behaviour Therapy = Assertiveness Skills Training > Control Group. It further shows that neither Rational Emotive Behaviour Therapy nor Assertiveness Training groups was more significant than the other in fostering healthy sexual behaviours among adolescents with learning disabilities.

Table 3 is therefore presented on the mean scores of sexual behaviours of adolescents with learning disabilities.

Table 3: The Mean and Standard Deviation Scores of Participants based on the Treatment, Age and Gender

Source	Mean	Std. Deviation	NO
Treatment			
REBT	165.36	9.14	28
AST	159.64	6.90	28
Control	145.29	11.78	28
Total	156.76	12.65	84
Age			
10-13 years	154.69	15.14	42
14-16 years	158.83	9.25	42
Total	156.76	12.65	84
Gender			
Male	157.29	12.24	42
Female	156.24	13.17	42
Total	156.76	12.65	84

Table 3 shows that the control group had the lowest mean score ($\bar{x}$= 145.29), followed by assertiveness skills training group with mean score of ($\bar{x}$ = 159.64) and rational emotive behaviour therapy had the highest mean score ($\bar{x}$ = 165.36). This implies that there is significant difference in the two treatment groups and control group showing that participants in the treatment groups benefitted better than the control group.

Hypothesis Two: There is no significant interaction effect of treatment and age on sexual behaviours of adolescents with learning disabilities.

The result in Table 1 revealed that there was no significant interaction effect of treatment and age in the pre-post test sexual behaviour scores of adolescents with learning disabilities in the experimental and control groups ($F_{(2, 71)} = 2.648$, $p > 0.05$). This implies that the effect of the interaction of treatment and age on sexual behaviours of adolescents with learning disabilities was not statistically significant and it shows that treatment is not dependent on age. Therefore, the null hypothesis is accepted.

The mean and standard deviation scores of participants based on treatment and age are presented in Table 4.

Table 4: The Mean and Standard Deviation Scores of Treatment and Age

Treatment group	Age	Mean	Std. Deviation	N
REBT	10 – 13 years	164.93	11.28	14
	14 – 16 years	165.79	6.76	14
	Total	165.36	9.14	28
AST	10 – 13 years	158.64	7.31	14
	14 – 16 years	160.64	6.58	14
	Total	159.64	6.90	28
Control	10 – 13 years	140.50	14.00	14
	14 – 16 years	150.07	6.53	14
	Total	145.29	11.78	28
Total	10 – 13 years	154.69	15.14	42
	14 – 16 years	158.83	9.25	42
	Total	156.76	12.65	84

Table 4 indicated that the mean scores of the experimental groups and control group in relation to age are revealed thus: Rational Emotive Behaviour Therapy ($\bar{x}$ = 165.36), Assertiveness Skills Training ($\bar{x}$ = 159.64) and Control ($\bar{x}$ = 145.29). This implies that there was no significant interaction between treatments and age on sexual behaviours of adolescents with learning disabilities (($F_{(2, 71)} = 2.648$, $p > 0.05$).

Hypothesis Three: There is no significant interaction effect of treatment and gender on sexual behaviours of adolescents with learning disabilities.

Table 1 revealed that there was no significant interaction effect of treatment and gender in the pre-post test scores of sexual behaviours of adolescents with learning disabilities ($F_{(2, 71)} = 1.673$, $p > 0.05$). This indicates that the effect of the interaction of

treatment and gender on the sexual behaviours of participants was not statistically significant. Therefore, the null hypothesis is accepted.

The mean and standard deviation scores of participants based on treatment and gender are presented in Table 5.

Table 5: The Mean and Standard Deviation Scores of Treatment and Gender

Treatment Group	Gender	Mean	Std. Deviation	N
REBT	Male	164.43	11.30	14
	Female	166.29	6.63	14
	Total	165.36	9.14	28
AST	Male	161.93	5.09	14
	Female	157.36	7.86	14
	Total	159.64	6.90	28
Control	Male	145.50	9.55	14
	Female	145.07	14.02	14
	Total	145.29	11.78	28
Total	Male	157.29	12.24	42
	Female	156.24	13.17	42
	Total	156.76	12.65	84

Table 5 shows that the mean scores of the experimental groups and control group in relation to age are revealed thus: Rational Emotive Behaviour Therapy ($\bar{x}$ = 165.36), Assertiveness Skills Training ($\bar{x}$ = 159.64) and Control ($\bar{x}$= 145.29). This implies that there is no significant interaction between treatments and gender on sexual behaviours of adolescents with learning disabilities ($F_{(2, 71)} = 1.673$, $p > 0.05$).

