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Effects of Client Centred Therapy and Reality Therapy in Fostering HIV Voluntary Counselling and Testing among the Secondary School Students in Oyo State Nigeria.

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Abstract

Voluntary HIV testing is being currently adjudged as one of the major ways by which one's HIV status can be ascertained so as to either maintain a negative status or seek health care services in case one is positive. However, submitting oneself to HIV test voluntarily has become difficult even among the elites due to various reasons, ranging from fear of being tested positive to HIV, misinformation, stigmatisation and discrimination. Counselling with an appropriate method remained the only way to achieve this. The objective of this study is to investigate the effectiveness of client centred and reality therapies in the improvement of VCT among secondary school students. the pre-test, post-test, control group, quasi-experimental design with 3x2x2 factorial matrix was used. Stratified simple random sampling was adopted in selecting 120 participants from three public secondary schools in Iseyin. Participants were subjected to six weeks of training in client centred therapy and reality therapy while participants in the control group received no training. Voluntary and counselling testing scale was used to collect data from the respondents. Data obtained were analysed using analysis of covariance (ANCOVA). Findings revealed that the students in the two experimental groups were significantly higher in their acceptance of HIV testing than those in the control group. This indicated that CCT and reality therapy were effective in fostering VCT.($F=22.46$, $df2, P<0.01$). Reality therapy was however most effective in fostering VCT and therefore, clinical psychologist, social workers, counselling and health care providers could make use of it in solving HIV/VCT related problems.

Introduction

It is no gainsaying that the HIV/AIDS epidemic is spreading far more than even assumed despite the continuous attempts to ameliorate the scourge. Global summary of HIV/AIDS epidemic (2005) avers that 40. 3 million people were living with HIV among which children less than 15 years of age were 2.3 million. The problem gets worse considering that 80% of the above estimation resides in sub Saharan Africa (SSA) (UNAIDS, 2000) and many do not know they have the virus. In lieu of this, it is opined that if we were able to prevent further transmission of HIV, we would still expect about 69,000 adults and 39,000 peadriatric AIDS cases between 1991 and 1995. The same argument still holds owing to the fact that there is no visible cure exits but only attempts at reducing the viral load is feasible (Menakaya, 1998)

According to Popoola (2003) in the absence of a known cure, the only alternative is a change in behaviour via an organised strategy. Fawole, Asuzu, Oduntan and Brieger (1999) re-echoed this viewpoint when they concluded from a study that attitude could be changed once there are convincing reasons for change. Among the diverse ways suggested in managing the problem one important strategy that seemingly depicts potent effectiveness is Voluntary Counselling and Testing, (VCT). Ekanem and Gbadegesin (2004) described aver that VCT is the process in which an individual undergoes confidential counselling to enable the individual to make an informed choice about learning his/her HIV status and to take appropriate action. VCT provides the opportunity for the client to confidentially explore and understand the inherent risks and his/her HIV infection status with the support of a counsellor. VCT is a core part of prevention but can also be seen as an entry point to care and support for HIV - infected individuals.

Gilliam and Straub (2009) report the efficacy of VCT in decreasing risky behaviours at individual levels in largely healthy populations. This is because VCT is an HIV-prevention intervention initiated by the client at his or her free will. Notably, the voluntary nature of VCT is one of its

fundamental principles. The counselling consists of pre-test, post-test and follow-up. The entire objective of the process is strategised to enable individuals assess their HIV risk behaviours, develop a risk reduction plan, access HIV testing, adopt risk reduction behaviour and access medical and psychosocial referral services. Apparently, if VCT is to be effective it must first be accepted.

