THE IMPACT OF ALCOHOL ON THE SEXUAL BEHAVIOUR OF ADOLESCENT MALES IN NKONKOBE MUNICIPALITY

BY

SINOVUYO TAKATSHANA

Dissertation submitted in partial fulfilment of the requirements for the degree of

Masters of Social Science (Psychology)

In the

Department of Psychology

Faculty of Social Science and Humanities

At

University of Fort Hare

SUPERVISOR: Mr. J.G. Kheswa

January 2013
ACKNOWLEDGEMENTS

The journey I undertook during writing this study has been very long and taught me a lot about perseverance. It gives me great pleasure to thank a number of people without whom this dissertation could not have been completed. I am indebted to my supervisor, Mr. Jabulani Kheswa, for his solid guidance and constructive advice in the completion of this study. I thank every learner who took part in this study, whose participation contributed to make this dissertation possible. Adv.Dalena Mostert, thank you for editing and proof reading. To my family: Mom, thank you for your unconditional love and continued understanding; Mbali and Unati, you have been the guiding light through the darkness. There are no words that can express how grateful I am to have your love and support. Thank you for always encouraging me to follow my dreams and teaching me that anything is possible; Luyanda, thank you for always being there when I needed you the most and for providing joy when I thought all was gloomy. This MSoc. Sc degree, I dedicate to you.

Most importantly, the Lord Almighty - Your wonders never cease. I thank you!
DECLARATION

I declare that THE IMPACT OF ALCOHOL ON THE SEXUAL BEHAVIOUR OF ADOLESCENT MALES IN NKONKOBE MUNICIPALITY is my own work and that all the sources that have been used or quoted from have been acknowledged by means of complete references.

Signature…………………………

SINOVUYO TAKATSHANA

Date………………………………
ABSTRACT

The study aimed at investigating the impact of alcohol on the sexual behaviour of male adolescents, with the purpose of establishing whether a relationship exists between alcohol use and risky sexual behaviour (i.e. multiple partners, unprotected-, and unplanned sex) by adolescent males. Data was collected by means of an anonymous, self-administered questionnaire. The sample consisted of 176 male high school learners, aged between 14 and 25, from one school in the Nkonkobe Municipality, Eastern Cape Province. The Statistical Package for Social Sciences (SPSS) was used to obtain data analyses which included descriptive statistics and cross-tabulation (with specific reference to Chi-square analysis), and all procedures were performed at 0.05 level of significance with 95% Confidence Interval. A relationship between alcohol use and risky sexual behaviour was found to exist. A statistically significant correlation was found in support of the alcohol/risky sex hypothesis. Another significant finding was the increase noted in safer sex practises among adolescents. Finally, the findings were correlated to implications for health education and recommendations for future research made.
CONTENTS

ACKNOWLEDGEMENTS .............................................................................................. i
DECLARATION ........................................................................................................... ii
ABSTRACT ................................................................................................................. iii
CHAPTER 1 ................................................................................................................ 1

ORIENTATION OF THE STUDY ........................................................................... 1

1.1. INTRODUCTION ................................................................................................. 1

1.2. PROBLEM STATEMENT ................................................................................... 2

1.3. PRELIMINARY LITERATURE REVIEW ......................................................... 3

1.3.1. Definition of key concepts ......................................................................... 3

1.3.2. Adolescent males’ sexual behaviour and alcohol abuse ......................... 5

1.3.3. Research on adolescent males’ sexual behaviour ..................................... 5

1.4. RESEARCH QUESTIONS ................................................................................. 6

1.4.1. Sub-questions ............................................................................................... 6

1.5. HYPOTHESES ................................................................................................. 7

1.6. THEORETICAL FRAMEWORK ...................................................................... 7

1.6.1. Problem behaviour theory ....................................................................... 7

1.7. RESEARCH METHODOLOGY ...................................................................... 8

1.7.1. Quantitative research ................................................................................ 8

1.7.2. Sampling and population .......................................................................... 9

1.7.3. Data collection techniques ........................................................................ 9

1.8. ETHICAL MEASURES .................................................................................. 9

1.9. SIGNIFICANCE OF THE STUDY ............................................................... 10
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10. ENVISAGED CHAPTERS</td>
<td>10</td>
</tr>
<tr>
<td>1.11. CONCLUSION</td>
<td>11</td>
</tr>
<tr>
<td>CHAPTER 2</td>
<td>12</td>
</tr>
<tr>
<td>THEORETICAL FRAMEWORK</td>
<td>12</td>
</tr>
<tr>
<td>2.1. INTRODUCTION</td>
<td>12</td>
</tr>
<tr>
<td>2.2. PROBLEM BEHAVIOUR THEORY</td>
<td>12</td>
</tr>
<tr>
<td>2.3. SOCIAL-COGNITIVE THEORY</td>
<td>14</td>
</tr>
<tr>
<td>2.4. ALCOHOL EXPECTANCY THEORY</td>
<td>17</td>
</tr>
<tr>
<td>2.5. ALCOHOL MYOPIA THEORY</td>
<td>17</td>
</tr>
<tr>
<td>2.6. RISKY SHIFT THEORY</td>
<td>18</td>
</tr>
<tr>
<td>2.7. GROUP POLARIZATION THEORY</td>
<td>19</td>
</tr>
<tr>
<td>2.8. SOCIAL EXCHANGE THEORY</td>
<td>19</td>
</tr>
<tr>
<td>2.9. CONCLUSION</td>
<td>20</td>
</tr>
<tr>
<td>CHAPTER 3</td>
<td>21</td>
</tr>
<tr>
<td>CONCEPTUAL FRAMEWORK</td>
<td>21</td>
</tr>
<tr>
<td>3.1. INTRODUCTION</td>
<td>21</td>
</tr>
<tr>
<td>3.2. PSYCHOLOGICAL WELL-BEING</td>
<td>21</td>
</tr>
<tr>
<td>3.2.1. Self-acceptance</td>
<td>22</td>
</tr>
<tr>
<td>3.2.2. Positive relations with others</td>
<td>22</td>
</tr>
<tr>
<td>3.2.3. Autonomy</td>
<td>23</td>
</tr>
<tr>
<td>3.2.4. Environmental mastery</td>
<td>23</td>
</tr>
<tr>
<td>3.2.5. Purpose in life</td>
<td>24</td>
</tr>
<tr>
<td>3.2.6. Personal growth</td>
<td>25</td>
</tr>
</tbody>
</table>
3.3. SELF-ESTEEM, SELF-EFFICACY AND SELF-WORTH ........................................... 26

3.4. SELF-DETERMINATION THEORY ...................................................................... 26

3.5. HOPE THEORY .................................................................................................. 27

3.6. EMOTIONAL INTELLIGENCE ............................................................................. 29

3.7. OVERVIEW OF ADOLESCENTS’ DRINKING PATTERNS AND SEXUAL
    BEHAVIOUR ........................................................................................................ 30

3.8. CO-OCCURRENCE OF SUBSTANCE USE AND SEXUAL INTERCOURSE
    .............................................................................................................................. 31

3.9. FACTORS INFLUENCING SUBSTANCE ABUSE AND RISKY SEXUAL
    BEHAVIOUR ........................................................................................................ 33

  3.9.1. Individual factors .......................................................................................... 33
  3.9.2. Family influences ......................................................................................... 34
  3.9.3. Dysfunctional families .................................................................................. 38
  3.9.4. Peers ............................................................................................................. 41
  3.9.5. Societal/community factors .......................................................................... 42
  3.9.6. Cultural- and traditional influences ............................................................ 45
  3.9.7. Sexual abuse and maltreatment .................................................................... 46
  3.9.8. Poverty ......................................................................................................... 47
  3.9.9. Mass media .................................................................................................. 48

3.10. DANGEROUS AND DEADLY CONSEQUENCES OF ALCOHOL ABUSE
    AND RISKY SEXUAL BEHAVIOUR ..................................................................... 50

  3.10.1. Sexually transmitted infections and HIV/AIDS ........................................ 50
  3.10.2. Rape and Sexual Assaults .......................................................................... 52
3.10.3. Unplanned fatherhood

3.11. CONCLUSION

CHAPTER 4

RESEARCH DESIGN AND RESEARCH INSTRUMENT

4.1. INTRODUCTION

4.2. THE RESEARCH INSTRUMENT

4.2.1. Questionnaire

4.2.2. Scaling technique

4.2.3. Format of instrument

4.3. VALIDITY AND RELIABILITY

4.4. RESEARCH SAMPLE

4.6. DATA PROCESSING

4.6.1. Chi-squared

4.6.2. Regression Model

4.6.3. F-Statistics

4.6.4. Durbin-Watson Statistic

4.7. CONCLUSION

CHAPTER 5

ANALYSIS AND INTERPRETATION OF EMPIRICAL DATA CONCERNING ALCOHOL USE AND SEXUAL BEHAVIOUR OF ADOLESCENT MALES IN Nkonkobe Municipality

5.1. INTRODUCTION

5.2. ANALYSES OF THE BIOGRAPHICAL DATA
5.3. DESCRIPTIVE ANALYSES OF THE SUBSTANCE USE BY ADOLESCENTS, THEIR PEERS AND THEIR CAREGIVERS ............... 66

5.4. DESCRIPTIVE ANALYSES OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO INFLUENCES SUCH AS THE MEDIA, THEIR COMMUNITIES, CAREGIVERS AND THEIR PEERS................. 67

5.5. DESCRIPTIVE ANALYSES OF THE RELATIONSHIP BETWEEN THE ADOLESCENTS AND THEIR CAREGIVERS .......................................................... 69

5.6. INTERPRETATION OF THE BIOGRAPHICAL DATA ........................................ 70

5.7. INTERPRETATION OF ALCOHOL USE BY ADOLESCENTS IN RELATION TO THEIR PEERS AND THEIR CAREGIVERS ................................................... 71

5.8. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO THE INFLUENCE OF THE MASS MEDIA ........................................ 72

5.9. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO THE INFLUENCE OF CAREGIVERS ........................................ 73

5.10. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO INFLUENCE OF THE COMMUNITY ........................................... 74

5.11. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO THE INFLUENCE OF PEERS ...................................................... 75

5.12. RELIABILITY TESTING .................................................................................. 76

5.13. HYPOTHESIS .............................................................................................. 78

5.14. CHI-SQUARE .............................................................................................. 79

5.15. CONCLUSION .............................................................................................. 79

CHAPTER 6 ........................................................................................................... 81

SUMMARY, RECOMMENDATIONS AND CONCLUSION ........................................ 81
6.1. INTRODUCTION .............................................................................................................. 81
6.2. OVERVIEW OF THE STUDY ....................................................................................... 81
6.3. BRIEF SUMMARY OF OVERALL STATISTICS ....................................................... 82
6.4. LIMITATIONS OF THE STUDY ................................................................................... 83
6.5. SUGGESTIONS FOR FUTURE RESEARCH ............................................................... 84
6.6. IMPLICATIONS OF THE STUDY .................................................................................. 84
6.7. CONCLUSION ............................................................................................................... 86

REFERENCES ....................................................................................................................... 87

APPENDICIES

APPENDIX 1: APPLICATION LETTER: PERMISSION TO CONDUCT RESEARCH
APPENDIX 2: REPLY FROM THE DEPARTMENT OF EDUCATION
APPENDIX 3: LETTER TO THE STUDENTS
APPENDIX 4: CONSENT FORM
APPENDIX 5: ANONYMOUS, SELF ADMINISTERED QUESTIONNAIRE

FIGURES AND TABLES
3.1. THE BROADEN- AND BUILD MODEL OF POSITIVE THINKING ......................... 28
5.1. GROUPS OF LEARNERS ACCORDING TO AGE .................................................... 64
5.2. MARITAL STATUS OF MOTHERS AND FATHERS ................................................ 65
5.3. ITEM TOTAL STATISTICS ....................................................................................... 76
5.4. SCALE STATISTICS ............................................................................................... 78
5.5. CHI-SQUARE TEST ............................................................................................... 82
CHAPTER 1

ORIENTATION OF THE STUDY

1.1. INTRODUCTION

It is an alarming statistic that alcohol remains the most commonly abused drug in South Africa, with binge drinking among adolescents (especially males) in excess of 25% in many communities (Parry & Abdool-Karim, 2000). Alcohol and drug use have been identified worldwide as potentially risky practices for the contracting and transmitting of HIV (Rich, 2004). Adolescent males face many pressures with regards to sexual decisions, alcohol- and other substance use (Kaiser Family Foundation, 2002). Substance use may increase the probability of the initiation of sexual activity and often sexually active adolescents would also engage in substance use. This risky behaviour may lead to unplanned and unprotected sexual intercourse, multiple partners, and being at risk of sexually transmitted infections, including HIV/AIDS (Kaiser Family Foundation, 2002). Although condom use among adolescents increased dramatically in the 1980’s and 1990’s, most of the adolescent males still do not use contraceptives correctly and consistently. In addition, adolescents tend to have multiple sexual partners, since adolescent relationships are frequently brief; the median duration of a romantic relationship among male adolescents (including both the sexual and non-sexual relationships), is about 10 months (Beaufort, 2002).

Using data from a Cape Town survey of 2779 learners in grades 8 to 11, Parry and Abdool-Karim (2000), found a strong association between substance use/binge drinking and other drugs, and unsafe sexual practices (e.g. multiple
partners). According to Rich (2004), a worthy investment in young people would be to endeavour to investigate and highlight risky sexual behaviour in an attempt to bring about changes in attitudes, beliefs and behaviour with regard to HIV/AIDS, safer sexual practices, alcohol consumption, and condom use.

1.2. PROBLEM STATEMENT

The sexual behaviour of adolescent males is highly influenced by the use of alcohol and drugs, which is believed to decreases decision-making skills and negatively impacts on their sexual behaviour (Sánchez, Comerford, Chitwood, Fernandez, & McCoy, 2002). A number of cross-sectional studies show that male adolescents who drink more heavily are less likely to use condoms, and more likely to have multiple sexual partners (Rich, 2004; Visser, 2003). A more extensive quantitative study revealed that, of 18,500 learners from 600 schools in South Africa, 49% (N= 9, 065) of those learners reported being sexually experienced, and only half of those used a condom during a recent sexual experience (Varga, 2000). The risky sexual engagement of such adolescents was reported to be exacerbated by the use of alcohol, loosened family ties and dependence on peers for approval (Insel & Roth, 2000). The combination of permissive attitudes, sexual experimentation and lack of accurate, supportive information from parents poses a threat to the sexual health of male adolescents and exposes them to risky sexual behaviour and its consequences (Bee & Boyd, 2003).
1.3. PRELIMINARY LITERATURE REVIEW

1.3.1. Definition of key concepts

In this section, the key concepts that will be used throughout this dissertation are discussed. They are as follows: adolescence and adolescent male; sexual behaviour; substance/alcohol abuse.