Hypothesis Four: There is no significant interaction effect of age and gender on sexual behaviours of adolescents with learning disabilities.

Table 1 indicated that there was no significant interaction effect between age and gender ($F_{(1, 71)} = 3.617$, $p > 0.05$). This shows that the impact of the interaction of age and gender on sexual behaviours of adolescents with learning disabilities was not statistically significant. Hence, the null hypothesis is accepted.

The mean and standard deviation scores of participants based on gender and age are presented in Table 6.

Table 6 shows that the mean scores of gender with age are revealed thus: Male ($\bar{x}$ = 157.29) and Female ($\bar{x}$ = 156. 24). This implies that there was no significant interaction between age and gender on sexual behaviours of adolescents with learning disabilities ($F_{(1, 71)} = 3.617$, $p > 0.05$).

Table 6: The Mean and Standard Deviation Scores of Gender and Age

Gender	Age	Mean	Std. Deviation	N
Male	10 – 13 years	155.19	14.29	21
	14 – 16 years	159.38	9.68	21
	Total	157.29	12.24	42
Female	10 – 13 years	154.19	16.29	21
	14 – 16 years	158.29	9.01	21
	Total	156.24	13.17	42
Total	10 – 13 years	154.69	15.14	42
	14 – 16 years	158.83	9.25	42
	Total	156.76	12.65	84

Hypothesis Five: There is no significant interaction effect of treatment, age and gender on sexual behaviours of adolescents with learning disabilities.

Table 1 revealed that significant interaction effect was found in the treatment, age and gender of the participants on their sexual behaviours ($F_{(2, 71)} = 3.491$, $p < 0.05$). This implies that the impact of the interaction of treatment, age and gender on sexual behaviours of adolescents with learning disabilities was statistically significant. Hence the null hypothesis was not accepted.

The mean and standard deviation scores of participants based on the treatment, gender and age are presented in table 7.

Table 7: The Mean and Standard Deviation Scores of the Interaction of Treatment, Gender and Age

Treatment group	Gender	Age	Mean	Std. Deviation	N
REBT	Male	10-13yrs	162.71	15.80	7
		14-16yrs	166.14	4.49	7
		Total	164.43	11.30	14
	Female	10-13yrs	167.14	3.85	7
		14-16yrs	165.43	8.87	7
		Total	166.29	6.63	14
	Total	10-13yrs	164.93	11.28	14
		14-16yrs	165.79	6.76	14
		Total	165.36	9.14	28
AST	Male	10-13yrs	160.43	4.65	7
		14-16yrs	163.43	5.41	7
		Total	161.93	5.09	14
	Female	10-13yrs	156.86	9.32	7
		14-16yrs	157.86	6.82	7
		Total	157.36	7.86	14
	Total	10-13yrs	158.64	7.31	14
		14-16yrs	160.64	6.58	14
		Total	159.64	6.90	28
Control	Male	10-13yrs	142.43	11.03	7
		14-16yrs	148.57	7.35	7
		Total	145.50	9.55	14

	Female	10-13yrs	138.57	17.15	7
		14-16yrs	151.57	5.77	7
		Total	145.07	14.02	14
	Total	10-13yrs	140.50	14.00	14
		14-16yrs	150.07	6.53	14
		Total	145.29	11.78	28
Total	Male	10-13yrs	155.19	14.30	21
		14-16yrs	159.38	9.68	21
		Total	157.29	12.24	42
	Female	10-13yrs	154.19	16.29	21
		14-16yrs	158.29	9.01	21
		Total	156.24	13.17	42
	Total	10-13yrs	154.69	15.14	42
		14-16yrs	158.83	9.25	42
		Total	156.76	12.65	84

Table 7 shows that the mean scores of the different treatment and control groups in conjunction with gender and age are revealed thus: Rational Emotive Behaviour Therapy ($\bar{x}$ = 165.36), Assertiveness skills Training ($\bar{x}$ = 159.64) and Control ($\bar{x}$ = 145.29). This implies that there were significant interaction effects among treatments, age and gender on sexual behaviours of adolescents with learning disabilities ($F_{(2, 71)} = 3.491$, $p < 0.05$).

9. Discussion

9.1 Effect of Treatment on Healthy Sexual Behaviours of Adolescents with Learning Disabilities

The result indicated that there was significant main effect of treatment on healthy sexual behaviours of adolescents with learning disabilities. This shows that significant differences exist among the three groups that is rational emotive behaviour therapy, assertiveness skills training and the control group. It indicates that adolescents with learning disabilities benefitted from the two treatment packages more than those in the control group. Also, it shows that neither rational emotive behaviour therapy nor assertiveness skills training proved more significant than the other.