Submitting oneself to HIV test voluntarily has however become difficult even among elites. Patrick (2008) maintains that poverty, lack of awareness, insufficient health facilities and poor attitudes are challenges impede submission to VCT. Notably, even when people take the test the fear of stigmatisation, if sero-positive, usually makes such persons not to return for counselling. As a result, many avoid VCT as if the test is the symbol of the virus itself. This problem may be attributed to the lack of the knowledge and understanding of the potency of counselling in managing and ameliorating the problem. In the opinion of Ojebode (1999), proper counselling from a trained counsellor is vital to the effectiveness of VCT. Akinboye and Adeyemo (2002) affirm that proper counselling could serve as an adjunct to medical intervention at all levels of preventive medicine. This view finds congruence with Orlans' (1996), expressed position on the subject. In this report, the effects of two therapeutic techniques in the fostering of VCT service particularly among secondary school students would be explored.

Client Centred Therapy and VCT

This is a form of humanistic therapy developed by Carl Rogers (1961-1980) in which the therapist provides a warm, supportive atmosphere to improve a client's self-concept and encourage him/her to gain insight into his/her problems. The theory is premised on an optimistic view of humankind and emphasised an unconditional positive regards to the client. It is generally conceived that the theory of client-centred therapy should be applied in HIV/AIDS counselling because it has advantage of making a client become self-confident and self-directing and as well as coming to terms with the fact that stigmatisation is not a barrier in

HIV/AIDS counselling and testing. He stresses further that such a client becomes flexible, changes is maladaptive behaviour, and thereby, adopts more mature attitude. This study would attempt to unravel the efficacy of the client-centred approach in facilitating HIV/VCT.

Reality Therapy and VCT

Reality therapy is practiced and taught in many cultures and countries, based on universal principles. The underlying theoretical basis states that all human beings are motivated by five current genetic instructions: survival or self-preservation, belonging, power or achievement, freedom or independence, and fun or enjoyment. Reality therapy emphasises choice and responsibility in connecting with others. It challenges the traditional view of mental illness, avoids focusing on symptoms, and rejects the notion of transference. Further, it maintains a "here and now" focus on choice, responsibility, commitment, and willingness to change. The effective reality therapist learns to adapt the methodology to individuals and groups from many cultures. The delivery system employs specific tools for helping clients identify and clarify their wants and desires, their hopes and dreams. Wubbolding, Al-Rashidi, Brickell, Kakitani, Kim and Lennon (1998) used the acronym WDEP to describe the key elements in counselling process of reality therapy: W = wants (what the client is looking for, what will make life better); D = doing (what the client is doing to bring about the wants and what is interfering); E = evaluation (is the client's behaviour working?), and P = planning (what the client is willing to do differently). An essential tenet of reality therapy is commitment.

Glasser (2005) notes that people can control only their own behaviour and that their level of commitment and how hard they are willing to work will dictate how successful they will be in developing new behaviours that clearly communicate their needs and help in attaining fulfillment. He further asserts that a person will not make a change in behaviour until the following two prerequisites are met: (a) using his or her own evaluation, an individual must decide that present behavior will either not attain what

is desired or take the person in the desired direction; and (b) an individual must believe that he or she has available another behaviour that will permit his or her needs to be satisfied reasonably well. The therapy has been applied to a plethora of clinical and counselling populations, including those facing financial management issues (Mottern and Mottern, 2006) athletes (Klug, 2006), and even catastrophic illness (Weisler, 2006). This study is an attempt to investigate its effectiveness in VCT.

Research Hypotheses

1. There is no significant difference in the choice of HIV/VCT of participants exposed to client centre therapy (CCT) and reality therapy and those in the control group.
2. There is no significant difference in the choice of HIV/VCT of participantly exposed to CCT and those exposed to reality therapy.

Methodology

The study adopted the randomised pre-test, post-test and control group quasi-experimental design with a 3x 2x 2 factorial matrix. The row consists of the two intervention groups and the control group. The row was crossed with the level of readiness varied at two levels (high and low). The varied levels of readiness is further delineated according to gender (male and female) of the participants.

Sample

Using simple random sampling, 120 Senior Secondary School students 11(SSS2) were selected for the study from three randomly selected schools within Iseyin, in Oyo State Nigeria. These were separated into three groups of forty (40) each (two experimental groups and control group).