1.3.1.1. Adolescence and Adolescent Male

Adolescence is derived from the Latin word “adolescere” which means to grow into maturity. In most cultures, adolescence occurs between the ages of 11 and 19 years (Bee & Boyd, 2003). Hall (1904), a key figure in the classic study of adolescence, regarded adolescence as being filled with “storm and stress” in which conflicts and confusion inevitably accompany awakening sexual impulses, bodily changes and an increased awareness of self and society (Swartz, De la Rey, Duncan & Townsend, 2011). Drawing from Erik Erikson’s theory of psychosocial development through stages, adolescence is a developmental transition between childhood and adulthood. It is the period from puberty until full adult status has been attained. During the fifth developmental stage (identity versus confusion), adolescent males learn how to answer the question of “Who am I?”, and they search for a true self, or an identity that will lead them to adulthood, because they now make deliberate decisions and choices, especially about vocation, sexual orientation, and life in general (Louw Van Eden & Louw, 2007). The anatomic structure of adolescent males is characterised by sexual organs (i.e. penis and scrotum) which grow in length and thickness as they progress in age (Swartz et al., 2011), pubic hairs around genitals, deepening voice, broadening shoulders and nocturnal emission (first wet dreams), as a sign of sexual maturity (Kail & Cavanaugh, 2000).
Adolescent males who fail to search for an identity and role will experience self-doubt, as they cannot integrate the various roles, and when they are confronted by contradictory value systems, they have neither the ability, nor the self-confidence to make decisions. This confusion causes anxiety, as well as apathy or hostility towards roles or values and the adolescent may indulge in self-destructive activities like the abuse of alcohol and unsafe sexual behaviour, especially when they are with their peers (Whitehead, 2007). Adolescent males tend to explore and experiment, and in doing so they are exposed to various health risks, such as substance abuse, unsafe sexual exploration and they seek to further their own identity, opinions and values as they experiment, which entails taking some risks (Swartz et al., 2011).

1.3.1.2. Sexual behaviour

Sexual behaviour refers to the manner in which humans experience and express their sexuality (Sigelman & Rider, 2009) and risky sexual behaviour can be defined as sexual behaviour that results in negative consequences. This behaviour could include: the failure to take protective action such as condom use and birth control; having casual/unknown or multiple sexual partners; the failure to discuss risk topics prior to intercourse; and sexually transmitted diseases, including HIV/AIDS (Whitehead, 2007).

1.3.1.3. Substance abuse

Substance abuse can simply be defined as a set pattern of the harmful use of any substance for mood-altering purposes (Budd, 2011). Substance abuse is also known as drug abuse and refers to a maladaptive pattern of use of a substance that is not considered a dependent. Alcohol abuse, as described in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) is a psychiatric diagnosis
describing the recurring use of alcoholic beverages despite negative consequences (Sigelman & Rider, 2009).

### 1.3.2. Adolescent males’ sexual behaviour and alcohol abuse

Many other studies which have been done on adolescents, college students and other young adults in the United States, have found profound risky sexual attitudes and behaviour. These studies have reported high rates of unprotected sexual activity, multiple sexual partners, and a decline in the age of sexual debut (Langer, Warheit & McDonald, 2001; Morris & Albery, 2001). Of the estimated 12 million new cases of sexually transmitted diseases (STI) diagnosed among Americans each year, three million involve people younger than the age of 20, and another four million occur among 20-25-year olds. Among adolescents, key behavioural risk factors for STD infection are initiating sexual intercourse, having multiple concurrent or sequential sexual partners, having a partner who has had multiple partners and failure to use barrier contraceptives.

### 1.3.3. Research on adolescent males’ sexual behaviour

Young people as young as twelve years are sexually active and they tend to disregard the consequences of unsafe sex, especially when their social context is marred with a lack of good role models, inconsistent parental supervision and support, and deviant peers (Cooper, 2002). These findings are confirmed in the Visser (2003), study of 460 primary school learners where she found that 14% drank alcohol either to get drunk in order for them to forget their problems, or to have “fun” and “feel good about themselves”. Of the 24% that indicated that they were sexually experienced, 40% protected themselves from HIV/AIDS, and only 35% used birth control measures. Peltzer (2003), notes that according to the Reproductive Health
Outlook (RHO) (2004) report, only 23% of men (aged 15 to 49 years), in the Northern Province of South Africa has never used a condom.

According to Rich (2004), approximately 50% of all high school learners in grades 9-12 have had sexual intercourse; 25 % of all 12th graders have had four or more partners, and only half of those reported having used a latex condom during intercourse.

Visser (2003), cites the following researchers’ findings:

(a) Flisher, Ziervogel, Chalton, Leger, and Robertson, (1996), reported that in a sample of 7 340 learners from 16 secondary schools in the Cape Peninsula, 53% of learners had alcohol drinking experiences.

(b) A survey of 6 000 (Grade 8 and 11) learners in 39 Cape Town schools, found that 50% of respondents reported current alcohol use and 36% reported binge drinking of more than five drinks per occasion (Parry & Abdool-Karim, 2000).

1.4. RESEARCH QUESTIONS

Based on the problem statement cited above, this research study attempts to answer the question: “What impact does alcohol have on male adolescents’ risky sexual behaviour (i.e. unplanned and unprotected sex, and multiple partners) and taking into account the HIV/AIDS crisis?”

1.4.1. Sub-questions

1. What is the relationship between adolescent males who drink alcohol and having multiple sexual partners?

2. What is the relationship between drinking patterns and condom use?
The specific **objectives** would be:

(a) To determine the correlation between adolescent males’ alcohol use and multiple sexual partners.

(b) To examine male adolescents’ drinking patterns in relation to condom use/non-use.

**1.5. HYPOTHESES**

**H1:** Male adolescents who drink alcohol frequently are more likely to have multiple partners.

**H2:** Male adolescents who drink alcohol frequently are less likely to use condoms.

**1.6. THEORETICAL FRAMEWORK**

A theoretical framework is defined as a statement of the assumption brought to the research task and reflected in the methodology as it is understood and employed. It thus serves as the basis for the method used to answer the research questions (Leedy & Ormrod, 2005). It reflects the researcher’s view about what is considered as true or valid knowledge within an existing theoretical framework (Babbie & Mouton, 2001).

Problem behaviour theory will be used as the theoretical framework for this study in understanding health-related behaviour and especially the risky behaviour of adolescent males.

**1.6.1. Problem behaviour theory**

According to Arnett (2001), Problem Behaviour Theory (PBT) serve a common social or psychological development goal, such as separating from parents,
achieving adult status, or gaining peer acceptance. Problematic behaviour may serve to assist an adolescent in coping with failure, boredom, unhappiness, rejection, low self-esteem, social anxiety or isolation. For example, adolescents could use substances as a means of gaining social status and acceptance from peers, whilst counteracting feelings of low self-worth. Rich (2004), therefore believes that adolescent males’ vulnerability can readily turn into deviance (e.g. unprotected sex, criminal behaviour, alcohol abuse) whereby the young person turns away from an accepted norm of behaviour by society. According to Arnett (2001), adolescent males’ problem behaviour may be compounded, especially when their locus of control is externalized (i.e. peer influence) and when they are raised in dysfunctional families.

1.7. RESEARCH METHODOLOGY

The quantitative research method will be employed by the researcher in this study. According to Nicholas (2008), quantitative research describes the data (i.e. descriptive statistics) and test the hypothesis (i.e. inferential statics).

1.7.1. Quantitative research

Quantitative research is systematic and objective in its application by using numerical data from a selected subgroup of the population, and applying the findings generally to the population so studied (Maree, 2010). The advantage of using a quantitative research design is that it enables a researcher to analyse data in order to test a hypothesis.
1.7.2. Sampling and population

The process of selecting a part of a group under study is known as sampling. It refers to the process of selecting a sample from a population of interest so that the results gained by these participants can be fairly generalized in terms of the population from which they were chosen (Nicholas, 2008). In this research study, the population will comprise of adolescent males in the Nkonkobe Municipality, Eastern Cape Province, South Africa. An estimation of 200 adolescent male participants from one African secondary school will be convened and sampled for this study. The reason for one secondary school is that it is central to learners from villages which are too scattered.

1.7.3. Data collection techniques

Data will be collected by means of closed-ended questionnaires, which will be self-administered. According to Delport, De Vos, Fouché and Strydom (2005), the basic objective of a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue.

1.8. ETHICAL MEASURES

Ethical principles will be complied with as they serve to safeguard the dignity, rights, safety and well-being of all participants in the research study (Miller, 2007). The researcher will ensure that the ethical principles meet the national and international standards governing research of this nature on human participants (Leedy & Ormrod, 2005).
Permission for the participation of the male adolescents will be obtained from the Eastern Cape Department of Education (see Appendix 1). Participation will be voluntary and non-discriminatory.

The following ethical measures will be adhered to during the research process: informed consent; confidentiality and anonymity of the participants; protection from harm; and honesty with professional colleagues.

1.9. SIGNIFICANCE OF THE STUDY

The significance of this study would lie in offering advice to adolescent males, thereby equipping them in making informed choices regarding delaying sexual intercourse and using condoms in order to reduce the spread of HIV/AIDS. Furthermore, this study intends to suggest ways to reduce alcohol consumption by adolescents, which will in turn contribute to their psychological well-being.

1.10. ENVISAGED CHAPTERS

Chapter 1: Orientation of the study. This will provide a background, the problem statement, objectives, research questions and the significance of the study.

Chapter 2: Theoretical framework. Various theories and sexual behaviour models will be explored.

Chapter 3: Literature review. It will provide an overview of literature on studies previously done by other researchers on the same topic and issues which will provide a theoretical framework on existing knowledge. This chapter serves to discuss the relationship between alcohol use and risky sexual behaviour by male adolescents.

Chapter 4: Research methodology. This chapter will discuss the methodology and sampling procedures that have been used in this research.
Chapter 5: Analysis and interpretation of data. The results will be presented and analyzed in relation to the research questions presented in chapter one. It will bring order, structure and meaning to the collected data.

Chapter 6: Discussions, conclusions and recommendations. The findings will be presented and conclusions will be drawn based on the results. Finally, recommendations will be made.

1.11. CONCLUSION

This chapter explored the problem statement concerning adolescent males’ sexual behaviour and alcohol abuse. The research questions, aims and objectives were summarised. The significance of the study was highlighted. Ethical issues which were outlined include informed consent, confidentiality, privacy, anonymity, and protection from harm.
CHAPTER 2

THEORETICAL FRAMEWORK

2.1. INTRODUCTION

The previous chapter looked at what the current research study is about, its objectives and its hypothesis. This chapter will present a summary of theoretical explanations for the existence of a link between substance use and risky sexual behaviour. This review will then be followed by a conclusion.

This study draws on seven theories: Problem Behaviour Theory, Social-Cognitive Theory, Alcohol Expectancy Theory, Alcohol Myopia Theory, Risky Shift Theory, Group Polarisation Theory and Social Exchange Theory. These theories have been proven to be of great value in understanding a wide range of health-related behaviour and especially risk behaviour in adolescents and young people.

2.2. PROBLEM BEHAVIOUR THEORY

According to Jessor and Jessor (1977), Problem Behaviour Theory (PBT) is a psychosocial model that attempts to explain behavioural outcomes such as substance use, deviancy, and risky sexual behaviour. Researchers have shown its applicability to adolescents and young adults. Donovan and Jessor (1985), state that PBT consists of three independent yet inter-related systems of psychosocial components. The personality system includes social cognitions, individual values, expectations, beliefs, and attitudes. The perceived environmental system consists of proximal and distal social influence factors such as family and peer orientation and expectations regarding problem behaviour. The third component of PBT, the behaviour system, consists of problem and conventional behavioural structures that work in opposition to one another. Examples of the problem behaviour structure
include alcohol abuse and deviant behaviour (e.g. delinquency and precocious sexual behaviour). Jessor and colleagues postulate that the problem behaviour stems from an individual’s affirmation of independence from parents’- and societal influence. In contrast, conventional behaviour structures consist of behaviour orientated toward society’s traditional standards of appropriate conduct such as church attendance and high academic performance. According to Jessor, proneness to specific problem behaviour entails a greater measure of involvement in other problem behaviour and less participation in conventional behaviour (Jessor and Jessor, 1977).

The Problem-Behaviour Theory framework has logical implications for developmental behavioural change. The theory has been organised to account for proneness to engage in problem behaviour — behaviour that departs from regulatory norms. Much of what is considered to be problem behaviour in youth is relative to age-graded norms and age-related expectations. The very same behaviour may be permitted or even prescribed for those who are older but proscribed for those who are younger. Drinking, for example, is prescribed for those under legal age but is permitted for those who are older; sexual intercourse, normatively acceptable for adults, is likely to elicit social controls for a young adolescent. When the initial occurrence of such age-graded behaviour takes place at a relatively young age or earlier than is normatively expected, it constitutes a departure from the regulatory age norms that define appropriate behaviour for that age or stage in life. Consensual awareness among youth of the age-graded norms for such behaviour carries with it, at the same time, the shared knowledge that occupancy of a more mature status is actually characterised by engaging in such behaviour. Thus, engaging in certain behaviour for the first time can mark a transition in status from "less mature" to "more
mature," from "younger" to "older," or from "adolescent" to "youth" or "adult." (Donovan, Jessor, & Costa, 1991).

Problem-Behaviour Theory has been employed in a wide variety of studies — both cross-sectional and longitudinal — and considerable evidence has accumulated in support of the generality and robustness of the theoretical framework. Investigators have used the psychosocial concepts and measures derived from Problem-Behaviour Theory, and they have been applied to the investigation of a broad variety of behaviour in childhood, adolescence, and young adulthood, including alcohol use, and early sexual intercourse (Donovan, et al, 1991).

The social-psychological framework of Problem-Behaviour Theory has been shown over the years to account for substantial percentages of variation in the numbers related to different types of problem behaviour, health-related behaviour, and pro-social behaviour in both adolescent and young adult samples. It has, in addition, demonstrated explanatory usefulness in accounting for developmental transitions in problem behaviour and health behaviour during adolescence (Donovan et al. 1991).

2.3. SOCIAL-COGNITIVE THEORY

According to Bandura (1994), Social-Cognitive Theory defines human behaviour as a dynamic and reciprocal interaction of personal, behavioural, as well as environmental influences. Individual behaviour is uniquely determined by each of these three factors. Young people need to learn how to be sexually responsible and accountable and to make safer sexual choices. Therefore, greatly emphasized in the Social-Cognitive Theory, are the importance of skills, self-regulation and self-efficacy (the judgment that one has the ability to perform a given behaviour) (Bandura, 1999). An individual’s self-efficacy can develop inter alia as a result of his/her history of
achievement in a particular area, through observational learning of others’ successes and failures, from persuasion by others, as well as from one’s own physiological state (e.g. anxiety or emotional arousal) whilst performing a behaviour. Difficulties can arise in the following of safer sex practices, as self-protection often conflicts with interpersonal and social pressures. The best informed judgment can be swayed by influences such as a desire for social acceptance, situational constraints, coercive threats and fear of rejection (Bandura, 1994).

Studies have shown that women have the lowest assurance in their ability to exercise control over pressures by a desirable partner to engage in unprotected sex, which places them at potential risk of HIV infection (Bee & Boyd 2003; Ryckman, 2008). Bandura (1994), notes that the weaker one’s perceived self-efficacy is, the more such social and affective factors increase the likelihood of risky sexual behaviour. According to Weiten (2011), beliefs of personal efficacy (or perceived self-efficacy), is the central foundation of human agency. He notes that, unless adolescents believe that they are capable of producing desired efforts by their actions, they will have little incentive to act or persevere in the face of difficulties. Desired outcomes have been shown to affect: whether people consider changing their behaviour; the degree of effort they invest in changing; and the long-term maintenance of behavioural changes (Bandura, 1999).

Studies suggest that perceived self-efficacy is important in substance abuse and HIV risk behaviour change (Bandura, 1994; 1999). This model proposes that health protective behaviour is the result of a process of cognitive appraisal that integrates knowledge, outcome expectancies that is associated with adopting risk deduction behaviour, as well as social influences (LaBrie, Schiffman & Earleywine, 2002). Emphasis is placed on four major components deemed necessary for
effective programs of change, aimed at altering each of the three above mentioned interacting determinants (Bandura, 1994). Informational – designed to increase people’s awareness and knowledge of risks; development of social and self-regulative skills; skill enhancement and development of self-efficacy (or confidence in one’s ability); and enlisting and creating social support structures for desired personal changes (Bandura, 1994).