This implies that the two therapeutic programmes proved to be effective in improving healthy sexual behaviours of adolescents with learning disabilities. The post test scores of sexual behaviours of participants in the experimental groups showed that the treatment gained was effective. On the other hand, the low scores attained by participants in the control group as observed in the post test mean score could be explained by the fact that they were not exposed to the same treatment package as the two experimental groups.

This finding proved that if adolescents with learning disabilities expressing ignorance in sexual matters and also involved in practicing risky sexual behaviours, are exposed to corrective interventions like rational emotive behaviour therapy or

assertiveness skills training, it could go a long way to help improve their sexual knowledge, beliefs and rights. Also, the results of the findings revealed that in fostering healthy sexual behaviour among adolescents with learning disabilities, adolescents in assertiveness skills training group performed equally well as their counterparts in rational emotive behaviour therapy group.

Different researchers in other studies found rational emotive behaviour therapy more effective than the control group as reported by (Maultsby, *et al.,* 1974; Omizo and Michael, 1986; Corsini and Wedding, 1989; Osiki, 1996; Olusakin, 2000; Rieckert and Moller 2000; Abosi, 2004; Kumar, 2009). Also, other studies reported that assertiveness skills training was more effective than the control group (Lazarus 1966; Akinade, 1988; Kelly *et.al.* 1990; Kling, 1990; Asuzu, 1998; Hammed, 1999; Chang, *et al.,* 2003; Mohebi, *et al.,* 2012).

9.2 Effect of Treatment and Age on Healthy Sexual Behaviours of Adolescents with Learning Disabilities

The result indicated that there was no significant interaction effect of treatment and age in the post test scores on healthy sexual behaviours of adolescents with learning disabilities. This shows that age did not influence the ability of the participants to benefit from the treatment. The participants benefitted from the treatment irrespective of their ages. It is therefore suggested that teaching of sexuality with rational emotive behaviour therapy and assertiveness skills training should commence early during adolescence period so that they can be helped in reducing risk taking behaviour and increase in sexual interest which are common in the middle adolescence period as noted by Get Organized (1999).

9.3 Effect of Treatment and Gender on Healthy Sexual Behaviours of Adolescents with Learning Disabilities

The result showed that there was no significant interaction effect of treatment and gender in the post test scores on healthy sexual behaviours of adolescents with learning disabilities. This implies that gender did not influence the ability of the participants to benefit from the treatment.

This implies that there was no significant difference observed among the groups in respect to gender of the participants. Moore (1999) supported that there was no significant difference in the male and female mean scores at the post study assessment of at-risk adolescents on the variables of rational thinking, attitude to school, social competence and anti social behaviours. On the other hand, Moody (1999) found that gender seemed a strong moderating factor in students sexual behaviours as main effects were found to be significant on the positive sex behaviour measure. There was significant interaction effect of treatment on the independent variables (moral value clarification and reproductive health education) as males had the higher post-test mean score than the female. The variations in the reports can be attributed to the nature of participants used

in the different studies as there was no interaction effect of treatment and age on sexual behaviours of adolescents with learning disabilities as compared to those without learning disabilities.

Therefore, this study shows that both rational emotive behaviour therapy and assertiveness skills training can be employed with either male or female adolescents with learning disabilities. Also, gender plays no part in determining which intervention makes the greatest difference in fostering healthy sexual behaviours among adolescents with learning disabilities. This suggests that both male and female adolescents with learning disabilities would respond equally well to either treatment.

9.4 Effect of Age and Gender on Healthy Sexual Behaviours of Adolescents with Learning Disabilities

The finding indicated that there was no significant interaction effect of age and gender in the post test scores on healthy sexual behaviours of adolescents with learning disabilities. This implies that age and gender had no moderating influence on the sexual behaviour scores of adolescents with learning disabilities. Whether an adolescent with learning disability is an early adolescent (10-13 years) or middle adolescent (14-16 years), male or female, there is no different in the way he/she expresses knowledge, beliefs and rights on issues of sexual behaviours. Hence age and gender do not have interactive effect on sexual behaviour of adolescents with learning disabilities.