Instrument

A self-developed scale was used for the study. The instrument, VCT scale comprises ten items, structured on a five-point likert format with responses ranging from strongly agree to strongly disagree. High scores implies readiness for VCT while low scores implies lack of readiness. The instrument was pilot-tested on some selected students and validated via an internal method of validation. The test reported a test retest reliability coefficient of 0.68 after an interval of four weeks.

Procedure

The procedure was organised in three phases, recruitment, treatment and post treatment evaluation. At the recruitment phase, the students were randomly selected and assigned into three equal groups, the two experimental groups and the control group. Only the two experimental groups were treated using client centred and reality therapy programmes for eight weeks. Afterwards all the groups(including the control) were post-tested with the study's instrument.

Data Analysis

Analysis of covariance is the major statistical tool used in testing the hypotheses in this study.

Results

Table 1: Analysis of covariance for the choice HIV/VCT, assessment scale between treated participants and the control group

Source of variation	Sum of squares	df	Mean squares	f- ratio	p
Rows	88.754	2	44.377	22.46	<0.01
Columns	.011	1	.011	.01	NS
interaction	1.154	2	.577	.29	NS
Within	4504.711	114	1.976		

Table 1 shows analysis of covariance on the choice of HIV/VCT assessment scale variable. The rows consist of the two treated groups and the control group. The columns comprise three levels of the choice of HIV/VCT (low and high) and the interaction describes the relationship of rows and columns. From the rows, there is a significant difference in the choice of HIV/VCT assessment scale scores of the treated groups and the control group ($F = 22.46$, $DF = 2/114$, $P< 0.01$). This shows that the treated groups benefited significantly from the treated programme compared to the control group. Therefore, the hypothesis of no significance is rejected.

Table 2: Analysis of covariance for the choice HIV/VCT, assessment scale between both treated groups.

Source of variation	Sum of squares	df	Mean squares	f- ratio	p
Rows	43.684	1	43.684	16.03	<0.01
Columns	.436	1	.436	.16	NS
interaction	.142	1	.142	.05	NS
Within	4141.965	76	2.725		

In Table 2, the rows consists of the two treatment groups client centred therapy and reality therapy. The columns consist of HIV/VCT (low and high) while the interaction shows the relationship between rows and columns. From the Table, it is observed that there is a significant difference in the choice of HIV/VCT scores of the client centered therapy and the reality group as shown by the rows ($F = 16.03$, df 1/76, $p< 0.01$). This shows that the client centered group benefited significantly higher than the reality group. Therefore, the hypothesis of no significance is rejected.

Discussion

The difference between the treated groups and the control group is as a result of counselling that has taking place. This finding finds congruence with Fawole, et al (1999) who conclude that attitude could be changed once there are convincing reasons for change. This change as averred can only occur as a result of proper counselling which this intervention programme has elicited. Akinboye and Adeyemo (2002) affirm that proper counseling could serve as an adjunct to medical intervention at all levels of preventive medicine. The position is that, with the guided and supporting approach of counselling one could only be better positioned to make strong decisions such as the decision to take an HIV testing. The view further finds congruence with the position of Anslem (1989) in his standpoint on conceptualising counselling. Hence, it is highly beneficial to provide adequate counselling service in VCT.

The second hypothesis which predicted that there would be no significant difference between the two treatment groups was rejected based on the results. The reality therapy group clearly demonstrated superiority over the client centred group. This could have occurred as a result of knowledge and learning experience the reality therapy group was exposed to during the therapy. Again, the vivacity associated with therapeutic approach of reality therapy as well as a resolution that is borne on the reality of occurrences could be a possible explanation for this finding. It should be noted that the reality therapy tends to focus more on enabling an individual become more responsible with self and occurrence with self. Glasser (2005) adds that people can control only their own behaviour and that their level of commitment and how hard they are willing to work will dictate how successful they will be in developing new behaviours that clearly communicate their needs and help in attaining fulfillment. In addition, it could be opined that while some evidences indicate that client centred therapy is effective with wide-range of individuals and problems, the evidence is not systematic or complete enough particularly in respect to clients who accept little responsibility of

their problem as in reality therapy. Based on this, the current finding may not be surprising.