An important factor in managing one’s sexuality is that people have to exercise influence over themselves and others by means of self-regulatory skills. Self-regulation motivates and guides one’s actions through internal standards, affective reactions to one’s conduct, and the use of motivating self-incentives and other forms of cognitive guidance (Bandura 1994). Self-regulatory skills therefore form an essential part of risk-deduction processes and determines how effectively one is able to resist socially induced potentially risky behaviour. Efficacy beliefs, coupled with goal aspirations, incentives and disincentives rooted in outcome expectations, serve to operate as a major cognitive motivator and regulator of behaviour. It is widely accepted that personal change occurs within a network of social influences that could serve to aid, retard or undermine efforts at personal change. Social-Cognitive Theory therefore also extends the conception of human agency to a collective agency needed to accomplish necessary social goals. Because substance abuse and HIV/AIDS is a social problem (and not just a personal one), peoples’ shared beliefs in their efficacy to improve their life circumstances, through unified social effort, is crucial for effective intervention processes (Bandura, 1999).
2.4. ALCOHOL EXPECTANCY THEORY

Alcohol Expectancy is defined as “the expected effects of drinking alcohol”. According to Alcohol Expectancy Theory (Korn & Maggs, 2004), the cognitive processes that occur before an adolescent male drinks play an integral role as to whether he will choose to drink, as well as how much alcohol will be consumed. The model posits that an individual’s behaviour after drinking is driven by pre-existing beliefs about alcohol’s effect on behaviour, in a manner of “self-fulfilling prophecy” (Cooper, 2002). Adolescent males who drink, view alcohol as an enhancer and that it disinhibits sexual feelings and behaviour, and might consume alcohol to enhance sexual activities.

Due to young people’s relative inexperience and their need for disinhibition, they may consume large amounts of alcohol based on preconceived alcohol expectancies which in turn may increase their risk of possible HIV infection (Morris & Albery, 2001). Therefore, teenagers who believe that alcohol excites them, is more likely to engage in risky sexual behaviour than those who do not hold these beliefs (Manganello, 2008). Risky behaviour includes initiating the dating of girls and then forcing them to have sex (Mpofu, Bility, Onya & Lombard, 2005).

2.5. ALCOHOL MYOPIA THEORY

According to Mpofu et. Al (2005) Alcohol Myopia postulates that intoxicated individuals are unable to attend to all relevant cues simultaneously because of the limitation of cognitive capacity associated with alcohol intoxication. In other words, alcohol produces a myopic effect, causing individuals to attend primarily to, and hence be more influenced by salient environmental cues at the expense of less salient cues. Adolescents who are not intoxicated, however, are not as easily
influenced by salient cues because they are better able to attend to all the relevant information in the environment. Evidence to support alcohol myopia has been found in the domain of health-relevant behaviour, such as drinking and engaging in unprotected sex (Mpofu et al, 2005).

Alcohol Myopia Theory is based on the belief that alcohol disinhibits behaviour as a result of its pharmacological effects on information processing. It creates a “myopic” (or narrowing) effect on attention, cognition, and information processing (George and Norris, 1991). Theoretically, alcohol myopia restricts intoxicated persons from recognising or responding to the relevant cues in the environment when faced with whether to have protected- or unprotected sex. Alcohol leads people to behave in a more restrained or impulsive manner depending on which cue is more salient or impelling (e.g. the possibility of sexual intercourse in conflict with the possibility of contracting a disease) (Chersich, Rees, Scorgie & Martin 2009).

2.6. RISKY SHIFT THEORY

According to the Risky Shift Theory, people tend to make decisions regarding behaviour differently when in groups, than they would have done if they were alone. When in a group, people are inclined to make riskier decisions because they believe that the risk is shared by the group members and therefore exposing themselves to less risk as individuals (Weiten, 2011).

During adolescence, risky shift may be closely linked to psychosocial immaturity. Adolescents whose locus of control is not internalised may find themselves in trouble (e.g. a criminal act) because, when under the influence of deviant peers, they tend to make irrational and uniformed decisions (Crockett, Raffaelli & Shen, 2006). For example, Gardner and Steinberg, (2005) found that risky shift
was more prevalent among adolescents who belong to deviant groups than those who maintain quality friendships. The deviant groups were reported to be ill disciplined and often displayed aggression towards authority figures.

2.7. GROUP POLARIZATION THEORY

According to Hogg, Turner and Davidson (1990), the Risky Shift Theory is interwoven to Group Polarization Theory and asserts that the presence of others tend to lead to increased risk-taking and that the behaviour of individuals depend largely on the risk taking tendencies of group members or peers.

McGarty, Turner, Hogg, Davidson and Wetherell (1992), argue that group polarization develops from a process of intra-group conformity to a polarized in-group norm. This means that low risk-taking individuals would become even more low risk-taking when grouped together with other low risk-takers and high risk-takers would become even higher risk-taking when grouped together with other high risk-takers. The Self-Categorization Theory refers to group polarization as a process of conforming to polarized norms which define one’s own group in contrast to other groups within a specific social context. This means that an ‘in-group’, confronted by a risk-taking ‘out-group’, would polarize towards caution, whereas an ‘in-group’ confronted by a low risk-taking ‘out-group’ would polarize towards risk (Hogg et al, 1990).

2.8. SOCIAL EXCHANGE THEORY

The Social Exchange Theory analyzes the interaction between two parties by examining the costs and benefits to each. Interactions are only likely to continue if each party gains more than it loses. Crucially, the exchange analysis assumes that
in each social interaction, each person gives something to the other and gains something from the other (hence the exchange) (Baumeister & Vohs, 2004). For example, adolescent males who buy gifts for their girlfriends in exchange for sex. The theory of Social Exchange explores the concept of “rationality” and “cost and reward” (White and Klein 2002). Axioms of this theory oppose fatalistic thinking because it assumes that the individual is not being externally controlled but instead has the complete ability to make “rational choices” based on the idea of “costs and rewards” (White & Klein 2002). From this perspective, individuals are rational in their thinking and can rationally come up with the costs and rewards of their decisions. In some situations, the individuals may have different “costs and rewards” or “motivations” that they associate with the behaviour (White & Klein 2002). The theory of Social Exchange assumes that, as individuals are “rational” and are able to deduce the “costs and rewards” of their behaviour, then they are fully aware of what repercussions, if any, their behaviour will yield, because their “motivations will explain their behaviour” (White & Klein 2002). However, “in order to understand any actor’s choice as rational there is a need to know what the person considers as rewarding and costly” (White & Klein 2002).

2.9. CONCLUSION

I believe that risky sexual behaviour among adolescents and teenagers is a particularly destructive social phenomenon and remains one of the main causes of death and illness among these young adults. Therefore this social phenomenon remains a complex issue that deserves further research and investigation.

The review of literature related to this study will be discussed in chapter three.
CHAPTER 3

CONCEPTUAL FRAMEWORK

3.1. INTRODUCTION

In the preceding chapter, the theories which underpin this study were discussed. In the current chapter, the psychosocial wellbeing of adolescents, with specific reference to the following constructs: self-acceptance; positive relations with others; autonomy; mastery of the environment; purpose in life; and personal growth will be described. Furthermore, the concentration will be on factors that enable adolescents to flourish rather than languish (e.g. self-esteem, self-efficacy, parent-adolescent interaction, and the school). As this chapter unfolds further, relevant studies done with regards to alcohol and unsafe sex practices will be explored. Of great importance is the determination of the factors which contribute to the link between drinking alcohol and the risky sexual behaviour of adolescent males. Finally, the consequences of unsafe sex practices, coupled with alcohol abuse among young people, will be discussed.

3.2. PSYCHOLOGICAL WELL-BEING

The roots of psychological health lie in the World Health Organisation’s (WHO) definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease” (Martikainen, Bartley & Lahelma 2002). Psychological well-being is an internal focused method of attachment to the quality of life; it is not something that could be achieved as a single goal, but is influenced by many variables. Some of these variables have little effect, whereas others have the possibility to make a huge impact (Le Roux, 2008).
Adolescent males who display positive psychological well-being strive for affective balance, mastery of the environment, autonomy, purpose in life and self-acceptance as suggested by Ryff (1989), who pioneered the psychological well-being scale (Vazquez, Hervas, Rohana & Gomes, 2009). According to Seifert (2005), the Ryff Scales of Psychological Well-Being is a theoretically grounded instrument that specifically focuses on measuring multiple facets of psychological well-being. These facets include the following:

3.2.1. Self-acceptance

Adolescent males who possesses a positive attitude toward the self, acknowledges and accepts multiple aspects of self, including good and bad qualities - they feel positive about their past life (Ryckman, 2008). They have a sense of self-worth and may display self-confidence, endurance, coping mechanisms, and have a tendency to view life as comprehensible, manageable and meaningful (Swartz et.al, 2011). However, when an adolescent male feels dissatisfied with self, disappointed with what has occurred in his past life, is troubled about certain personal qualities, wishes to be different than what he is, he may exhibit a pattern of poorer adjustment in multiple domains, such as academic achievement, disruptive family relationships, and misconduct such as bullying and violating the rights of his sexual partners (Ryckman, 2008).

3.2.2. Positive relations with others

Adolescents who are high scorers may be warm and have satisfying and trusting relationships with others. Furthermore, they may be concerned about the welfare of others; capable of strong empathy, affection, and intimacy; and
understand the give and take of human relationships (Seifert, 2005). In contrast, low scorers have fewer close trusting relationships with others; find it difficult to be warm, open, and concerned about others; are isolated and frustrated in interpersonal relationships; and are not willing to make compromises to sustain important ties with others (Vazquez et al, 2009).

3.2.3. Autonomy

Adolescents who are autonomous are self-determining and independent; able to resist social pressures; to think and act in certain ways that regulate behaviour from within; and evaluates self by personal standards (Vazquez et al, 2009). In the same vein, Pastorino and Doyle-Portillo (2011) found that such adolescents are endorsed by optimistic beliefs, a positive attitude and a positive outlook on life. They do not succumb to external stimuli, impulsive or instinctual processes. For example, in research conducted by Nolen-Hoeksema (2008), adolescents with a positive psychological well-being were reported to withstand or counter conditions with multiple stressors such as discrimination, the use of illicit drugs and deviant peers who would force friends to engage in antisocial activities (e.g. bullying girls to have sex with them; skipping of classes).

In contrast, adolescent males who lack autonomy tend to be overly concerned about the expectations and evaluations of others. They rely on the judgment of others to make important decisions, and conform to social pressures to think and act in certain ways (Le Roux, 2008).

3.2.4. Environmental mastery

Adolescents who are self actualised tend to develop competence in managing their environment, control a complex array of external activities, make effective use
of surrounding opportunities and are able to choose or create contexts suitable to personal needs and values (Seiffert, 2005). According to Kirby, Baumler, Coyle, Basen–Engquist, Parcel, Harrist, and Banspach (2004), such adolescent males with a positive psychological well-being tend to make informed decisions for themselves about sexuality and about how to develop healthy relationships. Whether from school, parents or the mass media, such youth tend to seek accurate and appropriate information in order for them to maintain their sexual health free of HIV/AIDS.

On the contrary, low scorers experience difficulty in managing everyday affairs, lack a sense of control over the external world, feel unable to change or improve the surrounding context and are unaware of surrounding opportunities (Seifert, 2005).

3.2.5. Purpose in life

According to Rand and Cheavans (2009), adolescents with a purpose in life have goals and a sense of direction, feel there is meaning to their present and past life, hold beliefs that give their life purpose and have aims and objectives for living. Comparatively, adolescent males who do not have the positive appraisal of family and social support often tend to experience feelings of emotional emptiness when faced with life’s stressors and resort to substance abuse and ultimately, unsafe sexual activities (Seiffert, 2005). Such youth lack a sense of meaning in life, have few goals or aims, lack a sense of direction, do not see the purpose of their past life and have no outlook or beliefs that give life meaning (Zhou, 2010).
3.2.6. Personal growth

Another component of psychosocial wellbeing is personal growth. Adolescents who experience feelings of continued development see themselves as growing and expanding and are open to new experiences. They realise their potential and constantly strive for improvement in ways that reflect more self-knowledge and effectiveness. In addition Ryckman (2008), found that such adolescents have the ability to control the self. Self-control means to have the ability to alter one’s own cognitive processes, feelings and behaviour to achieve healthier functioning. For example, Ryckman (2008) found that such adolescents tend to experience their sexual debut only after having matriculated, use protection and form monogamous romantic partnerships. In another research study by Compton and Hoffman (2010), academic achievement of adolescents who exhibit higher educational aspirations and better academic performance were associated with authoritative parents' unconditional support and a conducive atmosphere prevalent at home. Drawing from Antonovky's Salutogenic Model (1987), such an adolescent has a strong sense of coherence. From this perspective, Ryckman (2008) views such adolescents as resilient because they could display stability in terms cognitive, affective and moral development.

Comparatively, adolescents who lack a sense of coherence tend to experience a sense of personal stagnation; lack improvement or expansion over time; feel bored and uninterested with life; and feel inadequate to develop new attitudes or behaviour (Vazquesz et al, 2009).
3.3. SELF-ESTEEM, SELF-EFFICACY AND SELF-WORTH

Building adolescents’ self-esteem is an important tool in preparing responsible youth and will reduce the likelihood of them engaging in risky sexual behaviour (Zhou, 2010). Adolescents may be knowledgeable about HIV prevention, including condom usage, but there is still a challenge in whether and how this knowledge is translated into behaviour (Reproductive Health Outlook, 2004). Adolescents with a sense of direction and life goals are seen to have high self-efficacy for condom use and sexual negotiation in a relationship. These adolescents are more empowered in knowing their true self and their self-worth - hence they are in a position to negotiate relationship issues, thus reducing the likelihood of engaging in risky sexual behaviour (Rayckman, 2008).

A review of an article by Eaton, Flisher and Aaro (2003), indicates the fact that low self-esteem leads to risky sexual behaviour such as low condom usage. Adolescents do this to seek approval and affirmation from sexual partners. Another study of South African adolescents in Cape Town in grades 9 and 10 showed that having a bleak future and low self-esteem were associated with intentions not to use condoms (Bryan, Kagee, & Broaddus, 2006).

Closely linked to self-esteem and self-efficacy is the self-determination theory, hope theory and emotional intelligence.

3.4. SELF-DETERMINATION THEORY

Self-Determination Theory (Rayckman, 2008), postulates that certain inherent tendencies towards psychological growth, along with a core group of innate emotional needs are the basis for self-motivation and personality integration. In Self-Determination Theory the three basic needs are
(1) competence: the need for mastery of experience that allows a person to deal effectively with her or his environment;

(2) relatedness: the need for mutually supportive interpersonal relationships and

(3) autonomy: the need to make independent decisions about areas in life which are important to the person (Ryan & Deci, 2000).

Ryan and Deci, (2000) observed that these three needs appear to be essential for facilitating optimal functioning of the natural tendencies for growth and integration as well as personal well-being. If these three needs are met, the adolescent will show better adaptive functioning and higher well-being.

3.5. HOPE THEORY

Hope Theory (Snyder, Rand & Sigmon, 2002) is the result of two processes:

(1) pathway, or believing that one can find ways to reach desired goals; and

(2) agency, or believing that one can become motivated enough to pursue those goals (Snyder, Rand & Sigmon, 2002).

This theory holds that hope for the future is the result of believing that we can create both realistic plans and enough drive to reach important goals. People who are hopeful also tend to feel more positive emotions and they tend to anticipate greater well-being in their future, they are more confident and they can deal with stress more successfully (Rand & Cheavens, 2009).
Figure 3.1. The broaden- and build model of positive thinking.