9.5 Effect of Treatment, Age and Gender on Healthy Sexual Behaviours of Adolescents with Learning Disabilities

The result revealed that there was significant interaction effect of treatment, age and gender in the post test scores on sexual behaviours of adolescents with learning disabilities. This suggests that treatment, age and gender when combined influenced the sexual behaviour scores of adolescents with learning disabilities as reported in the result but when separated there was no significant different. This implies that both rational emotive behaviour therapy and assertiveness skills training can be employed with age and gender to foster healthy sexual behaviours of adolescents with learning disabilities. In other words, treatment, age and gender when combined are determining factors in fostering healthy sexual behaviours among adolescents with learning disabilities. The treatments (rational emotive behaviour therapy and assertiveness skills training) are also dependent on age and gender and have moderating effect on the healthy sexual behaviours of adolescents with learning disabilities.

10. Recommendation

- In fostering healthy sexual behaviours of adolescents with learning disabilities, researchers should study more intensely on sexual behaviours of adolescents with

learning disabilities and how to address them using therapeutic strategies like rational emotive behaviour therapy and assertiveness skills training.

- Special education teachers should be well trained in the area of sexual behaviour needs of adolescents with learning disabilities in order to help provide adequate interventions and professional assistance to addressing the unhealthy sexual behaviours of adolescents with learning disabilities.
- Parents should be involved in the sexuality education of their adolescents with learning disabilities by complimenting the efforts of the teachers at home and providing emotional supports to those going through any form of sexual abuse or the other. There should be communication between the home and school to create a cooperative and enabling atmosphere for successful learning both at home and in school environment. Special educators need to work in a supportive way with parents, and be sensitive to their experiences and concerns about their adolescents' level of vulnerability.
- The researchers recommend that the government have a great role to play by providing continuous in-service programmes/trainings, workshop, seminars and conferences for special educators on the issues of healthy sexual behaviours among adolescents with learning disabilities.
- Furthermore, the two treatment packages used in this study (rational emotive behaviour therapy and assertiveness skills training) should be introduced in schools for adolescents with learning disabilities irrespective of age or gender. Therefore, adolescents with learning disabilities should be encouraged to practice their sexual rights when the need arises and dispute any form of irrational beliefs about sexual behaviours in order to live a healthy sexual life.

11. Conclusion

This study determined the effects of rational emotive behaviour therapy and assertiveness skills training on healthy sexual behaviours among adolescents with learning disabilities in Ibadan, Nigeria. Training programmes were carried out in the two experimental groups and there was a control group. Data were generated from the study, analysed and discussed.

Special educators must come to understand their role in helping adolescents with learning disabilities foster healthy sexual behaviour with the use of appropriate strategies like rational emotive behaviour therapy and assertiveness skills training. The findings of this study have proved that rational emotive behaviour therapy and assertiveness skills training were effective in fostering healthy sexual behaviours among adolescents with learning disabilities over the control group.

Special educators and researchers in learning disabilities should come to term with the sexual behaviour needs of adolescents with learning disabilities which manifest mostly as a result of their poor academic achievement and inabilities to cope with school

activities. Appropriate curriculum should be developed for them in the area of sexuality education to help address these unmet needs of adolescents with learning disabilities.

Adolescents with learning disabilities can therefore be helped and assisted by special educators in fostering healthy sexual behaviours by giving them adequate information on sexuality through rational emotive behaviour therapy and assertiveness skills training in order to reduce the incidences of sexually transmitted diseases, unwanted pregnancies, HIV/AIDS, sexual abuses and other risky sexual behaviour reportedly common among adolescents with learning disabilities.

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Appendix 1: The Pupil Rating Scale Revised by Myklebust (1981)

A. Screening for Learning Disabilities

Pupil's Name: ……..…. Sex: …… Date: …….

Year/Month/Day

Residence: ……..…… Born: ……..…….

Year/Month/Day

Parents: …….. Age: ……

Years/Months/Days

School: ……..

Teacher: ……. Grade: ……..

Summary of Scores

Auditory Comprehension: …….
Spoken Language: …….. Verbal Score: ……
Orientation: ……
Motor Coordination: ……
Personal Social Beh.: …… Non Verbal Score: …….

Total Scale Score: …….

B. Instructions

Some children have deficits in learning which distinguish them from others in their class. The Pupil Rating Scale was developed so that these children can be more readily identified.

The scale consists of five behavioural characteristics:

1) Auditory comprehension and memory,
2) Spoken language,
3) Orientation,
4) Motor coordination, and
5) Personal social behaviour.

Rate each child on these five characteristics. Make your ratings on a five point scale. A rating of 3 is average. Ratings of 1 and 2 are below average. Rating of 4 and 5 are above average. A rating of 1 is the lowest and a rating of 5 is the highest that can be given. Indicate your rating by circling the number that represents your judgment of the child's

level of function. When making your evaluation, rate only one area of behaviour at a time, bearing in mind that a child might be functioning well in some respects but not in others.