Conclusion and Recommendation

Although, awareness programme are put in place, many people are yet to come to terms with the reality of HIV/AIDS and the centrality of utilising counselling opportunities. People lack the boldness to seek HIV/VCT, for fear of testing positive, stereotyped and/or stigmatized. Expectedly, counselling is a veritable tool and appropriate vehicle to break the barriers noted and facilitate testing. This study has demonstrated that HIV/VCT can be promoted and facilitated using any of the therapies explored in this study. Despite that reality therapy has not been used in HIV/VCT studies, the findings of this study have shown that it could be a potent facilitator for providing VCT. Based on this, it is of paramount importance that counsellor and health care providers can make use of these therapeutic approaches in resolving HIV/VCT-related problems.

References

Akinboye, J.Ò. and Adeyemo, D. A. /2002/ *Psychological principles for coping with stress in life and workplace.* Ibadan, Stirling-Horden.

Anslem, D.A. /1989/. *Theory of counselling and psychology.* Ibadan: Patrike.

Ekanem E. E. and Gbadegesin, A. /2004/. Voluntary counselling and testing (VCT) for human immunodeficiency virus: A study on acceptability by Nigerian women attending antenatal clinics. *African Journal of Reproductive Health.*8 (2):91-100.

Gilliam, P. and Straub, D. M. /2009/. Prevention with positives: A review of published research, 1998-2008. *Journal of the Association of Nurses in AIDS Care,* 20,2 92-109.

Glasser, W. /2005/. *Treating mental health as a public health problem.* Chatsworth, CA: William Glasser Institute.

Fawole, O Asuzu, M. C. Oduntan S. O. and Brieger W. R.(1999). A school-based AIDS education programme for secondary school students in Nigeria: A review of effectiveness. *Health Education Research*, 14 5, 675-683.

Menakaya, /1998/. Issues *in HIV/AIDS and STIs.* Lagos: Begko.

Klug, K. /2006/. Applying choice theory and reality therapy to coaching athletes. *International Journal of Reality Therapy, 25*(2), 36 -39.

Mottern, A and Mottern, R. /2006/. Choose wealth: A choice-theory-based financial management programme. *International Journal of Reality Therapy, 25*(2), 16–22.

Ojebode S. O. /1999/. *Psychology made simple.* Ilorin: Tessa.

Orlans, V. /1996/. Counselling psychology in the workplace. In Wolfe, and Dryden W. (Eds), Hand book of counseling psychology *London: sage publication.*

Patrick S. A. /2008/. *Short notes on medical pathology.* England: Mican.

Popoola /2003/ *Guidance and counselling education for tertiary institution.* Lagos. Peace. Publishers (Nigeria) Limited.

Rogers, C. /1975/ Empathic an unappreciated way of being. The Counselling Psychologist*; 5(2):2-10.*

The Voluntary HIV-1 Counselling and Testing Efficacy Study Group. /2000/ Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: A randomised trial. *Lancet,*356:103–112.

UNAIDS. /1999/. *Counselling and voluntary HIV testing for pregnant women in high HIV* prevalence countries: Elements and issues. Geneva: UNAIDS.

UNAIDS. /2000/. *Global summary of HIV/AIDS epidemic.* Lagos: FMOH.

Valdiserri, R. O. HIV counseling and testing: its evolving role in HIV prevention. *AIDS Education Preview* 1997. 9:2-13.

Weisler, S. /2006/. Cancer as a turning point in life. *International Journal of Reality Therapy, 26*(1), 27–28

Wubbolding, R. E., Al-Rashidi, B., Brickell, J., Kakitani, M., Kim, R. I. and Lennon, B. /1998/. Multicultural awareness: Implications for reality therapy and choice theory. *International Journal of Reality Therapy*, *17*(2), 4–6