Positive thinking produces more experiences of positive emotions, creating an upward spiral.

3.6. EMOTIONAL INTELLIGENCE

Emotions can serve a very useful purpose if used properly. One might even consider an ability to use emotions wisely as a type of intelligence (Compton & Hoffman 2010). Mayer, Salovey and Caruso (2000), define Emotional Intelligence as the ability to recognise the meanings of emotions and their relationships and to reason and problem-solve on the basis of them. Salovey and Mayer (1990), presented the original model of emotional Intelligence. They proposed five characteristics that define the idea:

- Emotionally intelligent adolescents know their emotions. Such adolescents are able to accurately recognise what they are feeling when they are feeling it. This includes the ability to accurately express their emotions.
- They have the ability to nurture interpersonal relationships. They are socially competent and good at displaying secure attachment which could be a protective factor to buffer against peer pressure.
- They are intrinsically motivated and are able to control and marshal their emotions in order to reach goals and remain focused.
- The ability to recognise emotions in others. This refers to the skill of reading what other people are feeling and being empathic.
- They have self-control and resilience. Very often they have a tendency to regulate their moods, handle stress and rebound after an emotional setback.

In the next section, adolescents’ drinking patterns and their sexual encounters will be discussed.
3.7. OVERVIEW OF ADOLESCENTS' DRINKING PATTERNS AND SEXUAL BEHAVIOUR

In South Africa, as in other areas of the world, substance use and sexual activity are fairly common, and sometimes problematic, among adolescents. A history of alcohol abuse has been correlated with a lifetime tendency towards high risk sexual behaviour, including unprotected intercourse, multiple sex partners and incorrect use of condoms (Cooper, 2002; Kaiser Family foundation, 2007). According to the 2002 South African Youth Risk Behaviour Survey, one in eight South African high school students begins drinking alcohol before the age of 13, and nearly one-quarter of students in grades 8 through 11 have engaged in binge drinking (Reddy, Panday, Swart, Jinabhai, Amosun, James, 2003).

There is evidence that alcohol usage increases the chances of risky sexual behaviour and that puts adolescents at the risk of contracting STI's and HIV. Of more than half of grade 11 students who have engaged in intercourse, nearly 1 in 10 reported to having had a sexually transmitted infection, and 13% reported having either been pregnant or having made someone else pregnant. Of particular concern in South Africa are the rates of HIV infection, which increase from 3% of children under the age of 14 to 23% of persons aged between 25 and 29 (Dialard, 2001).

Previous research shows that substance use and sexual activity tend to co-occur within individuals. However, little is known about how the initiation of this behaviour is sequenced, especially in the South African context (Dialard, 2001). The Buffalo City Municipality commissioned a study to the Fort Hare Institute of Social and Economic Research (FHISER) to investigate youth risk behaviour within the Buffalo City. This study, which was conducted in 2006, revealed that a large percentage of adolescents in Buffalo City continue to engage in risky sexual
behaviour such as unprotected sex and having multiple sexual partners, despite the known threats of contracting HIV/AIDS or other sexually transmitted diseases (Fort Hare Institute of Social and Economic Research (FHISER), 2007). The study highlights worrying levels of irresponsibility in the face of HIV and other dangers to the youth in this area. Palen, Smith, Flisher, Caldwell and Mpofu (2003), confirm these findings in their study which examines the covariance of substance use and sexual behaviour in over two thousand South African students. The findings of this study indicate that associations exist between lifetime substance use and certain sexual risk behaviour, such as the association between substance use and being unfamiliar with one’s sexual partner.

3.8. CO-OCCURRENCE OF SUBSTANCE USE AND SEXUAL INTERCOURSE

Adolescent males who have been exposed to alcohol use have a tendency to engage in multiple sex partners and unprotected intercourse (Malow, Devieux, Jennings, Lucenko, & Kalichman, 2001). Research with samples of African adolescents suggests that sexual behaviour and substance use tend to co-occur within broad time periods, such as lifetime, that is, adolescents who have ever engaged in one of the forms of behaviour are more likely to have also engaged in the other (Palen, et al. 2006).

Studies have consistently demonstrated that adolescents who strongly believe that alcohol enhances sexual arousal and performance are more likely to practice risky sexual behaviour after drinking (Dermen, & Cooper, 2000). In a research conducted with high school students from Cape Town, South Africa, it was demonstrated that lifetime use of alcohol is associated with higher odds of lifetime sexual intercourse. There are at least two general types of reasons why substance use and sexual behaviour may co-occur, which in turn have implications for
intervention strategies. First, the two types of behaviour may have common origins. This is consistent with the Problem Behaviour Theory in which factors like external locus of control and low parental monitoring contribute to multiple adolescent risk behaviour. In this situation, the initiation of substance use and sexual intercourse could occur in any order (including simultaneously), depending on the nature of the underlying variables or processes. Despite this body of research, there is a paucity of studies that indicate three different, but related categories of explanations are usually proposed to account for the relationship between alcohol use and sexual risk behaviour. One category of explanation is that alcohol consumption may represent other behavioural, lifestyle, contextual and/or personality factors which are associated with the engagement in high risk sexual behaviour (Hargreaves, Bonell, Boler, Boccia, Birdthistle, Fletcher, Pronyk, & Glynn 2002). For example, in certain instances, male alcohol consumers go to drinking venues which are also frequented by sex workers, and while in those venues they end up having casual and sometimes ‘higher-risk’ sexual encounters with those sex workers.

A second prominent explanation involves a more direct link. According to this explanation, the drug ‘ethanol’ acts on the central nervous system, reduces inhibitions, and consequently, increases people’s likelihood of engaging in risky sexual and other behaviour (Hargreaves et al., 2002). A third explanation presupposes that, in addition to alcohol’s ‘real’ effects on behaviour, people’s alcohol expectancies, that are their expectations about how alcohol will influence their behaviour, can also influence their actual behaviour. LaBrie, Schiffman, and Earleywine (2002), found that alcohol related expectancies regarding condom use were strong predictors of actual condom use in a sample of college students in the United States. However, there is no known published research examining alcohol expectancies and sexual behaviour among people in sub-Saharan Africa.
3.9. FACTORS INFLUENCING SUBSTANCE ABUSE AND RISKY SEXUAL BEHAVIOUR

According to Oshodi, Aina and Onajole (2010), the use of alcohol constitutes one of the most important risk-taking forms of behaviour among adolescents in secondary schools, especially males.

In this section, the discussion will therefore focus on the factors which have been researched and found to influence adolescent males to use alcohol and thereby lead to risky sexual behaviour. At an individual level, these factors could comprise of attitude and values. Furthermore, within the family, adolescent males’ sexual behaviour may be influenced by parenting style. Other factors are a drug-friendly environment, dysfunctional families, divorce, single parenthood and paternal absence, mass media and exposure to pornography, child headed households, culture and tradition, masculinity and power imbalances, sexual promiscuity of adults, boredom and unemployment, sexual abuse and maltreatment.

3.9.1. Individual factors

According to Oshodi et al. (2010), young people who tend to engage in rebellious and deviant behaviour tend to also be prone to using alcohol. On the other hand, greater religious involvement is associated with less alcohol use and drunkenness. A positive attitude to alcohol use means that the young person views the behaviour favourably and expects the positive outcomes to outweigh the negative consequences of the behaviour. For example, the short-term enjoyment that some adolescents believe can be derived from an evening of heavy drinking can be more salient and valued than the possible negative consequences of such behaviour in the long term. As already explained under the topic of psychological
well-being, young people who have a short-term focus are much more likely to abuse substances than are those with a longer-term view of life. Depressive symptoms and a poor sense of well-being have also been shown to be associated with the use of cigarettes and illegal drugs among young people.

**3.9.1.1 Attitudes and values**

Adolescents’ attitudes about sex are shaped by family values, cultural prescriptions as well as personal experience (Weiten, 2011). Societies which uphold cultural values and attitudes regarding sexuality (e.g. polygamy and gender inequality) can influence adolescents to initiate and practice sexual intercourse inappropriately (Crockett, Raffaelli, & Shen, 2003). For instance, where premarital sex is encouraged, adolescent males may engage prematurely in sexual activities and in turn become fathers, because pregnancy allows a determination of the fertility of potential marriage partners (Busari & Danesy, 2004). This poses a health risk as some cultures in South Africa believe that men can have as many women as they want to, that it is an acceptable norm and that a woman is not supposed to question that behaviour (Meel, 2005).

**3.9.2. Family influences**

**3.9.2.1 Parent-adolescent relationship**

According to Oshodi, Aina and Onajole (2010), the quantity and quality of the time that parents spend with their adolescent children is linked to those children’s use of alcohol and other risky behaviour. When parents/primary caregivers spend ample time with their adolescents, alcohol abuse and risky sexual behaviour by adolescents are less likely to occur. Parent–child relationships, parental control, and
parent-child communication have all been implicated in adolescent sexual behaviour. Better parent–child relationships are associated with postponing intercourse, less frequent intercourse and fewer sexual partners (Miller, Benson, and Galbraith, 2001).

On the other hand, adolescents without a nurturing home environment are more likely to seek out to others, and typically fellow age-mates, to fulfil their need for acceptance and recognition (Bee & Boyd, 2003). When parents hold on to the belief that by discussing sexuality with their adolescents it will increase sexual permissiveness, it could result in these adolescents contracting STI’s including HIV/AIDS (Pastorino & Doyle-Portillo, 2011).

### 3.9.2.2 Parenting styles

In the next three sub-sections, the discussion will focus on the types of parenting styles and how they affect male adolescents’ sexual behaviour and alcohol use. These types of parenting are: authoritarian parents, authoritative parents, and permissive parents.

- **Authoritarian parents**

  This type of parent tends to exhibit a high level of control and a low level of affection towards their children. They set high expectations for their children, but without explaining the reason behind their expectations (Pastorino & Doyle-portillo, 2011). Adolescents growing up in a family structure with high levels of demand and control but relatively low levels of warmth and communication do not do well in school and have a negative self-concept (Eaton, et al, 2003). In a series of large studies of secondary school students, including longitudinal studies of more than 6000 teens, developmentalists found that adolescents from rigid family structures have
poor grades and more negative self-concepts than did teenagers from family structures which are characterised by openness and encouragement from the caregivers (Bee & Boyd, 2003). These adolescents from homes with authoritarian parenting styles have low grades at school and therefore they tend to quit school, become dropouts and abuse alcohol. The reason attributed to this behaviour is to cover up their emotional problems.

- **Authoritative parents**

  According to Baumrind (1964), authoritative parents are both demanding and responsive. They monitor and impart clear standards for their children’s conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible, and self-regulated as well as cooperative. These types of parents set clear guidelines for their children. However, they also allow their children freedom within reasonable limits. Although they make demands and exercise control, these authoritative parents are also warm, sensitive and patient (Louw, Van Ede & Louw, 2007). When authoritative parents exhibit moderate levels of control, affection towards their children and reasonable expectations, children tend to respond in a respectful manner. They tend to have healthy relationships with their peers and respect their romantic partners. (Pastorino & Doyle-Portillo, 2011).

  As postulated in Problem Behaviour Theory (PBT), when adolescents males realise that their parents oppose alcohol abuse, early sexual experimentation and are always being monitored, they may in turn become prosaic and avoid to be involved in risky sexual behaviour (Jacobson & Crockett, 2000). Parenting style has been found to predict the child's well-being in the domains of social competence, academic performance, psychosocial development, and
problem behaviour. Adolescents whose parents are authoritative rate themselves, and are rated by objective measures, as more socially and instrumentally competent than those whose parents are non-authoritative (Louw, et.al.2007). In reviewing the literature on parenting style, one is struck by the consistency with which authoritative upbringing is associated with both instrumental and social competence and lower levels of problem behaviour in both boys and girls at all developmental stages. The benefits of authoritative parenting and the detrimental effects of uninvolved parenting are evident as early as the pre-school years and continue throughout adolescence and into early adulthood. Although specific differences can be found in the competence evidenced by each group, the largest differences are found between children whose parents are unengaged compared to their peers who have more involved parents. Just as authoritative parents appear to be able to balance their conformity demands with their respect for their children’s individuality, so children from authoritative homes appear to be able to balance the claims of external conformity and achievement demands, with their need for individualisation and autonomy (Louw, et.al.2007).

- **Permissive parents**

Permissive parents tend to show warmth and affection to their children, but have very little control over them. Discipline is lax. Children make their own decisions even when they may not be capable of doing so (Pastorino & Doyle-portillo, 2011). This type of parents may be uninvolved. Uninvolved parenting is characterised by parents not providing the necessary sexuality education as is expected to educate their adolescents, and this may leave adolescents with no choice but to rely on peers and the mass-media, which
may mislead them (Moronkola & Idris, 2000). More risky sexual behaviour, including unprotected sex with multiple partners, is one potential outcome for large numbers of unoccupied or bored young people having grown up in households led by permissive parents. Once again, the absence of a parent when growing up can have a significant effect on a young person’s attitude to sex and relationships (Holburn & Eddy 2011).

3.9.3. Dysfunctional families

According to Holburn and Eddy (2011), many South African children are not growing up in safe and secure families. Some are affected by poverty, while others are burdened by the effects of the HIV/AIDS pandemic. This pandemic has resulted in an epidemic of orphanhood and child-headed households, which has left many children having to fend for themselves. Single-parent households are a norm in South Africa, with the majority of children growing up with only one parent - most likely a mother. Increasing numbers of fathers are absent and a crisis of male role-models in South African homes seems to be perpetuating patterns of abuse and desertion (Holburn & Eddy, 2011).

3.9.3.1 Divorce

Divorce is the legal separation of two people, man and woman, who were previously married. Like other life changes, divorce brings with it stresses and adaptation which the family must negotiate. Typically, divorce is preceded by a period of conflict and dissatisfaction (Pastorino & Doyle-Portillo, 2011). It could have adverse outcomes on the emotional, economic and educational wellbeing of
adolescent males. As a result, male adolescents are more likely to misbehave, to be more aggressive, disrespectful, withdrawn or moody and their school performance may deteriorate. Such youth may experience conflict when their biological parents remarry after divorce. The male adolescents tend to develop disrespect towards their step-parents. Their disobedience manifests itself often in arriving home late and drinking alcohol when going out (Pastorino & Doyle-Portillo, 2011).

Failure in marriages may result to unsettling effects on family life especially where adolescents are involved. Adolescents could find an opportunity to experiment with alcohol as a way of coping with a stressful family life (Pastorino & Doyle-Portillo, 2011). Because the family ties are loosened and there is no secure attachment, adolescent males may join gangs which practise risky sexual behaviour such as having multiple sexual partners and unsafe sexual practices, which may lead to contracting sexually transmitted infections, HIV/AIDS and unwanted pregnancies (Swartz, et.al, 2011).

Divorce and the subsequent life in a single parent (caregiver) household, present the potential for the development of several kinds of psychological difficulties for both the parent and adolescent (Bee & Boyd, 2003). The most important consequence of divorce is that the children grow up with one parent and the absence of one of the parents makes them feel insecure. At the adolescent stage the children may feel that they have been discarded by the parent who left and may blame the parent with whom they live for the absence of the other. Male adolescents tend to become very aggressive. Such behaviour not only affects their relationships with the members of the household, but may also have an adverse effect on their relationships with their peers (Bee & Boyd, 2003). There is evidence that adolescents from single parent families are less well-adjusted than those where both parents are present. During adolescence they were found to be more likely to drink.
alcohol than adolescents whose parents live continuously as married families (Holburn & Eddy 2011).