The primary purpose of using the Pupil Rating Scale is to identify children who have learning disabilities. It is not intended that it serve as an indicator of inferior potential or lack of opportunity for observing each child before making your ratings only on the basis of the items on this scale without concern for their factors.

For your ratings to be as discriminating as possible, you should have extensive opportunity for observing each child before making your judgments. Also, study the definition of the items given in the manual. Your ratings are of considerable value. They serve as the initial screening so children who need further assessment can be identified.

C. Rate the Child on these Behavioural Characteristics

a. Auditory Comprehension and Memory

Comprehending Word Meanings	**Rating**
Extremely immature level of understanding	1
Fails to grasp simple word meanings, misunderstands words at grade level	2
Good grasp of vocabulary for age and grade	3
Understanding all grade level vocabulary as well as higher level word meaning	4
Superior understanding vocabulary; understands many abstract words	5

Following Instructions	
Unable to follow instructions; always confused	1
Usually follows simple instructions but often needs individual help	2
Follows instructions that are familiar and not complex	3
Remembers and follows extended instructions	4
Unusually skilful in remembering and following instructions	5

Comprehending Class Discussions	
Unable to follow and understand class discussions; always inattentive	1
Listen but rarely understands well, mind often wanders	2
Listens and follows discussions according to age and grade	3
Understands well; benefits from discussions	4
Becomes involved; shows unusual understanding of material	5

Retaining Information	
Almost total lack of recall; poor memory	1
Retains simple ideas and procedures if repeated	2
Average retention of materials; adequate memory for age and grade	3
Remembers information from various sources; good immediate	

and delayed recall	4
Superior memory for details and content	5

Score _____

b. Spoken Language

Vocabulary	**Rating**
Always uses immature, poor vocabulary	1
Limited vocabulary, primary simple hours; few precise descriptive words	2
Adequate vocabulary for age and grade	3
Above-average vocabulary; uses numerous precise, descriptive words	4
High-level vocabulary; always uses precise words; conveys abstraction	5

Grammar

Always uses incomplete sentences with grammatical errors	1
Frequently uses incomplete sentences; numerous grammatical errors	2
Uses and correct grammar; few errors in use of prepositions, verb tense and pronouns	3
Above average oral language: rarely makes grammatical errors	4
Always speaks in grammatically correct sentences	5

Word Recall

Unable to recall the exact word	1
Often gropes for word to express himself/herself	2
Occasionally searches for correct word; recall adequate for age and grade	3
Above average; rarely hesitate on a word	4
Always speaks well; never hesitates or substitutes	5

Story Telling – Relating Experiences

Unable to tell a comprehensible story	1
Difficulty relating ideas in a logical sequence	2
Average; adequate for age and grade	3
Above average; adequate for age and grade	4
Exceptional relates ideas in a logical, meaningful manner	5

Expression of Ideas

Unable to relate isolated facts	1
Difficulty relating isolated facts; incomplete and scattered ideas	2
Usually relates facts meaningfully; relates facts adequately for age and grade	3
Above average; relates facts and ideas well	4
Outstanding; always relates facts appropriately	5

Score _____

c. Orientation

Judging Time	**Rating**
Lacks grasp of meaning of time; always late confused	1
Fair time concept; tends to dawdle; often late	2
Average time judgments; adequate for age and grade	3
Prompt; late only with good reasons	4
Skillful in handling schedules; plans and organizes well	5
Spatial Orientation	
Always confused; unable to navigate around school, playground or neighbourhood	1
Frequently gets lost in relatively familiar surroundings	2
Can manoeuvre in familiar locations; average ability for age and grade	3
Above average; rarely lost or confused	4
Adapts to new situations and locations; never lost	5
Judging Relationships (big-little, far-close, heavy-light)	
Judgments always inadequate	1
Makes elementary judgments successfully	2
Average judgments forage and grade	3
Accurate but does not generalize to new situations	4
Unusually precise judgments; generalize to new situations and experiences	5
Knowing Directions	
Highly confused, unable to distinguish right-left, north-south, east-west	1
Sometimes exhibit confusion	2
Average; uses right-left, north-south-east-west	3
Good sense of direction seldom confused	4
Excellent sense of direction	5
Score	

d. Motor Coordination

General Coordination (walking, running, hopping, climbing)	**Rating**
Very poorly coordinated; clumsy	1
Below average; awkward	2
Average for age; graceful	3
Above average; does well in motor activities	4
Excels in coordination	5