It is however, important to note that some of the negative effects of divorce are due to factors that were present before the divorce (Bee & Boyd, 2003). In one investigation, Holburn and Eddy (2011), compared the families of 513 adolescents who drank alcohol and found that the adolescents who were addicted were more likely to come from broken homes, to have spent time with foster-parents or in institutions as children, to have left home at an early age and to have family members who have problems with alcohol.

3.9.3.2 Single parenthood

The term single-parent family refers to a situation that has arisen through the absence of the father or the mother from the family as a result of divorce, desertion or death. The largest single cause of single-parent families is divorce and in the majority of single-parent families the mother heads the household (Louw, et al., 2007).

According to Holburn and Eddy (2011), adolescent males who grow up with single parents (mothers in particular) have a tendency of engaging prematurely in premarital sex. Violence is often rife among them as they lack secure attachment. They tend not to sustain their romantic relationships, especially if their single parents also have multiple sexual partners.

Several negative consequences of single-parent families have been reported. For instance, it has been found that juvenile delinquency occurs more frequently among children from single-parent families, that these children enjoy school less than children from two-parent families, that they have poor relationships with teachers and friends and that they also have a poor self-image (Louw, et al., 2007).
3.9.3.3 Orphans and child headed families

In the year 2008, South Africa had 859 000 ‘double orphans’ (children of whom both parents have died), 2 468 000 paternal orphans, and 624 000 maternal orphans. Orphans have been associated with an early sexual debut compared with non-orphaned adolescents (Holburn & Eddy, 2011). (The study focussed on a selective group of black youth aged 14-18 years.) For some orphans, sexual activities become a form of survival and a form of escaping the poverty trap; hence sex becomes economically viable. Since they are in vulnerable positions, they have no or non-existent negotiating powers for safer sex practices, resulting in indulging in risky sexual behaviour.

Studies on the sexual behaviour of orphans showed that orphans are more likely to be abused compared with non-orphans (Thurman, Brown, Richter, Maharaj, & Magnani, 2006). Lacking parents or a protective guardian, persons from some communities take advantage of the orphans through unwanted sexual advances. In some cases the adolescents give in to these advances for fear of victimisation, and because they are in a vulnerable position, issues of safe sex become a problem as they are not able to negotiate condom use.

3.9.4. Peers

As children pass through childhood into adolescence, parental influences are thought to change or decline since the corresponding increase of peer influence and other factors related to extra familial socialisation emerge and they begin to be guided by their own internalised morals and values (Mostert, 1991).
According to Macphail and Campbell (2001), the strong desire to identify with models within the peer group may result in the adolescents acquiring anti-social behaviour. In the perceived absence of a legitimate opportunity structure, adolescents become vulnerable to the influence of adult criminals. Adolescents with a negative self-concept are likely to compensate for their inadequacies by drinking alcohol under the influence of their peers since they might fear to be rejected when not conforming to the group (Macphail & Campbell, 2001).

Curiosity, social pressure and peer group influence are reported to be some of the primary reasons for alcohol use and risky sexual behaviour among adolescents. Most often adolescents start by experimenting with the so called “gateways drugs” such as tobacco, alcohol and marijuana (Oshodi, et al., 2010), which impair their reasoning and thinking abilities, thereby indulging in unplanned sexual activities (Patric, Pallen, Caldwell, Gleeson, Smith & Wegner, 2012).

In a study conducted in Cape Town among 114 adolescents (N=52 males) [62 females], 56% of the adolescent males indicated that their motivation for engaging in sexual behaviour was solely due to peer pressure and the fear of rejection (Patrick et al., 2010). In another horrific incident, a group of seven boys, aged 13-19 gang raped a mentally disturbed teenage girl in Braamfischerville, (Sowetan, April, 2012). This is a clear example of how shocking adolescents’ risky sexual behaviour could turn out to be when they are acting under negative peer influence.

3.9.5. Societal/community factors

Analysis of male adolescent behaviour from an ecological perspective indicates that, at intrapersonal level, when the attitudes of adolescent males are not positive, adolescents might lack motivation and resort to binge drinking to “feel good” about themselves. At interpersonal level, if male adolescents are not monitored,
guided and supported by their parents or family in terms of sex education, they will tend to listen more to their peers and regard their peers’ advice regarding sex issues more highly. At community level, when the community lacks recreational facilities, chances are that male adolescents will engage in alcohol abuse and risky sexual behaviour and when schools do not provide programmes that will help adolescents to make informed decisions regarding alcohol use and safe sex practices, adolescents are most likely to indulge in alcohol and risky sexual behaviour (Panday, Makiwane, Ranchod & Lestoalo, 2009).

Societal norms and portrayals of drinking and drug use in films and alcohol advertisements which encourage drinking often target young people. Also, personal knowledge of adults who engage in anti-social behaviour is associated with more smoking, while subjective adult norms against drug use and community affirmation of positive behaviour have been found to be related to less smoking among young people. Neighbourhoods are a source of role-models for and information about sexual behaviour.

3.9.5.1 Drug friendly Environment

Both legal and illegal drugs are readily available to many young people in South Africa at the broader societal and the specific community levels. The easier it is for young people to access drugs, the more likely they will be to use them.

According to Morojel, Brook and Kachienga (2006), in addition to peer influence, adolescents whose environment is characterised by a relatively high rate of alcohol consumption, tend to develop identity confusion. Conformity is one kind of social influence that involves modifying individual behaviour in response to real or imagined pressures from others (Swartz, et al 2011). At community level, when adolescents are exposed to public drunkenness, adolescent drunkenness is more
likely to prevail (Oshodi, et al., 2010). The use of alcohol has a strong link to adolescents’ risky sexual behaviour where many young people are voluntarily engaging in activities that put them and their health at risk. 31% of the adolescents surveyed in the Lifestyle study reportedly had consumed alcohol. While that may sound relatively low, consider that the age range was 12-22 years. 35% had their first drink at age 14 or younger. Some 20% said they drank to relieve boredom, 18% did so because their friends drank, 14% because they wanted to get drunk and 3% because they were addicted to alcohol. Despite the knowledge which adolescent possesses on the harmful effects of alcohol, many young people choose to use and abuse alcohol (Holburn & Eddy, 2011).

### 3.9.5.2 Rural setting

Growing up in rural areas could be associated with earlier experimentation with sexual activities among adolescent males than growing up in urban areas. In a study conducted at two schools in KwaZulu Natal (one urban, the other rural), 34% of adolescent males from rural area reported multiple partners compared to 26% from the urban area. By the age of 15 years, 78% of male adolescents from the rural area were found to be sexually experienced (Pithey & Morojele, 2002). The reason for such behaviour could be attributed to the fact that in rural areas, there are limited recreational facilities for cognitive stimulation and boys tend to be left unsupervised by parents more frequently in comparison to girls. By exploring with peers while they are on their own, they learn about substance use, dating and consequently experimentation with sex become inevitable (Poon & Seawyc, 2009). In addition, Panday et al. (2009), found that adolescent males who live in rural areas miss the opportunity to talk about sex with their parents and because of disempowerment due
to a lack of knowledge about sex education, the majority of boys contract sexually transmitted infections such as gonorrhoea and HIV/AIDS.

3.9.5.3 School and academic environment

A school is by definition a social link for adolescents. The school’s unlocking function is to actualise the adolescents’ potential and operates under the guidance of a definite ground motive or mission/goal. The school functions in conjunction with other social relationships such as the state, the caregiver, and other social and religious organisations (Kheswa 2006).

The National Minister of Health in South Africa announced that sex-education should be a priority in order to reduce the high rate of teenage parenthood and other social ills which young people are exposed to (Kharssany, Mlotshwa, Frohlich, Zuma, Samsuder, Karim & Karim, 2012). In addition, having low academic aspirations and performing poorly at school have been found to be related to adolescents’ use of alcohol (Oshodi, et al., 2010). When adolescents fail grades and attend school irregularly, they may eventually develop a tendency to use alcohol. This constant failure and the accompanying feelings of incompetence tend to be discouraging and demoralising. Feeling worthless can be depressing and as a result, adolescent males may indulge in alcohol and engage in risky sexual behaviour (Kheswa, 2006).

3.9.6. Cultural- and traditional influences

In the next paragraph another dimension to be considered is male circumcision and how it impacts on the sexual behaviour of adolescent males.

Male circumcision refers to the removal of the foreskin of the penis and among the Xhosa speaking nation, traditional circumcision dates back to 1789. It
marks the transition from boyhood to manhood (Meel, 2005). Literature indicates that when adolescent males have undergone traditional circumcision they tend to express their masculinity by having multiple sexual partners, being aggressive and engage in alcohol abuse (Peltzer, Nqeketo, Petros & Kanta, 2008). In a research conducted among 160 Xhosa initiates ranging from 16 to 26 years of age in the Eastern Cape, Peltzer et al., (2008), found that 88% of the initiates indicated that they have had sexual intercourse with multiple partners and only 38% indicated that they had used a condom. 10% indicated to have had sex under the influence of alcohol. Based on these findings it will be difficult to curb HIV/AIDS transmission for as long as adolescent males do not practise safe sex.

3.9.7. Sexual abuse and maltreatment

According to Heise and Garcia-Moreno (2002), minimal facts are known about the sexual health implications for males who have experienced coercive sex within dating relationships. However, there is some evidence to suggest that the association of forced sexual contact and high risk behaviour also holds for adolescent males who have been victimized. Studies have found that male high school students who have reported to having been pressured or forced to have sexual intercourse, were more likely to report a higher number of recent male and female sexual partners, engaging in alcohol use and not using condom (Sieving, McNeely & Blum, 2000).
3.9.8. Poverty

Poverty has long been a risk factor that overwhelms the self-concept and predisposes adolescents to alcohol use and other social morbidities such as risky sexual behaviour (Monti & O’Leary, 2001). It is also linked with a lower family income and lower parental educational attainment which in turn is associated with a greater likelihood of teenage intercourse and unplanned fatherhood (Sieving, et al. 2000).

Frustrations and anger at being poor may give way to feelings of weakness, victimisation and loss of control. These factors are often expressed as pessimism, loss of hope, depression and alcohol use, and adolescents may find that to continue with school is difficult because their caregivers do not support them. Consequently, they resort to drinking alcohol as a solution to their misery (Holburn & Eddy 2011).

Holburn and Eddy (2011), state that it is common for teens growing up in poverty and around violence to question whether they will survive into adulthood. He concludes that poverty and violence may vitiate an adolescent's sense of safety, security and hope, leaving little room for long-term aspirations and planning. As a result, patterns for risky sexual behaviour and alcohol abuse transpire for male adolescents. In a study titled “Hopelessness and risk behaviour among adolescents living in high-poverty inner-city neighbourhoods”, respondents reporting high levels of hopelessness are more likely than those reporting low levels of hopelessness to have had sexual intercourse during the previous week; to have a child; to have at least got drunk during the previous week; and to be currently trying to get someone pregnant.
3.9.8.1 Unemployment

In addition to poverty, adolescents’ inability to handle anxiety and depression may be exacerbated by unemployment (Holburn & Eddy, 2011). Oshodi, et al. (2010), claim that unemployment of caregivers impacts negatively on the lives of adolescents. Very often, the caregivers are unable to meet the educational needs of these adolescents and as a result, these adolescent become delinquents, abuse alcohol and get involved in risky behaviour because there is no motivation and guidance from home, as parents may be overwhelmed by stress.

According to Pastorino and Doyle-portillo (2011), economically deprived adolescents may feel pressured to start earning money for themselves to overcome feelings of shame, insecurity and hopelessness due to the unemployment of their caregivers. However, this adventure impacts adversely because in most cases a significant decline in their school performance is manifested. Bee and Boyd (2003), found that the harder the adolescents work at unstable jobs with no fringe benefits owing to lack of skills, the more they use alcohol, the more aggression they show to peers and the more arguments they have with the caregivers and their sexual partners.

3.9.9. Mass media

According to most theories on media effects, the influence of media depends largely on the content it contains. Much of the research linking media and sex — particularly studies of attitudinal effects — has focused on television. Television viewing remains the most common medium and platform, and it makes up the largest chunk of adolescents’ media use, accounting for 4.5 hours of media time out of nearly 11 total hours spent with media daily. Television includes a great deal of
sexual content, creating a strong potential for observing such effects (Collins, Martino & Elliot, 2011). The extensive viewing of sexual violence and rape could be detrimental to the cognitive and moral development of adolescents (Weiten, 2011). As the media is flooded with sexual images on a daily basis, adolescent males receive misleading information on sexuality issues, which is likely to skew the teenagers’ sexual perception and even encourage risky behaviour such as the use of ineffective means of contraception (Weiten, 2011).

3.9.9.1 Pornography

Adolescent curiosity about sexuality is a normal and healthy aspect of human development and for many generations of youths, sexual exploration included such actions as sneaking peaks at pictures of naked indigenous peoples in National Geographic. However, today the scene is very different. The Internet and cable television have ushered access to hardcore pornographic images, and adolescents are jumping in head first for the ride (Griffiths, 2001). The amount of pornography available for adolescents has roared into everyday life so overwhelmingly that it has challenged the ability of social science to create models of treatment and outcome to keep up with the pace of the changes (Fisher & Barak 2001). However, what is certain is that for many adolescents, pornography is not a casual interest but an addictive force that is leading to a quiet epidemic of young people who cannot control their online- or television habits. Because of their accessibility, the Internet and cable porn channels have the ‘super fix’ for a new breed of addicts who literally sacrifice health and happiness to indulge in the magic images they quietly worship (Griffiths, 2001).

The exact effects of pornography on adolescents is a hotly debated topic, as few empirical studies exist which definitively examine the issue. Reason for this lack
in clinical research include the reluctance of many teens to talk about their sexual habits and the monumental ethical dilemmas of setting up research studies involving youths and their exposure to pornography. Nevertheless, numerous studies have pointed to the potential for serious harm. These include modelling and imitation of inappropriate behaviour; unhealthy interference with normal sexual development; emotional side effects (including nightmares and residual feelings of shame, guilt, anxiety and confusion); stimulation of premature sexual activity and the development of misleading and potentially harmful attitudes towards sex. For example, Mkhuthuka & Prince (2012), reported in the Daily Dispatch newspaper on an incident in which explicit cell phone video clips, showing an underage school girl having sex with a series of different boys, were distributed. These school children were imitating what they have possibly seen on pornographic movies. Other risks that have been suggested range from aggressive patterns of acting out sexually and the depersonalisation of women (Griffiths, 2001).

3.10. DANGEROUS AND DEADLY CONSEQUENCES OF ALCOHOL ABUSE AND RISKY SEXUAL BEHAVIOUR

According to Mabille (2009), alcohol abuse among adolescents leads to irresponsible sexual behaviour.

3.10.1. Sexually transmitted infections and HIV/AIDS

Too many adolescents acquire sexually transmitted infections (STI’s) including the human immunodeficiency virus (HIV) by not using condoms and this behaviour accelerates the spread of HIV (Mabille, 2009).

The incidence of the HIV infection worldwide is not only staggering, but the daunting statistics show that currently, half of new HIV infections occur in people
between the ages of 15 and 25. As most people initiate sexual activity during adolescence, (many having sex before the age of 15), a total of nearly 12 million young people is reported to be living with AIDS worldwide and many will die before the age of 35 Reproductive Health Outlook (RHO), (2004). Alarming reports state that South Africa has the largest percentage of people living with HIV/AIDS in the world, with estimates that over 1500 people become infected daily (Goldstein, Pretorius & Stewart, 2003). Figures for HIV infected 20- to 24 year old South Africans topped 26% and it is believed that half of all 15 year olds are likely to die of AIDS (Parry, 1998). It is possible that many AIDS cases now appearing among those aged 20 to 24 may be coming from those exposed to the virus during their adolescent years (Langer, Warheit & McDonald, 2001).

The misuse of alcohol is increasingly being recognised as a key determinant in risky sexual behaviour, and consequently, an indirect contributor to HIV transmission in sub-Saharan countries (Fritz, Woelk, Bassett, McFarland, Routh, Tobaiwa & Stall, 2002). Numerous cross-sectional investigations which have been conducted have shown consistently that alcohol use is associated with HIV infection (Clift, Anemona, Watson-Jones, Kanga, Ndeki, Changalucha, Gavyole, & Ross, 2003). However, the relationship between alcohol consumption and unprotected sex is equivocal. Some studies, (Fritz et al, 2001), have found a significant relationship between alcohol consumption and unprotected sex, whereas others have not (Fritz et al., 2001).
3.10.2. Rape and Sexual Assaults

Researchers estimate that alcohol use is implicated in one- to two-thirds of sexual assault and acquaintances or “date” rape incidents among adolescents. In a survey of university students, 55% of sexual assault perpetrators and 53% of sexual assault victims, admitted to be under the influence of alcohol at the time of the assault.

A study of college women found that alcohol use is one the strongest precursors of college women rape. A survey of high school students found that 18% of females and 39% of males say it is acceptable for a boy to force sex if the girl is ‘stoned drunk’ (Fritz et al., 2001).

3.10.3. Unplanned fatherhood.

Statistics from the Department of Education suggest that pregnancy in schools is increasingly becoming a problem. In 2007, nearly 50 000 pupils fell pregnant while in school, a 151% increase since 2003. Some 53 pupils in Grade 3 fell pregnant during 2007. School drop-out as a result of pregnancy is not an issue facing girls only: some 54% of 14- 22 year-old young men surveyed in KwaZulu Natal said that they had left school because of fathering a child (Holburn & Eddy, 2011).

3.11. CONCLUSION

The leading causes of morbidity and mortality among adolescents are related to health risk behaviour: behaviour that leads to alcohol and sexual behaviour which contributes to unintentional pregnancies and STI's, including HIV infection. (Essendrup, 2008).
Due to the importance placed on monitoring this behaviour and the relative lack of research conducted on adolescents, it seems appropriate to extend this form of inquiry to South African students. Chapter 4 will provide a detailed account of how this study was carried out.
CHAPTER 4

RESEARCH DESIGN AND RESEARCH INSTRUMENT

4.1. INTRODUCTION

According to Leedy and Ormrod (2005), research is a systematic process of collecting, analysing and interpreting information (data) in order to increase our understanding of the phenomena about which we are interested or concerned.

From the literature study in chapter three it became evident that research on the influence of alcohol on male adolescents’ sexual behaviour has been done before. The review of literature in chapter three provided a framework of reference for the research design of the study.

The purpose of this chapter is to explain the research instrument employed in this study. The validity and reliability of the research instrument that was developed will also be discussed.

4.2. THE RESEARCH INSTRUMENT

A structured questionnaire with each question rated on a five-point scale was used. The theoretical framework in chapter two provided the basis for developing questions around the research problem.

4.2.1. Questionnaire

The research aims at determining the correlation between adolescent males’ alcohol use and engaging in multiple sexual partners and also to examine male adolescents’ drinking patterns in relation to condom use/non-use. It was clear that a structured questionnaire is the most appropriate instrument to use in order to accomplish the purpose of this investigation.
According to Cohen, Manion and Morrison (2004), some of the advantages of a structured questionnaire as a means of collecting data are as follows:

- They are more cost effective to administer than personal (face-to-face) interviews.
- Data obtained through structured questionnaires is relatively easy to analyse.
- Most people are familiar with the concept of a questionnaire.
- They reduce the possibility of interviewer bias.
- They are perceived to be less intrusive than telephone or face-to-face surveys and hence, respondents will more readily respond truthfully to sensitive questions.
- They are convenient since respondents can complete it at a time and place that is convenient for them.

Although a structured questionnaire is a useful tool for researchers, it takes time and effort at the onset to compile the questions effectively.

4.2.2. Scaling technique

A five-point scale was chosen to accomplish the aim of this research study.

The advantages of the five-point scale are as follows:

- Each question can be weighed on its own merit by the participants.
- The use of a wider spectrum of statistical techniques is possible.
- It enables participants to express reasonably fine judgements.
- Items are of the same format and the same anchor points are chosen for each question (Best & Kahn 1993).
4.2.3. Format of instrument

The questionnaire (Appendix 1) is divided into two sections: the first section requires the participants’ personal particulars such as age (Question 1), grade (Question 2), home-language (Question 3), type of house the participant is living in (Question 4), whether the mother is alive (Question 5), employment status of mother (Question 6), whether the father is alive (Question 7), employment status of the father (Question 8), marital status of both parents if they both are alive (Question 9), and the caregiver of the participants (Question 10).

The second section of the questionnaire contains questions around the aspects covered in the literature in chapter three. These aspects include: caregivers, peers, the mass media, socio-economic status and school/environmental social factors which may encourage adolescents to drink alcohol and engage in risky sexual behaviour.

There are 52 items in the questionnaire. The participants indicate their opinions by making an X in the appropriate number on the scale as provided. The lowest rating indicates that the statement is not applicable to the participants, whereas selecting the highest rating “too a large extent” indicates that the statement is applicable to the participants.

The five point scale allows the participants a varied scope of opinions from which to choose.
4.3. VALIDITY AND RELIABILITY

The subject of validity is complex, controversial, and particularly important in behavioural research (Kerlinger & Lee, 2000). In general, it is accepted that the concept of validity refers to the extent to which an instrument measures what it purports to measure (Vockell & Asher, 1995).

Vockell and Asher (1995), expresses concern that there are many threats to internal validity that could affect the desired research outcome. If validity is not controlled, a researcher could mistakenly attribute the changes in the dependent variable to the effect of the independent variable. The changes could actually have been the result of some extraneous event during the time frame of the experiment, or as the result of the normal passage of time (maturation), rather than the treatment. These threats to internal validity could invalidity the results of the research.

There are various types of evidence for validity. Content validity refers to the representativeness or sampling adequacy of the content - the substance, the matter, and the topic - of a measuring instrument or questionnaire. Content validation is guided by the question: “Is the substance or content of this measure representative of the content or the universe of the content of the property being measured?” (Kerlinger & Lee, 2000). Each of the questions that were formulated in this questionnaire was based on literature that was reviewed in the previous chapter, forming the conceptual framework for the questions and thereby enhancing the content validity.

Furthermore, every attempt was made to ensure the content validity of the questions by using some ideas of questions gained from published questionnaires.
Another type of evidence for validity is construct validity. Construct validity is one of the most significant advances of modern measurement theory and practice (Kerlinger & Lee, 2000). Internal validity was also enhanced by ensuring that the interference as discussed by Vockell and Asher (1995), were checked with regard to:

- Questioning was conducted in the month of October, and at a time when extraneous activities at the schools were at a minimum.
- Questioning was also conducted during the normal school programme.
- Groups were of a similar age, gender distribution, cultural composition and school grade.
- When completed, the questionnaires were returned to the person applying the questioning, a review of all the pages was done to ensure that all pages’ questions were properly answered.
- All the adolescents that had been identified through the sampling process completed the questionnaires. There were no adolescents who did not complete the questionnaire who were purposively selected.
- The research was conducted during a normal period of the day for learners at the school, ensuring that the answering of the questionnaire was as unobtrusive as possible.

An analyses of the reliability was then conducted on these two factors by calculating the Cronbach alpha coefficient (Schumacher & McMillan, 1993).

4.4. RESEARCH SAMPLE

The school was randomly selected from other schools around Alice and the participants were purposively sampled. The researcher, together with the person assigned by the principal went to the relevant classes (grade 10, 11 and 12). 176
male students participated in this research study and their ages ranged from 14 to 25 years. This was done after having gained permission to do so from the principal of the school.

4.5. ETHICAL MEASURES

According to Marks and Yardely (2004), ethical measures are concerned with the protection of the rights and interests of research participants, including their right to privacy, the right to informed consent, the right to withdraw from the testing without penalty and the right to confidentiality. The researcher attempted to abide by applying the following measures that form part of Vockell and Asher’s (1995), guidelines:

- The public school was purposively selected.
- A letter was addressed to the principal requesting the cooperation in the research.
- During the testing phase, learners were given the opportunity to withdraw from participation in the research without penalty, if they choose so. None of the learners availed themselves of this opportunity, and all who were selected completed the questionnaires.
- During the administration of the questionnaire, learners were given the assurance that their answers would at all times be treated in the strictest confidence. The questionnaires were completed anonymously and after they had returned their completed questionnaires to the person conducting the testing, there was no way of attaching the answers provided on their questionnaires to any specific adolescents.
4.6. DATA PROCESSING

After the 176 questionnaires were received back, each one was carefully checked for obvious errors. Thereafter they were sent to the statistical consultation service at the University of Fort Hare for the analysis of data.

4.6.1. Chi-squared

The value in the Total column is called $X^2$ (Chi-square, pronounced 'Ki' as in kite). This is the test statistic for the comparison of the observed and expected frequencies. As with other test statistics, the obtained value is compared with the critical value to determine whether to reject or retain the null hypothesis.

For a Chi-square test, the null hypothesis is that the two sets of frequencies (i.e., observed and expected) are equal. The alternative hypothesis is that they are unequal. The closer the obtained Chi-square is to zero, the more similar the two sets of frequencies are - or, stated another way, the better the observed data fit the expected pattern. This interpretation is where the term "goodness of fit" originates. As with previous comparisons of obtained and critical values of the test statistic, it can determine whether to reject or retain the null hypothesis. The Chi-square distribution is similar to the t and F distributions in that it takes different forms, based on the degrees of freedom associated with the test, if the Asymp. Sig. (asymptotic significance) Value is greater than 0.05, it has failed to reject the null hypothesis.

4.6.2. Regression Model

Coefficient of determination ($R^2$):

A high $R^2$ indicates that the data points are close to the values predicted by the multiple regression equation and that, as a group, the independent variables are a good predictor of the dependent variable. In a multiple regression, $R^2$ is interpreted
as the proportion of variation in the response variable explained by all the predictor variables simultaneously. A low $R^2$ indicates that the data points are scattered away from the values predicted by the multiple regression equation and that the independent variables are a poor predictor of the dependent variable. It is possible to find evidence for a statistically significant relationship between the response variable and all the predictor variables ($p<0.05$) but a very low $R^2$. In this case, one should indicate that, while the relationship is significant, the independent variables are a poor predictor of the dependent variable.

4.6.3. F-Statistics

When interpreting the multiple regression analysis, it is necessary to first consider the statistical significance of the full model before going on to interpret the significance of the individual predictor variables. If one fails to find a statistically significant relationship between the response variable and all the predictor variables simultaneously, then one fail to reject the null hypothesis for the full model and consequently must conclude that the model as a whole is not a good fit for the data. It is not appropriate to interpret the effects of the individual predictor variables from a full model that has been rejected. However, if one do find evidence for a significant relationship between the response variable and all the predictor variables as a group, then it is appropriate to interpret the effect of each of the individual predictor variables (residual models).

Calculated $F > \text{critical } F$, $p \leq 0.05$ means one can reject the null hypothesis for the full model and can find significant statistical evidence for a relationship between the response variable and all the predictor variables simultaneously (as a group). The probability that one would find a relationship among the variables due to chance
is less than or equal to 5%, which is an acceptable level of error for ecological experiments.

4.6.4. Durbin-Watson Statistic

The "Durbin-Watson test for autocorrelation" is a statistic that indicates the likelihood that the deviation (error) values for the regression have a first-order auto regression component. The regression models assume that the error deviations are uncorrelated.

Small values of the Durbin-Watson statistic indicate the presence of autocorrelation. One may consult significance tables in a good statistics book for exact interpretations; however, a value lesser than 0.80 usually indicate that autocorrelation is likely.

4.7. CONCLUSION

This chapter focussed on the research design. The research instrument was discussed. The next chapter will focus on the analysis and interpretation of data.
CHAPTER 5

ANALYSIS AND INTERPRETATION OF EMPIRICAL DATA CONCERNING ALCOHOL USE AND SEXUAL BEHAVIOUR OF ADOLESCENT MALES IN Nkonkobe Municipality

5.1. INTRODUCTION

In this chapter, the focus is on the analyses of the data that was obtained from completed questionnaires as filled out by male adolescents in one school in the Alice-Nkonkobe region. After completion, the questionnaires were received from the participants and were sent to the statistical consultation service at the University of Fort Hare for analysis of the data.

After the description of the biographical data, the results of the analysis concerning validity and reliability will be discussed. Finally, the results of the various differential and relational analyses will be presented and discussed.

5.2. ANALYSES OF THE BIOGRAPHICAL DATA

In this paragraph the focus will be on the descriptive analyses of the biographical data. Within the scope of this dissertation, 176 male adolescents from one school in the Nkonkobe Municipality participated in this study. This sample was purposively selected. All of the 176 learners were males. These learners were in grade ten, eleven and twelve with an age range from a low of 14- to a high of 25 years. The mean age was 18.06 years while the standard deviation was .144.

In question 2 (see Appendix 1) the participants were asked to indicate what grade they were in, either grade 10, 11 or 12. A total of 35.2% learners were in grade 10 (N=62), 34.1% learners were in grade 11 (N=60) and 30.7% were in grade 12 (N=54). All the participants were Xhosa speaking.
Furthermore, 61.9% of the learners (N=109) indicated that they lived in brick houses, while 22.2% of the learners (N=39) indicated that they lived in RDP houses and 7.4% of the learners (N=13) indicated that they lived in a shack.

**TABLE 5.1 GROUPS OF LEARNERS ACCORDING TO AGE**

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-17</td>
<td>77</td>
<td>43.7</td>
</tr>
<tr>
<td>18-21</td>
<td>90</td>
<td>51.1</td>
</tr>
<tr>
<td>22-25</td>
<td>9</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>176</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

With regard to question 5 (see appendix 1), learners were asked to indicate if their biological mothers were alive; 89.2% (N=157) indicated that their mothers were alive and only 10.2% (N=18) said that their mothers were not alive. Question 6 asked the employment status of their mothers and 38.6% (N=68) indicated that their mothers were unemployed, 31.3% (N=55) indicated that their mothers were employed full-time, while 11.9% (N=21) indicated that their mothers were employed on part-time basis. 10.8% (N=19) indicated that their mothers were pensioners and 7.4% (N=13) learners did not respond to this question. Question 7 asked whether the fathers of the learners were alive. 80.1% (N=141) indicated that their fathers were still alive and 19.9% (N=35) indicated that their fathers were not alive. With regard to question 8 (see appendix 1), 38.1% (N=67) learners indicated that their fathers were employed full-time, 21.0% (N=37) indicated that their fathers were unemployed, 13.6% (N=24) learners indicated that their fathers were pensioners, 13.1% (N=23)
indicated that their fathers were employed part-time and 14.2% (N=25) learners did not respond to this question.

Furthermore, the learners were asked to indicate the marital status of their mothers and fathers. 34.7% (N=61) indicated that their mother and father were legally married, 23.3% (N=41) indicated that their mother and father were divorced, 24.4% (N=43) indicated that their mother and father were staying together but were not married, 17.6% (N=31) of the learners did not reply to this question because either their mothers or fathers were not alive so it did not apply to them.