Balance	
Very poor balance	1
Below-average ability, fails frequently	2
Average ability for age adequate equilibrium	3
Above average ability in activities requiring balance	4
Excels in balance	5

Manual Dexterity	
Very poor in manual dexterity	1
Awkward, below average in dexterity	2
Adequate dexterity for age, manipulates well	3
Above-average dexterity	4
Excels; readily manipulates new equipment	5

Score _____

e. Personal-Social Behaviour

Cooperation	**Rating**
Continually disrupts classroom; unable to inhibit responses	1
Frequently demands attention; often speaks out of turn	2
Waits his/her turn; aver all age and grade	3
Above average; cooperates without adult encouragement	4
Excellent ability; cooperates without adult encouragement	5

Attention	
Never attentive; very distractible	1
Rarely listens; attention frequently wanders	2
Attention adequate for age and grade	3
Above average; in attention, almost always attends	4
Always attends to important aspects; long attention span	5

Organisation	
Highly disorganized; very slovenly	1
Often disorganized in manner of working; inexact, careless	2
Maintains average organization of work, careful	3
Above-average organization, organizes and complete work	4
Highly organized, completes assignments in meticulous manner	5
New Situations (parties, trips, changes in routine)	
Becomes extremely excitable, totally lacking in self control	1
Often overreacts; finds new situations disturbing	2
Adapts adequately for age and grade	3
Adapts easily and quickly with self-confidence	4
Excellent adaptation, shows initiative and independence	5
Social Acceptance	
Avoided by others	1
Tolerated by others	2
Liked by others, average for age and grade	3
Well liked by others	4
Sought by others	5
Responsibility	
Rejects responsibility, never initiates activities	1
Avoids responsibility; limited acceptance of role for age	2
Accepts responsibility; adequate for age and grade	3
Above average in responsibility, enjoys responsibility; initiates and volunteers	4
Seeks responsibility, almost always takes initiative with enthusiasm	5
Completion of Assignments	
Never finishes even with guidance	1
Seldom finishes even with guidance	2
Average performance; follows through on assignments	3
Above average performance, completes assignment without urging	4
Always completes assignments without supervision	5
Tactfulness	
Always rude	1
Usually disregards feelings of others	2
Average tact; behaviour occasionally inappropriate socially	3
Above average in tactfulness; behaviour rarely inappropriate socially	4
Always tactful; behaviour never socially inappropriate	5
	Score

Appendix 2

1. Sexual Abstinence Scale

By Asuzu, C. C. (2013)
Department of Guidance and Counselling
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University of Ibadan, Ibadan

This questionnaire is designed to obtain information on sexual abstinence as a way to STD/HIV/AIDS prevention in Ibadan, Nigeria. There are no true or false answers. Please answer all the questions. Your answers will be treated with utmost confidentiality. Thank you for your cooperation.

A. Social Demographic Data

1. Age.....(in years as at last birthday)
2. School.....
3. Gender/Sex: Male/Female
4. Type of family: 1. Monogamous 2. Polygamous
5. Goal in life.....
6. Religion: 1. Christianity 2. Muslim 3. Others.....

B. Please respond appropriately to the items below by ticking in the box the number corresponding to your response:

1. Strongly Disagree
2. Disagree
3. I don't Know
4. Strongly Agree

Part 1: Knowledge of Sexual Abstinence

S/N		**1**	**2**	**3**	**4**	**5**
1	Sex with animals instead of human beings is partly abstinence					
2	Masturbation(sexual self pleasuring) is part of the practice of chastity or sexual abstinence					
3	Sex with a virgin can cure HIV/AIDS					
4	Oral sex is part of abstinence					
5	Anal sex is part of abstinence					
6	Heavy petting without intercourse is part of sexual abstinence					

Part 2: Perceived Risks of Sexual Abstinence

S/N		1	2	3	4	5
1	Abstinence can lead to mental breakdown					
2	Abstinence can prevent the making of otherwise good friends					
3	Abstinence encourages bad relationship					
4	Abstinence does not provide basis for trust					

5	Abstinence can lead to late marriage					
6	Abstinence can cause some diseases due to having sex late in life					

Part 3: Attitude towards Sexual Abstinence

S/N		1	2	3	4	5
1	Abstinence can only be reinforced through verbal campaigns reinforced by right values					
2	People who teach or insist on abstinence for youths do not love them					
3	Abstinence is good but is generally impossible for anybody to practice					
4	People who insist on abstinence for youths are unreasonable					
5	Helping youths to be sexually abstinent is an unfriendly act towards the youth					