**TABLE 5.2. MARITAL STATUSES OF MOTHERS AND FATHERS**

<table>
<thead>
<tr>
<th></th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legally married</td>
<td>61</td>
<td>34.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>41</td>
<td>23.3</td>
</tr>
<tr>
<td>Living together (but not married)</td>
<td>43</td>
<td>24.4</td>
</tr>
<tr>
<td>N/A</td>
<td>31</td>
<td>17.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>176</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Regarding question 10 (see appendix 1), 35% (N=62) learners indicated that both their mothers and fathers take care of them, 27.3% (N= 48) indicated that only their mothers take care of them, and another 27.3% (N=48) indicated that their guardians take care of them.
In question 17 the learners were asked to indicate whether or not they were involved in a romantic relationship. 75.6% (N=133) of learners indicated that they were involved in a romantic relationship, 23% (N=41) learners indicated that they were not involved in a romantic relationship and only 1.1% (N=2) of the learners did not respond to this question. Furthermore, the learners were asked to indicate whether they had more than one sexual partner. 40.9% (N=72) learners indicated that they had more than one sexual partner, 57.9% (N=102) learners indicated that they only had one sexual partner and 1.1% (N=2) of the learners did not respond to the question.

5.3. DESCRIPTIVE ANALYSES OF THE SUBSTANCE USE BY ADOLESCENTS, THEIR PEERS AND THEIR CAREGIVERS

Questions 19 - 23 (see appendix 1) asked the learners to rate from strongly disagree to strongly agree with the statements relating to alcohol use. 46.6% (N=82) of the learners strongly disagreed that they drink alcohol, while 24.5% (N=43) indicated that they agreed to drink alcohol and 29.0% (N=51) indicated that they were neutral to this statement - they do not fully agree nor fully disagree to this statement. When asked about smoking dagga 86.4% (N=160) disagreed and 9.1% (N=16) agreed that they smoked dagga. 74.4% (N=131) of the learners disagreed to smoking cigarettes and only 25.6% (N=45) agreed that they smoked cigarettes.

Furthermore, the learners were asked to indicate whether their peers had any influence on their drinking patterns. 60.3% (N=106) of the learners indicated that they disagreed to the statement that said “I drink more alcohol (binge drink) when I am with my peers” and 39.7% (N=70) of the learners agreed to this statement.

In question 23, the learners were asked to indicate whether their sexual excitement was influenced by drinking alcohol and 69.1% (N=123) of the learners
disagreed with that, while 30.1% (N=53) of the learners agreed that they become sexually excited after drinking alcohol. Question 29 asked whether the learners agreed or disagreed to the statement that said “I am inclined to demand sex when I am drunk”. 81.9% (N=144) of the learners disagreed with this statement while 18.1% (N=32) of the learners agreed with the statement.

Of the 176 learners, only 9% (N=16) indicated that their caregivers smoked dagga while 90% (N=160) indicated that their caregivers do not smoke dagga. 78.4% (N=138) of the learners indicated that their caregivers do not smoke cigarettes and only 21.5% (N=16) indicated that their caregivers smoke cigarettes.

5.4. DESCRIPTIVE ANALYSES OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO INFLUENCES SUCH AS THE MEDIA, THEIR COMMUNITIES, CAREGIVERS AND THEIR PEERS

With regard to question 24 (see Appendix 1), which asked the learners to indicate whether or not they negotiated safe sex with their sexual partners, of the 176 male adolescents, 58.5% (N=103) indicated that they agreed on negotiating safe sex with their partners as compared to 41.4% (N=73) who disagreed with the negotiation of safe sex. Question 28 asked the learners to rate whether they agreed or disagreed with the statement that said “I become aggressive towards my sexual partner when they suggest that I should use a condom”, only 22.7 % (N=40) of the learners agreed to this statement and 77.2% ( N=136) of the learners disagreed with the statement.

Other questions regarding the adolescent’s sexual behaviour were asked in order to determine the factors that influence them to behave in a particular manner. The learners were asked whether the media had any influence on their sexual behaviour. 88.7% (N=156) of the learners indicated that the media did not influence
their decision on their sexual behaviour, while only 11.3% (N=20) of the learners indicated that they agree that the media has an influence on their decisions on sexual behaviour. Furthermore, these 176 male learners were asked to indicate whether they surf the Internet to watch pornography. Only 17.3% (N=29) of the learners indicated that they watched pornography on the Internet and 83.5% (N=147) of the learners indicated that they do not surf the Internet to watch pornography.

Question 48 asked whether the adolescent’s peers had multiple sexual partners. 66% (N=116) indicated that their peers did not have multiple sex partners, while 34.1% (N=60) of the learners indicated that their peers had multiple sex partners. The learners were further asked if their peers had any influence on their sexual behaviour and 84.2% (N=148) of the learners indicated that their peers do not influence their sexual behaviour and only 16% (N=28) of the learners indicated that their peers did influence their sexual behaviour.

The learners were asked to indicate whether or not they agreed or disagreed to the statement that said “my sexual behaviour is influenced by my culture”. 88.9% (N=151) of the learners disagreed with the statement while 21.6% (N=25) agreed with the statement. The learners were asked whether their community members influenced their sexual behaviour and 89.7% 9 (N=158) of the learners indicated that their community members did not influence their sexual behaviour and only 10.2% (N=18) of the learners indicated that their sexual behaviour was indeed influenced by their community members. The school also has an influence on sexual behaviour of the adolescent. When the learners were asked to indicate whether or not they receive sex education at school, only 51.7% (N= 91) indicated that they receive sex education at school and 48.7% (N=85) indicated that they are not educated about sex at school. Lastly it was asked that the learners indicate whether or not their
caregivers had multiple sex partners and 90.4% (N=159) of the learners indicated that their caregivers did not have multiple sexual partners, while 9.6% (N=17) of the learners indicated that their caregivers indeed had multiple sexual partners.

5.5. DESCRIPTIVE ANALYSES OF THE RELATIONSHIP BETWEEN THE ADOLESCENTS AND THEIR CAREGIVERS

Questions on the relationship between the adolescent and the caregiver were asked in order to determine if their relationship will have any influence on the adolescent with regard to the use of alcohol and their sexual behaviour.

Trust is a very critical issue, especially in the adolescent stage. The learners were asked to indicate whether or not they think/feel that their caregivers trusted them. 67.7% (N=130) of the learners indicated that their caregivers trusted them and only 32.4% (N=36) of the learners indicated that they were not trusted by their caregivers.

Question 40 (see appendix 1) asked whether the caregiver warns the adolescent about HIV/AIDS and 50% (N=88) of the learners indicated that they caregivers do not warn them about HIV/AIDS as compared to 50% (N=88) of the learners who responded that their caregivers do warn then about HIV/AIDS. It was further asked in question 41, whether or not their caregivers talk to them about safe sex and only 59.6% (N=105) of the learners indicated that their caregivers talk about safe sex practices while 40.4% (N=71) indicated that their caregivers do not talk to them about safe sex practices. Furthermore, the learners were asked to indicate whether or not their caregivers disciplined them when they changed sex partners. Of the 176 male adolescents, 69.3% (N=122) of the learners indicated that did not discipline them when they change their sex partners and 30.7% (N=54) indicated that their caregivers do discipline them when they change sex partners. Lastly, the
learners were asked whether they agreed or disagreed with the statement that said “my caregiver does not care if I do not sleep at home”. 86.3% (N=152) of the learners disagreed with the statement, while only 13% (N=23) of the learners agreed with the statement.

5.6. INTERPRETATION OF THE BIOGRAPHICAL DATA

From Table 5.2, which displays that only 34.7% (N=61) of adolescent males are raised by parents who are legally married, the implication of this finding could be that a staggering 65.3% (N=115) of youths may grow up without proper guidance as their parents might be divorced or live in cohabitation. They may be at risk of experiencing external locus of control in such a way that the deviant peers and drug friendly environment lead them astray (e.g. early sexual debut and alcohol abuse). In families which display a lack of consistency in terms of the disciplining of adolescents, unplanned fatherhood and aggressiveness are common among boys. This finding is in line with the research by Kheswa (2006), who found that adolescent males from the Soweto township indicated that their anti-social behaviour was a result of not experiencing positive communication with the caregivers because they were raised in families where values and principles were not emphasized by parents - hence they resolved to drink alcohol.

Regarding the employment status of the adolescents’ mothers and fathers, only 31.3% (N=55) indicated that their mothers, and 38.1% (N=67) indicated that their fathers were employed full-time. It is therefore implied that the majority of these youths may be prone to risky sexual behaviour, truancy and prematurely drop out of school because the financial status of parents is unstable as some parents are pensioners and others do odd-jobs. From this perspective, the question could be: “Upon completion of Grade 12, will these students be educationally supported to
study further?” Also, considering the rate at which adolescent males abuse alcohol in many societies characterised by poverty, as suggested by Myburgh and Poggenpoel (2009), the likelihood of being aggressive towards their partners (including their sexual partners), is greater than adolescent males who come from non-poverty-stricken backgrounds.

5.7. INTERPRETATION OF ALCOHOL USE BY ADOLESCENTS IN RELATION TO THEIR PEERS AND THEIR CAREGIVERS

In this paragraph, alcohol use by adolescents in relation to their peers and their caregivers is interpreted. It is clear that adolescent males do not use alcohol as it is indicated in section 5.3. For example, 46.6% (N=82) of the learners strongly disagreed that they drink alcohol, while 24.5% (N=43) indicated that they agreed to drink alcohol and 29.0% (N=51) indicated that they were neutral. There could be many factors which might have contributed to the alcohol abstinence of these adolescent males, namely: parent-child relationships, motivation from school and quality friendships. A study which supports this finding is one by Seifert (2005), which states that adolescents who have friends have better family relationships and more positive attitudes towards life, as they provide optimism and aspiration. Friendships can also compensate for inadequate families. For example, adolescents who have low levels of family cohesion but have close and supportive friends, have levels of self-worth and social competence equal to their peers who come from cohesive families.

Friends allow for high self-esteem (which includes freedom from depression) and self-worth, thereby promoting the exploration and development of personal strengths (Ryckman, 2008). Furthermore, adolescents who are engaged in friendships are more likely to be altruistic, display affective perspective-taking skills,
maintain positive peer status, and have continued involvement in activities such as sports or the arts. As such, these adolescents do not get the opportunity to engage in social ills such as drinking alcohol, experimentation with drugs and ultimately unsafe sexual behaviour (Rand et al., 2009). Although peers are very important to adolescents during this developmental stage, parents also play an influential role in adolescents’ lives. Compton and Hoffman (2010) found that adolescents whose friends and parents support academic achievement perform better than adolescents who receive support from only one, or neither. Hence, both parents and friends are important in adolescents’ development. Moreover, adolescents are less influenced by friends when they have close and involving relationships with their parents (Nolen-Hoeksema, 2008).

5.8. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO THE INFLUENCE OF THE MASS MEDIA

The media has long been tagged as one the things that influence people the most. It is so because, when one talks about the media, it covers radio, television and print. There is also electronic media which includes use the use of computers and other gadgets such as cell phones (e.g. Facebook, Twitter). With all the technology readily available to everybody, it cannot be denied that whatever adolescents see and hear, will have an effect on them.

This paragraph will interpret adolescents’ sexual behaviour with regard to the influences of the mass media. The learners have indicated that the media does not influence their sexual behaviour, for example 88.7% (N=156) of the learners indicated that the media did not influence their decisions on their sexual behaviour, while only 11.3% (N=20) of the learners indicated that they agree that the media has an influence on their decisions on sexual behaviour. Furthermore, the learners were
asked to indicate whether they surf the Internet to watch pornography. Only 17.3% (N=29) of the learners indicated that they watched pornography on the Internet and 83.5% (N=147) of the learners indicated that they do not surf the Internet to watch pornography. The youth represent the majority of the population. Adolescents and young adults are part of this group. They represent the most significant percentage of people who are self-conscious of their image; hence they are the target audience of producers and advertisers. The influence can either be good or bad, depending on how the individual responds. Parents can reduce the negative influence of media on adolescents by limiting and monitoring the programs which the adolescents watch. Parents should also teach the adolescents the values of self-worth so that the adolescents cannot be easily influenced by whatever is popular in the media.

The reason indicated by adolescent males for not surfing the Internet for pornography might be influenced by poverty as a result of caregivers’ unemployment as it is already explained in 5.6. When parents cannot afford to buy them (i.e. adolescents) cell phones or computers on which to download websites containing explicit sex, one could say it is advantageous to both the parents and adolescents themselves.

5.9. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO THE INFLUENCE OF CAREGIVERS

Research suggests that parents can strongly influence their adolescents’ sexual behaviour. The adolescents were asked whether or not their caregivers talk to them about safe sex practices and only 59.6% (N=105) of the learners indicated that their caregivers talk about safe sex practices as compared to only 40.4% (N=71) who indicated that their caregivers do not talk to them about safe sex practices. The implication of this finding is that, despite being raised by parents who may be
unemployed or working odd jobs, when there is secure attachment and positive communication in the family, chances are that adolescent males will practice safe sex and sustain monogamous relationships because parents warn them about HIV/AIDS and other sexually transmitted infections. These findings which indicate the positive influence that parents/or caregivers exercise on the adolescents are documented by various authors. For instance, Louw et al. (2007) and Pastorino et al. (2009), found that positive communication between parents and adolescents not only protects adolescents from developing anti-social behaviour but inculcates purpose in life, a sense of self-worth and accountability among adolescents.

Furthermore, adolescent males whose mothers discuss the social and moral consequences of being sexually active are less likely to engage in sexual intercourse (Guilamo-Ramos Jaccard, Dittus, & Bouris 2006). According to Bersamin, Todd, Fisher, Hill, Grube, and Walker (2008), teens whose parents watch television with them more frequently and limit their television viewing, are less likely to be sexually active. The more often parents watch television with their teens and the more they limit television viewing, the less likely adolescents were to have sex. Finally, Aspy, Vesely, Oman, Rodine, Marchall and McLeroy (2007), found that adolescents whose parents talk with them about standards of sexual behaviour were more likely to remain abstinent than peers whose parents did not.

5.10. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO INFLUENCE OF THE COMMUNITY

When asked whether their community members influenced their sexual behaviour, 10.2% (N=18) of the learners indicated that their sexual behaviour was indeed influenced by their community and the community members. The reason for this would be that, at community level, when the community lacks recreational
facilities, chances are that male adolescents will engage in alcohol abuse and risky sexual behaviour and when schools do not provide lessons that will help adolescents to make informed decisions regarding alcohol use and safe sex practice, adolescents are most likely going to indulge in alcohol and risky sexual behaviour (Panday et al. 2009).

5.11. INTERPRETATION OF THE ADOLESCENT’S SEXUAL BEHAVIOUR WITH REGARD TO THE INFLUENCE OF PEERS

The learners were asked if their peers had any influence on their sexual behaviour and 84.2% (N=148) as compared to 15.8% (N=28) of the learners indicated that their peers do not influence their sexual behaviour. The implication of this finding might be that these adolescents have a positive psychological well-being and a supportive family structure to such an extent that they do not easily fall under peer pressure. On the other hand, it might be that these adolescents have positive friendships with their peers. The literature which supports this finding is by DiClemente, Lodico, Grinstead, Harper, Rickman, Evans and Coates (1996), who found that the decision by friends to use condoms provides an example of positive peer influence on adolescent sexual behaviour and adolescents who perceived a supportive peer norm regarding condom use, were more likely (than adolescents who did not), to be consistent condom users.