Part 4: Benefits of Sexual Abstinence

S/N		1	2	3	4	5
1	Chastity or abstinence grants you freedom from unwanted pregnancy and HIV/STI					
2	Abstinence frees you from depression					
3	Abstinence increases the chances of your developing yourself in full					
4	Abstinence increases your ability to improve in academic performance					
5	Abstinence increases your ability to love people clearly, fully and to develop real and lasting relationships with them					
6	Abstinence increases your ability to plan your mind and future with a clear mind					
7	Abstinence from sexual intercourse is the only sure way to avoid out of wedlock (and all) pregnancies as well as sexually transmitted diseases					
8	Abstinence discourages the having of children outside marriage which may have harmful consequences for the child, his parents and the society					
9	Abstinence protects the most delicate sex organ, the mind					
10	Abstinence enables one to make decisions for the future					
11	Abstinence enhances communication between you and your friends					
12	Abstinence provides opportunity to make parents proud					

Part 5: Sexual Abstinence Self-Efficacy

S/N		1	2	3	4	5
1	I do not know how to practice sexual abstinence					
2	I need training in acquiring sexual abstinence skills					
3	I know how to practice sexual abstinence					
4	I am able to abstain from sexual intercourse for as long as i want					

Part 6: Sexual Abstinence Education

S/N		1	2	3	4	5
1	Sexual abstinence as a value should be taught at home					
2	Sexual abstinence education is the primary responsibility of parents					
3	Sexual abstinence education of children is not the role of extended family members					
4	Sexual abstinence education should be taught in formal schools.					

5	Sexual abstinence education is the primary responsibility of religious organizations					
6	Sexual abstinence education can boost self-image					

Appendix 3

1. Safe Sex Behavior Questionnaire

By Dilorio, C. (2009)
Department of Behavioural Sciences and Health Education
Rollins School of Public Health
Emory University, Atlanta, GA

The Safe Sex Behaviour Questionnaire (SSBQ) was designed to measure frequency of use of recommended practices that reduce one's risk of exposure to, and transmission of, HIV.

2. Demographic Information

Please tick and fill appropriately in the spaces provided

Age: 10 - 13 ☐ 14 – 16 ☐
Sex: Male ☐ Female ☐
Religion: Christianity ☐ Islam ☐ Traditional ☐
Others (Specify) …….
Ethnicity: Yoruba ☐ Igbo ☐ Hausa ☐
Others (Specify)…….
School:…….
Class:……

Directions: Below is a list of sexual behaviours. Please read each statement and respond by indicating your degree of use of these practices.

S/N		1	2	3	4
*1	I am currently having sexual intercourse				
2	I insist on condom use when I have sexual intercourse.				
*3	I use cocaine or other drugs prior to or during sexual intercourse.				
4	I stop foreplay long enough to put on a condom (or for my partner to put on a condom).				
5	I ask potential sexual partners about their sexual histories.				
6	I avoid direct contact with my sexual partner's semen or vaginal secretions.				
7	I ask my potential sexual partners about a history of bisexual/homosexual practices.				
*8	I engage in sexual intercourse on a first date.				
9	I abstain from sexual intercourse when I do not know my partner's sexual history.				
10	I avoid sexual intercourse when I have sores or irritation in my genital area.				

11	If I know an encounter may lead to sexual intercourse, I carry a condom with me.				
12	I insist on examining my sexual partner for sores, cuts, or abrasions in the genital area.				
13	If I disagree with information that my partner presents on safer sex practices, I state my point of view.				
*14	I engage in oral sex without using protective barriers such as a condom or rubber dam.				
*15	If swept away in the passion of the moment, I have sexual intercourse without using a condom.				
*16	I engage in anal intercourse.				
17	I ask my potential sexual partners about a history of IV (hard) drug use.				
18	If I know an encounter may lead to sexual intercourse, I have a mental plan to practice safer sex.				
19	If my partner insists on sexual intercourse without a condom, I refuse to have sexual intercourse.				
20	I avoid direct contact with my sexual partner's blood.				
*21	It is difficult for me to discuss sexual issues with my sexual partners.				
22	I initiate the topic of safer sex with my potential sexual partner.				
*23	I have sexual intercourse with someone who I know is a bisexual or gay person.				
*24	I engage in anal intercourse without using a condom.				
*25	1 drink alcoholic beverages prior to or during sexual intercourse.				