Also, peers could be a good or a bad influence. In adolescent boys with a negative self-concept and external locus of control they tend to be encouraged by their peers to indulge in early sex during their teen years. They are likely to conform to a group and experiment with risk taking behaviour which could lead them to drink alcohol but when they are a good influence, they may encourage them to practise safe sex (Zhou, 2010).
5.12. RELIABILITY TESTING

The Cronbach Alpha for the 33 items in section B was 0.793, meaning that the questionnaires were relevant to the study of alcohol and sexual behaviour of adolescent males.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Squared Multiple Correlation</th>
<th>Cronbach’s Alpha if item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink Alcohol</td>
<td>.390</td>
<td>.791</td>
</tr>
<tr>
<td>Smoke dagga</td>
<td>.329</td>
<td>.793</td>
</tr>
<tr>
<td>Smoke cigarettes</td>
<td>.364</td>
<td>.788</td>
</tr>
<tr>
<td>Drink more alcohol with peers</td>
<td>.353</td>
<td>.795</td>
</tr>
<tr>
<td>Sexually excited after drinking alcohol</td>
<td>.322</td>
<td>.785</td>
</tr>
<tr>
<td>Negotiate safe sex</td>
<td>.375</td>
<td>.789</td>
</tr>
<tr>
<td>Physically abuse sex partner</td>
<td>.403</td>
<td>.792</td>
</tr>
<tr>
<td>Emotionally abuse sex partner</td>
<td>.480</td>
<td>.785</td>
</tr>
<tr>
<td>Sexually abuse sex partner</td>
<td>.563</td>
<td>.784</td>
</tr>
<tr>
<td>Become aggressive when partner wants to use condom</td>
<td>.340</td>
<td>.789</td>
</tr>
<tr>
<td>Inclined to demand sex when drunk</td>
<td>.325</td>
<td>.790</td>
</tr>
<tr>
<td>Contracted STI</td>
<td>.579</td>
<td>.783</td>
</tr>
<tr>
<td>Sex behaviour influenced by media</td>
<td>.438</td>
<td>.782</td>
</tr>
<tr>
<td>Browse the Internet for porn</td>
<td>.445</td>
<td>.783</td>
</tr>
<tr>
<td>Sex behaviour influenced by peers</td>
<td>.430</td>
<td>.784</td>
</tr>
<tr>
<td>Sex behaviour influenced by culture</td>
<td>.336</td>
<td>.787</td>
</tr>
<tr>
<td>Sex behaviour influenced by</td>
<td>.374</td>
<td>.787</td>
</tr>
<tr>
<td>Community members</td>
<td>VARIANCE</td>
<td>Std DEVIATION</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>Suggests to initiate porn movie</td>
<td>.378</td>
<td>.788</td>
</tr>
<tr>
<td>Caregiver smokes dagga</td>
<td>.492</td>
<td>.787</td>
</tr>
<tr>
<td>Caregiver smokes cigarettes</td>
<td>.393</td>
<td>.786</td>
</tr>
<tr>
<td>Caregiver has multiple sex partners</td>
<td>.406</td>
<td>.788</td>
</tr>
<tr>
<td>Caregiver warns me about HIV/AIDS</td>
<td>.467</td>
<td>.793</td>
</tr>
<tr>
<td>Caregiver talks to me about safe sex</td>
<td>.539</td>
<td>.789</td>
</tr>
<tr>
<td>School teaches sex education</td>
<td>.331</td>
<td>.793</td>
</tr>
<tr>
<td>Caregiver aggressive</td>
<td>.342</td>
<td>.785</td>
</tr>
<tr>
<td>Caregiver trusts me</td>
<td>.418</td>
<td>.793</td>
</tr>
<tr>
<td>Caregiver encourages me to study</td>
<td>.534</td>
<td>.795</td>
</tr>
<tr>
<td>Caregiver disciplines me when I change sex partners</td>
<td>.314</td>
<td>.784</td>
</tr>
<tr>
<td>Caregiver does not care if I sleep out</td>
<td>.358</td>
<td>.792</td>
</tr>
<tr>
<td>Peers have multiple sex partners</td>
<td>.485</td>
<td>.786</td>
</tr>
<tr>
<td>Peers physically abuse their sex partners</td>
<td>.598</td>
<td>.785</td>
</tr>
<tr>
<td>Peers emotionally abuse their sex partners</td>
<td>.699</td>
<td>.784</td>
</tr>
<tr>
<td>Peers sexually abuse their sex partners</td>
<td>.585</td>
<td>.789</td>
</tr>
</tbody>
</table>

Table 5.4. SCALE STATISTICS

<table>
<thead>
<tr>
<th>MEAN</th>
<th>VARIANCE</th>
<th>Std DEVIATION</th>
<th>N of ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>75.75</td>
<td>243.613</td>
<td>15.608</td>
<td>33</td>
</tr>
</tbody>
</table>
According to Louw et al (2007), when adolescent males are raised by caregivers who abuse alcohol, they are more inclined to also use alcohol than are those who do not experience alcohol/drug-taking in their homes. Adolescents who are exposed to such behaviour are more likely to model it and/or to consider it acceptable. Drawing from social learning theory, such adolescents may even be sexually aggressive towards their partners if their caregivers would fight with one another when under the influence of alcohol.

Today, adolescents with basic computer skills can find thousands of X-rated images with a couple of clicks of their computer mouse, and many adolescents are subsequently being overwhelmed with sexual stimuli before they have the developmental capacity to integrate the material into their healthy sexual identity formation and therefore they are not inclined to negotiate safer sex (Stack, Wasserman & Kern, 2004).

5.13. HYPOTHESIS

According to Weiten (2011), a hypothesis is a conjecture, a tentative statement or supposition about the relationship between two or more variables and is symbolised by H1, whereas the null hypothesis (Ho), refers to the statement of significant difference or the significant relationship between the two compared groups. For a Chi-square test, the null hypothesis is that the two sets of frequencies (i.e., observed and expected) are equal. The alternative hypothesis is that they are unequal.
5.14. CHI-SQUARE

In 4.6.1 above the Chisquare is explained. When applied to the test results the following is observed.

About 58.5 % (N=103) of the respondents agreed (irrespective of the strength of agreement, i.e. agree or strongly agree), that negotiation of safe sex is associated with alcohol consumption. The Chi-Square test of association however revealed the Chi-Square value of 34.529, degree of freedom of 16, and with a P-value of 0.005. This indicates that there is a significant association between alcohol and negotiation of safe sex and, consumption of alcohol and negotiation of safe sex. Refer to the table below:

Table 5.5. Chi-Square Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Asympt. Sig (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>34.529</td>
<td>16</td>
<td>.005</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>37.530</td>
<td>16</td>
<td>.002</td>
</tr>
<tr>
<td>Linear- to Linear Association</td>
<td>4.663</td>
<td>1</td>
<td>.031</td>
</tr>
<tr>
<td>McNemar-Bowker Test</td>
<td>65.480</td>
<td>10</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>176</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a.10 cells (40%) have an expected count of less than 5. The minimum expected count is 1.19

5.15. CONCLUSION

According to the data it is clear that adolescents who do not drink alcohol are more likely to use a condom, negotiate safe sex and that they are less likely to have
multiple sexual partners. In contrast, adolescents who drink alcohol have shown to be irresponsible and display a lack of empathy in the sense that they both emotionally and physically abuse their sexual partners, their care-giver/s smoke dagga and are aggressive. Furthermore, these adolescents do not receive sex education at school, their sexual behaviour is influenced by the mass media, their caregivers do not discipline them when they change sexual partners, their peers sexually abuse their sexual partners, they become aggressive when their partner wants to use a condom and they are at risk of contracting sexually transmitted infections (STI’s).

These findings support the literature study findings that when adolescents do not have a positive psychological well-being, they tend to be less motivated, more aggressive and may engage in risky and deviant behaviour.

Regarding the person taking care of the adolescent, the data has revealed that parenting styles play quite a significant role in the development of adolescents.
CHAPTER 6

SUMMARY, RECOMMENDATIONS AND CONCLUSION

6.1. INTRODUCTION

In this chapter the results of the study are summarised and explained. The limitations and implications of this study, as well as suggestions for future research are provided. The chapter concludes with a summary of the entire thesis.

6.2. OVERVIEW OF THE STUDY

It appears that alcohol consumption and risky sexual behaviour is the norm among teenagers and young people. Every day, adolescents face many pressures with regard to alcohol consumption and sexual decisions. There are many factors that contribute to alcohol abuse and high-risk sexual behaviour in male adolescents. These factors include in a non-exhaustive list, individual factors such as psychological and behavioural influences, family influences such as parent-adolescent relationship and parenting styles, dysfunctional families, peer influences, poverty and the mass media.

The purpose of the study was to investigate the impact of alcohol on the risky sexual behaviour of male adolescents. The general hypotheses of this study was, firstly, that male adolescents who drink alcohol frequently are more likely to have multiple partners and secondly, male adolescents who drink alcohol frequently are less likely to use condoms.

There are many theories about adolescent risky sexual behaviour but none agree on the particular reasons why adolescents would participate in such behaviour, which makes this social phenomenon a complex issue that deserves
further research. Effective mediation programmes require research that clinches numerous aspects of risky behaviour, including awareness on how and to what extent, different types of risky behaviour are relate to each other. Research in this regard would provide intervention planners with specific information that would make interventions more target specific and effective.

6.3. BRIEF SUMMARY OF OVERALL STATISTICS

176 male adolescents from one school in the Nkonkobe Municipality participated in this study. These learners were in grade ten, eleven and twelve with ages ranging from a low of 14 to a high of 25 years. 35.2% of learners were in grade 10, 34.1% of learners were in grade 11 and 30.7% were in grade 12. All the participants were Xhosa speaking.

46.6% of the learners strongly disagreed that they drink alcohol, while 24.5% indicated that they agreed to drink alcohol and 29.0% indicated that they were neutral to this statement. 60.3% of the learners indicated that they disagreed that they drank more alcohol when in the company of their peers and 39.7% of the learners agreed to drinking more alcohol when they are with their friends.

When asked to indicate whether their sexual excitement was influenced by them drinking alcohol, 69.1% of the learners disagreed with that while 30.1% (N=53) of the learners agreed that they become sexually excited after drinking alcohol. Furthermore, when asked whether they were inclined to demand sex when they were drunk, 81.9% of the learners disagreed with this statement while 18.1% of the learners agreed.
Of the 176 learners, only 9% indicated that their caregivers smoked dagga, 58.5% of the learners indicated that they agreed on negotiating safe sex with their partners and only 41.4% disagreed with negotiation safe sex.

88.7% of the learners indicated that the media did not influence their decision on their sexual behaviour, while only 11.3% of the learners indicated that the media has an influence on their decisions on sexual behaviour. Furthermore, only 17.3% of the learners indicated that they watched pornography on the Internet and 83.5% of the learners indicated that they do not surf the Internet to watch pornography. 66% indicated that their peers did not have multiple sex partners. 84.2% of the learners indicated that their peers do not influence their sexual behaviour. The school also have an influence on the sexual behaviour of the adolescent. Only 51.7% indicated that they receive sex education at school.

The above statistics suggest that a changing pattern has begun to emerge in young peoples’ sexual behaviour. The above data provides reasons for optimism, as it is common knowledge as previous research have indicated, that adolescents’ sexual behaviour is characterised by risk taking such as alcohol use, multiple sexual partners and unprotected sex. The National Health risk behaviour survey found that 8 out of 10 college students (between the ages of 18-24) have had intercourse and that 25% have had 6 or more partners, with fewer than 25% reporting always using a condom (Cooper, 2002).

6.4. LIMITATIONS OF THE STUDY

There are a couple of limitations in this study. Firstly, discussions around sex and sexuality are quite sensitive and some respondents may not have been completely honest while answering the questions, although they were assured of
privacy and confidentiality. Secondly, as the responses were self-reported, it was expected that respondents might deliberately conceal responses or might provide responses that are subject to limited recall. Another limitation of this study is that the sexual behaviour questions only included vaginal sexual intercourse and no other forms of sexual activity such as oral sex or anal sex. While measures were taken to reduce these inaccuracies, it is likely that the proportion of respondents that engaged in high risk activities is actually higher than what was reported in the study. While the researcher was fluent in both English and the local language (IsiXhosa), there might have been instances where questions asked could be misinterpreted by respondents upon translation.

6.5. SUGGESTIONS FOR FUTURE RESEARCH

Future studies could be conducted to compare risky sexual behaviour between male and female adolescents. Studies should be conducted to determine whether young people/students had undergone HIV testing and have knowledge of each other’s HIV status, as well as current sexual negotiation scripts. These studies could provide crucial data for educating young people about the consequences of their positive and/or negative sexual behaviour.

6.6. IMPLICATIONS OF THE STUDY

This study confirms (though not statistically significant), the existing link/relationship between alcohol use and unsafe sex practices such as none/inconsistence condom use and multiple sex partners.

As young people in South Africa become sexually active at an early age, schools should initiate programmes to prepare adolescents against risk-behaviour such as HIV/AIDS, substance abuse and crime.
Public health efforts should continue to be aimed at promoting consistent condom use and monogamy in young people who are already sexually active and choose to continue so, as it decreases (although not fully eliminate), the likelihood of transmitting STI’s, including HIV.

Abstaining from sexual intercourse should therefore remain (or become), a major focus of primary preventative measures in order to decrease teenage pregnancy, STI’s and HIV infection. Young people who have been previously sexually active could be convinced of the benefits of postponing future sexual activity (American Academy of Paediatrics, 2001). This intervention process is promoted through Bandura’s (1994), Social-Cognitive Theory - supporting the idea that young people will display the motivation to learn a new skill or behaviour when they believe it to be a useful and effective in practice.

Finally, whilst the exact extent of alcohol consumption as a risk factor for enhancing HIV transmission is unclear, alcohol abuse and risky sexual behaviour, prevention and/or reduction should be integrated into life-skills and HIV/AIDS education lessons. This should be done simply because alcohol- and other drug abuse are major causes of crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability and the escalation of chronic diseases such as AIDS (Parry & Abdool-Karim, 2000).

This time-period is critical for implementing health-protection programmes in the lives of young people, as many adults who are currently living with HIV/AIDS, were infected during adolescence (Parry & Abdool-Karim, 2000). By investing in the prevention and reduction of alcohol use and risky sexual behaviour, the spread of HIV/AIDS is both prevented and controlled.
6.7. CONCLUSION

It was expected that alcohol use among male adolescents would lead to an increase in unsafe sex practices such as non-condom use and multiple partners, and that male students would be more likely to use alcohol before sexual activity.

These hypotheses were only partially supported. Never the less, descriptive results revealed that alcohol users were more likely to engage in unsafe sex practices (i.e. multiple partners and non/inconsistent condom use).

Despite results confirming the link and/or relationship between the above-mentioned variables the overall picture of this study reveals an increase in safer sex practices among adolescents. There appears to be a shift to committed relationships, an increase of condom use and a decrease in engaging with multiple sex partners. In addition, the vast majority of learners report to have decreased possible HIV infection by abstaining, using a condom more often, and having fewer sexual partners.
REFERENCES


expectancy as moderators of alcohol’s relationship to condom use.

Experimental and Clinical Psychopharmacology, 8


Rinehart & Winsten Inc. New York


Kaiser Family Foundation, (2002). Youth Knowledge and Attitude on sexual
health: A national survey of adolescence and young adults. National Centre on
addiction & substance abuse (CASA) Columbia University.

edition. Harcourt College Publishers, the University of California.

Kharsany, A.B.M., Mlotshwa, M., Frohlich J.A., Zuma N.Y., Samsunder N.,
opportunities for schools – based HIV testing programme & sexual reproductive

adolescents in Soweto. [MEd dissteration]. University of Johannesburg: Johannesburg

Kirby, D.B., Baumler, E., Coyle, K., Basen–Engquist, K., Parcel, G., Harrist
R., & Banspach, S.W. The “Safer Choices” Intervention: Its impact on the sexual
behavior of different subgroups of high school students. Journal of Adolescent
Health. 442–452.

style & alcohol use among university students. Journal of Youth and Adolescence
33(3).


Ryff (1989) The *Ryff Scales of Psychological Well-Being*