1 = Never; 2 = Sometimes; 3 = Most of the Time; 4 = Always
*Negatively worded items

Appendix 4

Adolescents with Learning Disabilities' Sexual Behaviour Scale

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Instruction

This scale is designed to assess the sexual actions and beliefs of adolescents with learning disabilities. Kindly respond by giving your opinion to issues raised below in the questionnaire. All information supplied will be treated with utmost confidentiality and will only be used for academic purposes.

Part 1

Demographic Information

Please tick and fill appropriately in the spaces provided

Age: 10 - 13 ☐ 14 – 16 ☐

Sex: Male ☐ Female ☐

Religion: Christianity ☐ Islam ☐ Traditional ☐

Others (Specify) …….

Ethnicity: Yoruba ☐ Igbo ☐ Hausa ☐

Others (Specify)…….

School:…….

Class:……

Part 2

Please rate the following items using the 3 point scale below. Tick the one that represents your response as:

- Agree
- Disagree
- Undecided

Section A

S/N	Sexual Knowledge	Agree	Disagree	Undecided
1	It is proper for the adolescent to be educated about reproductive organs of the male and female bodies.			
2	An adolescent girl can get pregnant at first sexual intercourse			
3	Having sex while standing or sitting do not prevent unwanted pregnancy			
4	Pregnancy can occur few days before menstruation			
5	Pregnancy cannot occur during menstruation			
6	Pregnancy can occur at the end of menstruation			
7	I do not feel shy to talk about sex			
8	Sex education can prevent unwanted pregnancy			
9	Sex education services are important to adolescents			
10	Wet dream is an erotic dream resulting in ejaculation			
11	Ovulation is the release of matured egg from the ovary			
12	Changes in the body do occur during puberty			
13	It is not difficult to obtain information about sexual behavior			
14	I need to discuss family planning method with partner before sex			
15	Birth control pills protect users against pregnancy			
16	Condom protects users against sexually transmitted diseases /HIV/AIDS			
17	Condom cannot be used more than once			

18	Injectable hormonal contraception is effective for preventing pregnancy			
19	Most contraceptives are safe for adolescents			
20	Abstinence is the best contraceptive method for adolescents			
21	HIV/AIDS is real			
22	AIDS can be transmitted to any body			
23	Sexual intercourse is not the only means of transmitting HIV/AIDS			

Section B

S/N	Sexual Beliefs	Agree	Disagree	Undecided
1	I believe female's body belongs to the male			
2	I believe females have less sexual desire			
3	I believe female bodies are shameful			
4	I believe that homosexuality is a kind of healthy sexual behaviour			
5	I believe that masturbation is not a healthy sexual behavior			
6	I believe that the use of contraceptive can cause abnormalities in babies			
7	I believe that mosquitoes can cause HIV/AIDS			
8	I believe that if a boy kisses a girl she will become pregnant			
9	I believe that if a girl have sexual intercourse with many boys within a month, she will not be pregnant because the sperms will kill each other			
10	I believe that if a girl takes some aspirin or paracetamol and a small bottle of stout before every sexual intercourse, she cannot be pregnant			
11	I believe that menstruation is the period of illness in every woman			
12	I believe talking about sex to people is an indecent talk. People should avoid it			
13	I believe, if you can play it safe there is no need for contraceptives			
14	I believe making condoms available to adolescents will increase sexual activities			
15	I believe that birth control pills cause cancer			
16	I believe there is no method of birth control that is 100% effective			
17	I believe that a girl is impure during menstruation			
18	I believe that if you talk with or educate adolescents about sexual health, they will experiment with sex			
19	I believe that males cannot be raped			

20	I believe that sex is the most important thing to an adolescent			
21	I believe everyone is doing it			
22	If you really love a boy or girl, you would want to sleep with him			

Section C

S/N	Sexual Rights	Agree	Disagree	Undecided
1	I have the right to make my own decisions regarding intercourse or other sexual activity regardless of the other person's wishes			
2	I can use contraceptive regardless of the other person's wishes			
3	I can tell the other person when I want to make love			
4	I can tell the other person I don't want to make love			
5	I can tell the other person I won't have intercourse without birth control			
6	I can tell the other person I want to make love differently			
7	I have the right to masturbate to orgasm			
8	I have the right to tell the other person he/she is being too rough			
9	I can tell the other person I want to be hugged or cuddled without sex			
10	I can tell my relative I am uncomfortable being hugged or kissed in certain ways.			
11	I have the right to ask the other person if he/she has been examined for S.T.Ds and HIV.			
12	I can stop foreplay at any time, including the point of intercourse			
13	I can refuse to have intercourse even though I might have had sex with the same person before and enjoyed it.			